Contributing to Health Reform:

Urban Aboriginal Women Speak Out

by

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Acknowledgements

My journey over the last several years has touched my life in so many ways and helped shape me into a proud Métis woman. The journey was filled with ‘aha’ moments, challenges, heart crushing sadness, disbelief, joy, amazement and respect.

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Dedication

I dedicate the writings and teachings in this document to my family, my parents who have believed in me, to my children who have taught me, and to All My Relations that have gone and those to come. To the urban Aboriginal women who inspired me in this work and the new horizons that have arisen.

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Abstract

In this thesis I critically examine Canadian Aboriginal women's experiences, most particularly Aboriginal women residing in British Columbia, of their health care and their visions for health care reform. Using Indigenous Methodology to guide the research, I honoured cultural traditions and protocols that required me to include the urban Aboriginal women participants in all aspects of the project. That was fundamental to my success in navigating Western and Indigenous worldviews, philosophy, and protocols.

This community-based Indigenous led research used traditional Talking Circles to create a culturally safe environment for urban Aboriginal women to talk about their health care experiences. Listening to their stories helped me understand the historical, socioeconomic, and political practices that are root causes of Aboriginal health disparities.

Through the Talking Circles, the women also formed their collective vision for change. They formulated what I called a 'Taking Action Strategy' that promotes respectful non-racist, non-discriminatory health care. They have already begun to enact this strategy with health care providers, educators, and policy makers.

Throughout the thesis, I share a personal account of my journey as an Aboriginal researcher walking the borderlands between academic and Indigenous worldviews. The fluid, nonlinear, unpredictable pathway, common in Indigenous Methodologies, challenged some seemingly unyielding university policies. I had to find a way to stay true to Indigenous Methodology, whilst respecting the requirements of the academy. From this experience I offer some ideas for working within the university without losing sight of respect, commitment, accountability, and the benefit of research to Indigenous peoples.

Key Definitions

These key definitions have been provided as a way of ensuring clarity throughout the document.

In Canada, the term *Aboriginal*, is a collective name of the original people of North America which refers to First Nations (historically referred to as Indian), Métis and Inuit (Constitution Act, 1867). These three distinct groups have unique histories, languages, cultural practices and spiritual beliefs. Some people may fit into more than one of these categories. According to the 2006 Census (Statistics Canada, 2009), over one million individuals in Canada identify themselves as an Aboriginal person. The term *Indigenous* refers to Aboriginal peoples globally (Indian and Northern Affairs Canada, 2010).

The terms *Indian* and *native,* although replaced by the term *First Nation*, continue to be used interchangeably because these terms are used in the Constitution Act 1982 (Constitution Act, 1867) and the Indian Act. The *Indian Act* (Indian Act, R.S.C. 1985) first passed in 1876, and amended numerous times over the years categorizes First Nations people as *status Indian* and *non-status Indian* (Hurley, 2009). Throughout Canada, there are groups or societies of First Nations people, *bands,* who share the same geographic, political or Aboriginal culture and linguistic lines.

A *band* is a group of Indians who have common values, traditions and practices rooted in their ancestral heritage and whose land and benefits of the land along with money, have been set aside by the government. Today, many bands prefer to be known as First Nations (Indian and Northern Affairs Canada, 2010). Each band has its own governing band council that often consists of one chief and several councilors. Members of the band have varying entitlements: to live on reserve, vote for band council and chief, share in band moneys, and own and inherit property on band reserves (Indian Act, R.S.C. 1985; Hurley, 2009).

Status Indian, also referred to as a *Registered Indian,* is a person who is registered under the Indian Act of Canada and is identified as such to federal and provincial governments. *Treaty Indian* refers to a First Nation or a member of an Indian band that signed a treaty with the Crown. Registered or Treaty Indians are Status Indians. Registered Indians are entitled to a range of programs and services administered by federal agencies and provincial governments (Indian and Northern Affairs Canada, 2010).

A *non-status Indian* is an Indian person who is not registered under the Indian Act because he or she has either not applied to be registered under the Act or even though a descendent of persons who are registered under the Act, has lost their status rights and is not entitled to be registered under the terms of the Act (Statistics Canada, 2007b).

On-reserve Indian or First Nation people are those that reside on government designated land, *reserve*, set aside for specific groups as part of the Indian Act. *Off-reserve* Indian or First Nation people refers to those who are not part of a reserve. *Urban* Aboriginal people refers to Métis, Inuit, and First Nation, who may or may not be *status, treaty,* or *registered* Indians, and who reside in urban areas.

The term *Métis* refers to Aboriginal people who are from mixed First Nation and European heritage and identify themselves as distinct from First Nations, Inuit, and non-Aboriginal people of Canada (Métis Nation, 2011; Royal Commission of Aboriginal Peoples of Canada, 1996).

The term *Inuit*, replaces the term Eskimo, and refers to Aboriginal people who reside in specific northern regions of Canada (Nunavut, Northwest Territories, Northern Quebec and Northern Labrador) (Indian and Northern Affairs Canada, 2010).

A *Treaty* is a legal agreement between the Canadian government and First Nations communities throughout Canada, with the exception of British Columbia. Through negotiation, First Nation Chiefs sign over the band rights, titles and privileges to land in exchange for designated areas of lands that cannot be claimed by settlers or non-Treaty Indians. The agreement includes rights responsibilities and relationship about land ownership, roadways, forestry, fisheries and other natural resources; wildlife management; environmental protection governance and intergovernmental relations; financial benefits to the Band, and taxation laws (Province of British Columbia, 2007).

Residential schools, defined as the Residential School System of Canada, were institutions attended solely by Aboriginal children as mandated by the Canadian government. They were named variously as industrial schools, boarding schools, boarding day schools, homes for students, hostels, billets, residential schools, with the majority of day students or a combination of both. Residential schools also evolved to include convents, day schools, mission schools, sanatoriums, and settlement camps (Reimer, Bombay, Ellsworth, Fryen, & Logan, 2010). These were operated by various religious organizations with a commitment to Christianity. The teachers and administrators of the schools were non-Aboriginal missionaries, priests, and nuns. This system was considered part of the assimilative policies that the Canadian government directed at Aboriginal peoples from the 1880s onward.

CHAPTER 1: THE JOURNEY

Situating the Journey

In this study I explore the experiences of fourteen urban Aboriginal women and their encounters within the Canadian health care system. My experiences as a nurse led me to understand that Aboriginal people have poorer health relative to white people and I wondered why this was so. In addition, I was involved in a previous study in which Aboriginal women told some stories about receiving poor health care and so I had a beginning, though unsophisticated, understanding that all was not well. I was also interested to know what these women wanted from the health care system; what they thought was missing that resulted in health inequities, and what they thought could be done to result in improvement of their own health and that of their families, while at the same time positively influencing the nature of their encounters with health care professionals.

The aim of my study was specifically to provide a safe environment for urban Aboriginal women to share their experiences of health care and their vision for health care reform. To address these aims, I formed two research questions:

1. What has been your experience of health care in Canada; and
2. What is your vision for health care reform?

There was another underlying aspect to my interest in undertaking this study. For most of my life I did not know I was Aboriginal and I was largely ignorant about the history of Aboriginal people. I was unaware of the real picture of Aboriginal people's health. Once I discovered, or more truthfully perhaps, accepted my Métis heritage, I became determined to address my ignorance. The more I read and the more I listened to my women Aboriginal friends and colleagues, the more I understood that issues existed with Aboriginal health generally, which led to my passion to explore with urban Aboriginal peoples' their experiences with health care in my local area. At that time I had no inkling of how absorbed I would become in this study nor how powerfully it would impact me personally. Having written this, I acknowledge that not all people of Indigenous descent wish to claim their Aboriginality or live within an Aboriginal worldview. I make no claims about these people one way or another. Instead, I focus on my own journey and the stories of the Aboriginal women who participated in this research.

1.1 Commencing the Journey

One thing I did know, right at the outset, was that if I wished to study an Aboriginal question it needed to be with the full support and participation of the Aboriginal community. I had developed a solid relationship with an Elder who guided me through the preliminaries that I needed to consider before I did anything at all in relation to carrying out this study. This Elder taught me that it was crucial to find appropriate and culturally safe pathways that best fit with what the women who joined the study wanted and would accept as relevant and meaningful. As Smith (1999) stated, the process, methodology and method in collaborative community-based research is far more important than the outcomes of the research. This research needed to be respectful, safe, to prioritize the women's voices and to be guided at all times by the women themselves. Thanks to my Elder mentor, that much I knew. With her help and after much consideration and consultation with Aboriginal and non-Aboriginal colleagues, family and Elders I embarked on my doctoral studies.

This study is grounded in an Indigenous perspective. Indigenous ways of being and protocols guided the direction of the inquiry processes and decision making every step of the way, from shaping the human ethics application, to review of the literature, methodologies, information gathered, and the sharing of knowledge generated.

The Indigenous perspective generated a research approach that I used and that can inform researchers within universities who wish to work with Aboriginal people or communities. The journey I now describe with the reader is not only about critique of theory or ‘book learning’ about Indigenous knowledge, research methodologies and methods, but it also details insights I gained into how an Indigenous academic can remain authentic to a non-traditional methodology and present it in a scholarly way to the academic world.

The methodology chosen was a living process, not a static framework, model, or flowchart of step-by-step lists of things to do along the way. The study and methodology were developed, monitored, implemented and evaluated by myself in collaboration with doctoral supervisors; community Elders and particularly the Elder who was and is my mentor; the women who participated in the study; the study Advisory Committee; and the study Steering Group. The Advisory Committee included members who were Aboriginal and experts in Indigenous research, education and culture. They oversaw Stage 1 of the research. The Steering Group consisted of women who participated in the study who wanted to take on a collaborative leadership role and become more intimately involved in the research.

Talking Circles and gatherings were used as culturally safe ways for urban Aboriginal women to share stories of their health care experiences as well as their visions for change. The work presented in this dissertation is based on stories shared by the women. The stories are not fictional or fantasy, they tell of real encounters with health care services and personnel in several places throughout

Canada, but mainly in the Interior of British Columbia. It is through storytelling that the realities of these women's lived experiences came alive and exposed the colonization of Canadian Aboriginal peoples that is both historical and contemporary.

The voices of the urban Aboriginal women who participated in this inquiry unfolded the intimacies of the women's day to day lives living as colonized persons and how they manage each and every day in a world that is often unjust and cruel. The women continue to endure unjust experiences just because they are Aboriginal. The stories shared are often painful though at other times there is joy and celebration related to successes in life. A vital finding of this thesis is the wisdom of the urban Aboriginal women and particularly the ways in which they were prepared to speak out and act on behalf of themselves, their families and their community.

1.2 Outlining the Journey: Overview of the Thesis

The study described in this thesis was a two-stage project. In Stage 1, urban Aboriginal women, Elders, Aboriginal and non-Aboriginal registered nurses and nurse educators, were invited to form Talking Circles to firstly engage in dialogue describing their experiences with Canadian health care services. Secondly, the women were encouraged to identify strategies that could be used by health care providers, Aboriginal and non-Aboriginal health care professionals and policy makers, to promote and provide respectful, non-racist, non-discriminatory health care for Aboriginal people.

A local urban Aboriginal Centre and Aboriginal youth agency welcomed us and provided a place for our Talking Circles and most gatherings to occur. Gatherings included meetings with the women, the Advisory Group and the Steering committee. In all, four Talking Circles were conducted, facilitated by myself with one of the Elders.

Following analysis of the stories told in Stage 1, a second stage was envisioned. Stage 2 was to consist of forming a Steering Group comprised of interested Aboriginal women participants of the Talking Circles. This Steering Group would co-lead the rest of the study. People from various professional groups such as social workers, medical doctors, health professional educators, policy makers and others considered by the Steering Group to be influential, were to be invited to join future Talking Circles and engage in dialogue about visions for health care reform. Stage 2 did not eventuate as planned. The reasons for this and how this stage was reconceptualized and conducted will be detailed in chapter 5 of this thesis.

The knowledge that shaped my research journey and from which a collective Indigenous vision for health care reform emerged, came not only from the women. A comprehensive review of the literature, conversations and teachings from Aboriginal and non-Aboriginal scholars, colleagues, researchers, and community members all contributed. This inquiry highlighted the importance of knowing the history of Aboriginal people to understand the influence of historical contexts on the health and wellbeing of Aboriginal people in Canada and other parts of the world.

1.3 Mapping the Journey

I use a non-traditional approach to the presentation of this thesis. I do not use the chapter sequencing of Introduction, Literature Review, Methodology, Findings, and Discussion which is the more traditional thesis format. Rather, I commence with my own story of journey at the beginning to situate myself. I then present the research findings. Placing the findings at the front end of the thesis is purposeful, in accordance with Indigenous ways of knowing where knowledge is generated and transferred through lived experience, historical understandings and storytelling. The Literature Review and Methodology chapters are presented after the findings, and then at the end, I return to the findings again and engage in in-depth discussion.

Though the claim that I use a non-traditional approach to present my research methods and findings is generally true, the reader will undoubtedly notice that in this first chapter I adopt a rather usual stance and present the study aims and objectives; some contextual features of this study; and a description of the organization of the thesis to orientate the reader to how the chapters of the thesis unfold. Immediately following this chapter ***Introduction: The Journey***, the departure from normal academic standards of writing becomes apparent.

Chapter 2 titled ***Situating Self*** reveals the many and varied (but always deeply personal) meanings and insights that I brought to the study, which not only influenced my decision to engage in this study, but which also ultimately dictated the ways in which this study was conceptualized, designed and carried out. In this chapter I specifically situate myself as an Aboriginal woman and researcher and the importance this has first and foremost when embarking in Indigenous research. I readily admit that my immersion in this study was deeply personal; however, it was not devoid of academic rigour and the requirement to present work that is scholarly and makes a significant contribution to knowledge development. Thus, in this chapter I share forces that shaped my decision to carry out this study, but I also reveal tensions that are inherent in being involved in insider research and key decisions that I made to ensure the research was robust and provided a clear trail on decisions made throughout my research journey.

In Chapter 3: ***Our Stories, Our Truths***, I continue with a non-traditional approach by providing excerpts from the intimate and personal stories told by the urban Aboriginal women who joined in the study – the findings. Placing these stories in a separate chapter immediately at the beginning of the dissertation indicates the appropriateness, indeed the urgency, to let the stories speak for themselves and for the reader to hear the profound realities of the women's lives.

The women's stories were told within the safety of Talking Circles, facilitated by an Elder. Some initial explanation of the protocol of Talking Circles, a traditional method for storytelling, is given here in order to situate these stories and the circumstances in which they are told. These stories are left to stand alone, without comment or explanation which comes in later chapters. The starkness of the stories promote a sense of unease at the least, but more likely shock and disbelief.

The women who shared their stories have either chosen or been assigned pseudonyms by which they will be known in this thesis. No demographics will be given that would identify them in a close knit community. Specifically chosen quotes from each of the women's stories are repeated in chapter 5 where the stories generate discussion. The stories and quotes used in this thesis are done so with the understanding that none of them are held as less important or less meaningful than those presented in another's story.

Chapter 4: ***Exploring the Written Terrain*** provides the reader with an in-depth critique of literature and other sources of information, selected because they informed the commencement of the study. This review includes the historical, social, and political context of Aboriginal peoples' health, in particular, the impact of colonization. The structure of the Canadian health care system is explained in order to highlight the complexities and the difficulties many Aboriginal people have in accessing health care. Statistical information regarding Aboriginal people's health is given to highlight the discrepancies and inequities between Aboriginal and non-Aboriginal Canadians in contemporary Canada. In order to explain these discrepancies, the review moves to the social determinants that are now understood as influencing Aboriginal health and well-being. I then move beyond social determinants to uncover root causes that relate back to colonization, a situation that I argue is as pervasive today as ever it was. The chapter concludes with discussion regarding research and the need to promote conduct of research by and with Aboriginal people, women in particular, for health care policy and service delivery change.

Chapter 5: ***Walking the Borderlands: Embracing Indigenous Methodologies*** presents a comprehensive discussion of the research methodology selected for this study that arose from discussions with Elders, literature and from my past research. The discourse of Indigenous Methodologies and knowledge are presented within an Indigenous worldview. In this chapter, I argue the need to locate a decolonizing research methodology rather than accepting the common Western academic research philosophy that can unintentionally (or intentionally) support a colonized view. The discourse adds to and builds on the seminal work of Indigenous and non-Indigenous authors from Canada, New Zealand, Australia, United States, Mexico, Africa and Norway. My intention is specifically to highlight Indigenous perspectives that support and strengthen control over Indigenous ways of knowing through research that must be done by and with Indigenous people. This chapter also gives insights into what I as the researcher, discovered about building respectful and life-long relationships with the urban Aboriginal women and managing the intersections (and sometimes disconnections) between the Aboriginal and academic communities.

Chapter 6: ***Teachings in Our Circle*** returns to the women's stories to reveal the difficulties that they experience at the hand of health care workers and others. Exploration of the Talking Circle transcripts led to identification of the many root causes of health inequities, but also showed how these women are shaping a future through hope and determination. Their stories show that they are moving forward, standing strong and making a difference. With a collective vision for present and future generations, they talk about how they come to demand respect, use their voice, challenge colonial practices in health care and offer help to each other, their families, communities and the health care community. In order to share the knowledge generated in the dissertation, as a whole or in parts, as teachings, the language used is purposeful so that it can easily be understood by the people we are working with in both worlds – Indigenous communities and within academic communities.

The final chapter ***The Circle Continues***, presents a summary of the research findings with insights and directions for the future based on the women's collective vision. The quest to improve the health and wellbeing of urban Aboriginal Peoples in Canada needs to challenge the political, societal, and ecological forces that interfere with their right to non-racist, non-discriminatory health care services. This chapter also provides insights for researchers who wish to work with Aboriginal people in pursuit of understanding and change.

CHAPTER 2: SITUATING SELF

2.1 The Blonde Blue Eyed Girl

A blond haired, blue eyed, seven year old girl is sitting comfortably and secure, with her mother, father, sister and brother, in the family's brand new car. She is wearing a new dress. Her hair in styled in two braids, one on each side of her head, with pink satin bows hanging down from each end. It is Sunday, after church, and the family is driving in the downtown area of a large Canadian prairie city, going out for lunch. The girl is kneeling on the seat looking out the rear car window thinking:

Don't look down that street – that's where you will see them. Don't go by the railroad tracks on Albert Street. Don't cross Broad Street. That's where they are. You can't trust them. They'll steal from you. They all drink too much. They'll beat you up!

Why do people say those things about those people with dark skin anyway? If they are so bad why are they allowed to be out in the open, on the streets, where we can see them? Are they all drunk all the time? Why don't they work? Are they really dirty? Don't look at them!

Why do people say they are lazy and they should get a job? Why don't they go home and get off the street. They scare me. Why are they like that? Indians are supposed to live on places away from us - those reserves - I think they call them, where we don't have to see them or hear them. Why are they living in my city?

Why do I feel I want to look at them from the safety of the car when I'm with my mom and dad? Those Indians are so different. Not like us. I'm going to look at them. It won't hurt for me to look at them. They don't even have cars. Where are their kids? Are they hidden under the bridge by the overpass? People say their kids are taken away from them because they drink too much and hit them?

Do you see that one over there? That Indian lady. Is she a "Squaw"? What does that mean anyway? Look at that one – he has long black hair, it's in an Indian braid, like we see on TV. Look at his dark skin, his dirty clothes, his teeth! – oh they are really bad. What's in that bag he's holding? Is he drunk? Drive faster Dad! Faster! Don't look at him! Hurry he's going to get us!!! I want to go home where it's warm and safe!

But wait! I am so confused. My best friend is Bernadette, she has brown skin. I stop at her house everyday on the way to school so we can walk together. We sit beside each other whenever we can. We are true best friends. Some kids say "Indians live in that house" and "You'd better be careful; don't go near them" and they run past their house because they are scared. I am not afraid. Sure her house is older than mine and hidden in the trees and her clothes are old and faded and different than most other kids at school, but why should I be afraid? Who says I should be afraid, anyway? She is so different than those people out on that street downtown. She is my best friend and we have so much fun together.

The year is 1964. Who is this girl? Where did she learn to fear and judge Aboriginal people? From her parents? School? Her teachers or friends at school? TV? Books? She really does sound confused. Does she really believe what she is saying? Is she only saying these things because she has been told to think this way? What will she be like when she grows up? Will she continue to fear and judge people, or be friends with, those who are different to her?

2.2 The Blonde Blue Eyed Woman

The room is full of women, mostly Aboriginal, sitting in a circle on comfortable couches and rocking chairs. The smell of mouth watering food and fresh coffee from the adjoining kitchen fills the room. The sounds of Aboriginal children laughing and playing in the playroom across the hall, filters into the room. The walls are decorated with remarkable native art and pictures of happy Aboriginal children and families. On the floor in the centre of the room, there is a ceremonial patterned wool blanket covered with specially placed native drums, pine cones, rocks, cedar boughs, pine tree branches, and a large native hand-carved wooden Talking Stick. A short white candle flame softly flickers in the quietness of the room, radiating a soft amber light throughout the room. One of the Aboriginal women is speaking. Her voice is focused, strong, yet gentle. She looks middle-aged with long salt and pepper hair and warm soft blue eyes. She is holding a rock and is rubbing it as she speaks. The room is full of women of all ages, some with long black hair, one with short white hair, some with short black hair, a few with brown or blonde hair; their skin of different shades of brown and white. They are all sitting quietly, listening intently and watching the woman who is speaking.

One woman looks familiar. It's that blonde blue eyed girl! The one sitting in the car with her family, so very long ago. She was so confused about Aboriginal people and whether they were friends or foes. She is a middle aged woman now and sitting beside the woman who is speaking. What is she going to do? What is she going to say? Why is she here? What is she thinking? Is she judging everyone here? Who invited her? Her hair has changed from blonde to a darkish blonde brown colour. She is not smiling. Her blue eyes are transfixed on the woman beside her. They both have tears in their eyes. Looking around the room, everyone is quiet, sitting still, listening intently. Everyone looks sad. All of the women have tears glistening in their eyes. They are all looking at the woman who is speaking. She is telling a story about a recent visit she had at the local emergency department. Her voice is soft, serious and somewhat unsteady as she speaks:

Here I am at the emergency room again. Unfortunately because I have a specific heart disease, I have to take a medication that makes my blood clot not so fast. It is an anticoagulant. I have to be very very careful because if I bang myself I get a big bruise. Working in my kitchen putting the dishes away from the dishwasher and what did I do, I banged my eye on the corner of the cupboard door. I got a big black eye. I was concerned that I may have done some damage because there was blood in the white part of my eyeball too. My husband said "I am taking you to the hospital".

So I went into the hospital to the registration desk and the clerk said, "boy do you have a black eye". I said, "Ya, it's that Coumadin, the blood thinner medication". That was fine, she was very nice. The nurse came and took me to the eye room, sat me down and said the doctor will be in with you in a few minutes. I sat there and waited and thought at least I don't have to take my clothes off and that is a good thing.

Finally, the doctor came in; he took one look at me and said "hmm, how much did you have to drink last night?" I thought to myself, "I beg your pardon, how much did I have to drink last night? What has that got to do with my bruised eye?" Then I thought "there's that old thing popping up again, that 'dirty drunken Indian', I guess. I haven't drank anything for over twenty years. I thought, I don't have to take this, I'm just leaving!!"

The reason I left was because as a nurse I realized that I had vision in my eye and my concern was that I might lose some vision with the bleeding and I thought since I can see, it can wait until I can see my family doctor in the morning. I did feel quite angry and then I felt very sad. I thought, why me, why did he ask me that question. But again, I guess that is part of the history of what has happened.

I guess we have to look at the history of our people. Going to residential school has created most of our problems. Sexual abuse, physical and verbal abuse, silencing of voice, fear and being made to be ashamed of being an Indian woman and not being worthwhile has created this complexity of feelings.

Why do health and social service providers buy into the provisions of care as it is today – factory assembly line treatment? We are numbers. We are well educated, world travellers. Many of us have worked in other countries and we discuss cultural differences. However, what occurred to First Nations people forty years ago continues in many ways today.

The year is 2007. I am the dark blonde haired blue eyed girl, now a woman, sitting beside the Aboriginal Elder woman who is sharing her story. This is the first meeting with a group of women as part of my doctoral work. I am speechless. My mind is whirling. I am angry! I am shocked! I find it hard to believe. I ask myself, "Does this happen to Aboriginal people all the time and in other countries? Is it happening somewhere right now?"

The Elder speaks of mistreatment and racism that is happening today and has been going on for hundreds of years for Canadian Aboriginal Peoples. I thought we were finished with this unjust treatment of our Aboriginal people. I thought Canada was okay, a fair and just country. How do we account for the disregard and marginalization of Aboriginal people, especially as in this case, urban Aboriginal women? Why do her health issues lack voice and autonomy? How do we as health care professionals justify our role in perpetuating unjust treatment and absence of informed choice for health care services? I thought colonization was over – clearly it is alive and harsh. Where is the respect and honour within practice that we as health care professionals are ethically responsible for?

As a health care professional, I am severely shocked. It is so hard to believe, my great loving and caring friend, my respected colleague and wise inspirational mentor continues to face unjust treatment on a regular day to day basis. More disheartening is that she tells me this is common for most other Aboriginal people and that she believes this will not change in her life time, but hopes it will be better for her grandchildren.

2.3 Situating Myself as an Aboriginal Woman

Before I talk about my doctoral journey and research discoveries, I need to ground myself in where I am located and choose to locate myself – as a daughter, mother, friend, nurse, academic, and most importantly as an Aboriginal woman. Although I have said Aboriginal woman last, it does not mean that it is of least importance. Quite the contrary, I am pretty clear about my identity as a daughter, mother, friend, nurse and academic but my journey in this research is about learning, and coming to know and identify myself as an Aboriginal woman and to connect with my Aboriginal extended and universal family.

Absolon and Willett (2005), Brown and Strega, (2005b) and Smith (1999) highlight the importance for Aboriginal researchers to write about themselves and their positioning within the world at the outset of their work as a promise that the research will not take place without the trust of the community. Stating one's Aboriginal heritage, Band and Aboriginal name, tells who you are, who you are related to, and where you come from – geographical location, all of whom you are accountable to. In locating oneself, personal historic details are offered in respect of one's family and land, and let it be known in case others know your people or the land you are from so they can relate to who you are. By sharing these personal details, the person is also asking for mutual trust based on these relations and connections.

My experience in working with Aboriginal people has made me realize that I too experienced consequences of colonization. I do not remember when I found out that I have "Native blood", and that my birthright is Aboriginal. Not the day, year or time in my life, the place or the way in which I found out. I knew my parents were from German, French and Irish heritage, but not Aboriginal. My father's parents were both German. I remember as a child thinking it was bad being part German because I had experienced the brunt of people's comments about Hitler's regime that I did not understand but clearly got the message that no German could be trusted. Germany was a far away country and my father's family was from a German community in Russia, not Germany. My father was born in Canada and had never been to war. The Germans that most people viewed as so awful were those connected to the regime and who lived in Germany not Russia. They were certainly not Canadian citizens like my father. I am proud of my father, he is a loving father and husband, with a strong faith. He is the kindest man I know. He built a family business and was a very successful business man. At eighty fours years of age he is still involved in activities in the church and community. He also continues to support me in the choices I make in my journey in life, celebrates my successes and holds me when times are tough.

Being native is another story. Even though I do not remember exactly the day, place or situation when I found out I was Native, I wonder if this *forgetting* is my own unconscious or conscious way of hiding my identity as a Native. *Indians*, *Natives* and *Half-breeds* were very much a part of the population where we lived but they were the minority population. They were labeled and stigmatized by non-Aboriginal people as being *dirty, drunk, wife beaters, prostitutes, thieves, unemployed, lazy, stupid*, and we should not trust *them*. These terms will be repeated throughout this thesis purposefully, to remind the reader the labels continue to be used each and everyday in our current society. In fact, I remember how my own extended family members both Aboriginal and non-Aboriginal labeled them in this way.

My mother however, was not this way. She used to have dark black hair when she was younger, although it is dyed dark brown now, her eyes remain soft brown. She warned us about safety and being street smart as every mother does, but not in a way that labeled, judged or isolated populations. As long ago as I can remember, she has always been a warm, caring, loving and friendly, kind and generous to all people no matter what race, gender, or class. She maintains this way of being today. She has a great sense of humour, she says she got this from her father. I have since found out that humour and lovingly teasing family members is common in Aboriginal families. Our family is a very close family, myself as the youngest of three children – I have an older brother and sister. We were also close to our extended maternal and paternal families and always seemed to have a maternal cousin, aunt, uncle or other relative living with us when we were growing up. My mother’s parents lived next door to us for years. They have passed long ago

– they watch over us now and guide my journey of life and discovering my Aboriginal roots.

My mother has been a strong female role model for me and my siblings. She was a career woman, uncommon in the sixties when most of my friends' mothers worked in the home. She is the first feminist I ever knew. She also has a very strong faith and continues to contribute to her community. Mom recognizes difference without prejudice. Was her openness because she knew of her native heritage and hid it from us but taught us that difference was a part of life and communities; and being "different" was no reason to be shunned, ignored and oppressed by the dominant (white) society in which we lived? It was okay to be different. This may be why my journey in life has come to this place today of wanting to know more and wanting to be part of my Aboriginal family. From my mother's teachings, as far as I can remember and as far as I know, I have never used race or difference as a barrier to my exploration and joy of life and being with people. I have friends from a variety of ethnic, spiritual, cultural, and philosophical ways of being. However, I realize I am privileged in a white middle class world and have never really experienced being the one as "different" because of my skin colour.

So what has happened along the way of my life? I was raised in a middle income mid-sized Canadian city, went to school with white and a few Native children and white teachers and attended the local church pastored by a white priest and where most of my white friends, schoolmates and their families went. What do I know about Indians, all I know was that all of my family and extended family members such as my aunts, uncles, and cousins were white, except for two cousins whose father was Indian. I was afraid of him. He had really dark brown skin and black hair, drank too much, and physically and emotionally hurt my Auntie, mom's youngest sister. She would come to our house to run away from him and to be safe. She finally left him after several years of abuse, but our house and family were always a safe and loving place for her and her children to come to.

I also remember an Indian boy with dark skin and black hair who used to live and work on a farm in rural Saskatchewan owned by one of my mom's other sisters. I was afraid of him. I am not sure why. Was it because of his dark brown skin and dark hair, and how he dressed and spoke differently than we did? I never knew about his family or why he was living with my relatives. He would disappear for days without reason and return as if nothing happened. He was mysterious. He seemed so "different" from "us" - my white middle class family. Most distinctly, though, I remember how much our families cared about him and loved him, as son, brother, and cousin. I recently found out he has been a church pastor for several years. Now that I think about it many of my maternal aunties, uncles and cousins had skin darker than mine and most also had dark hair and brown eyes.

Thinking back about our summers at our cabin in remote northern Saskatchewan, of the twenty-five cabins and families that vacationed there, our family was only one of two who were friends with the local Indians who lived in the bush. Or I should say, that the Indians would trust enough to speak to us and come in or sit on the deck for tea. We would visit them by boat, at the end of the lake and take them Red Rose tea and they would give us blueberries they had picked. Often we would buy berries from them, give them rides or help out if they needed anything. I was little hesitant toward them because they were different and they could not speak English, but I never felt threatened or unsafe. I remember when they visited with my parents they would all be laughing and everyone was happy. I still did not know we had native blood. The year is 1970.

It has been only in the most recent years that my mother has started to talk about her Native background. She had told us her father was French and Irish and her mother French and American. We did not know until the last fifteen years or so that her maternal grandmother was Mohawk, and her paternal grandfather was part Cree and Ojibwa from the Red River area of Manitoba, Canada. She smiles when she tells us that her father told her, “We are *Métis roug*e” which means red-haired Métis. Métis is the French word for persons who were half Native and half French (white), called “Half-breed”, mongrel, cross-bred, mestizo or metif blood, who are in the space of part white and part Native (Métis Nation of the Northwest, 2010). Being half Native was worse. A race of group of specific peoples not acknowledged by the Canadian government. Only full blooded Indians were acknowledged, singled out and officially labeled as Indian through legislation. Legislated identities regulated who was an Indian and who was not and what legal, health coverage and land rights were granted. Half-breeds were ignored and had no status or land entitlement rights; therefore, the Métis lost all status as Indigenous people (Adams, 1999). In 2002, the Métis National Council adopted a national definition for Métis - a person who self-identifies as Métis, is of historic Métis Nation Ancestry, is distinct from other Aboriginal peoples and is accepted by the Métis Nation. In September 2003, the Supreme Court of Canada ruled that the Métis people were a Distinct People and adopted the national definition of Métis for citizenship within the Métis Nation (Métis Nation of the Northwest, 2010).

The year is 1975, I am thinking that being Indian was worse than being German. I don’t want to be like those Indians labeled in our city and society. I remember hoping my friends would not find out I was Indian. No one will ever know because my skin is white, my hair blond, and my eyes blue, like my Dad. He’s not Indian. No Indian in him at all. My aunties and uncles say I look like Dad’s mom. Thank goodness!! My mom, brother, and sister have dark hair and brown eyes. They don’t look Indian, or do they?? No. The Indian blood in our family is so long ago, it is probably out of us by now. We are a white middle class family. We go to church. We are good people. We are a respectful family. We can’t have any Indian blood. If we did we would be bad like those Indians that people name and blame as dirty, lazy and drunk. How long have I oppressed it and kept it hidden from my friends, or myself? How long have I been silent about it and not asked my mom about her ancestors? How long have I been ashamed? Am I ashamed? Why should I be ashamed? How could this happen to me – to have Indian blood in me?

As a registered nurse working in a variety of settings since the late 1970s – emergency care, operating room, general acute care and community nursing, I have seen judgmental attitudes and racism of Aboriginal people by my colleagues. Is this just because of different skin colour and stereotypes placed on them by society? I find it hard to understand. As a diabetes educator in the 1990’s, I began to learn about and question the health disparities and inequities of Aboriginal people in Canada. Why are there so many Aboriginal people with diabetes? Why is it that they die younger, are sicker, poorer, less educated, and less privileged than the rest of Canadians? This is not right, they deserve more. What is happening? I feel uneasiness in my heart, in my inner being. I begin to become more and more interested in learning more about these people, my people, my relations. Maybe I can help. I begin to wonder, are the societal assumptions, labels, and health disparities and inequities for Aboriginal people in Canada really true or are they just blown out of proportion? Whose problem is it? Who is to blame? I can help those that visit the diabetes centre, but there are only one or two that come because they do not live in this valley. I am living in an all white community in the Interior of British Columbia. I wonder how I can make a difference for Aboriginal people that I am related to – throughout Canada. The year is 1997, nothing is resolved as I am struggling to deal with my own life issues. Once again, I pack away my Aboriginality, my roots, my family history, not really knowing the details or connections.

2.4 Finding Myself as an Aboriginal Researcher

It is 2000, and I find myself living in a new community, starting a new job, coping with my own family breakdown and major changes in my life and that of my children. The unrest inside me about where I am from, where I am going, and who my Aboriginal ancestors are, and how I can make a difference in the health of Aboriginal people begins to resurface. It is erupting; exploding, I am talking to my mother, my uncle, and my cousins about who we are as Aboriginal people. I want to know more. I am looking for opportunities to work with Aboriginal people. Here I am at a university teaching nursing students and working with university academics and local urban Aboriginal people on community based research study exploring barriers and challenges that cause urban Aboriginal people, living in three local communities, to seek Aboriginal health directed services rather than mainstream health and social services. I listened to the audio-taped stories shared by urban Aboriginal women describing their experiences with mainstream health and social service providers. The majority of the stories were similar in that they were shocking and as I listened I became more shocked, angry, and saddened as they told one story after another describing their experiences with unjust treatment within the health care system. What became clear is that there are currently major injustices in our society that continue to oppress and colonize Aboriginal people in Canada. In particular, little was being done within the health care system to help improve these issues within these local communities. I begin to ask more questions wanting to know more, wanting to understand, and needing to get involved to help.

Being situated in the understanding that I was educated within an Eurocentric worldview, I am learning now about Aboriginal worldviews and this has helped me choose the area of inquiry and methodology that is best suited for the research journey that I embark. As I find myself walking within two worlds I often wonder where I fit *living in the space* between my white and Native heritage. I ask myself if my work will add to the voice of Aboriginal people, the nursing profession, and the academic world? I also wonder if I am Indian enough to be accepted by Aboriginal people as an Aboriginal relative and researcher, or if am I too white, inside and out – skin colour, upbringing and education.

It is through sharing some of my own experiences with my Aboriginal friends and colleges that brought me from denying my Aboriginal heritage to embracing it with pride, honour, humility and a lingering bit of anger. Societal views are wrong, so very wrong about Aboriginal people! I am an Aboriginal woman who has the privilege of working with other Aboriginal women and their families, honouring their experiences, and holding on to the passion to carry forth with the work as a proud Aboriginal woman, who is also a mother, sister, friend, researcher, and other identities. I have a unsettling need to uncover the hidden past of not only my hidden Aboriginal past but the plight of Aboriginal Peoples in Canada, the silent voices and the denial of human rights as I particularly situate my voice and the women's in my research. This is within the core of existence that I believe needs to be in the forefront of working with my Aboriginal relations. I find myself wanting to learn more – more about the history of my own family and more about other Aboriginal people and families. There is an urgency, an unrest deep inside me to find out more about the history of my peoples' tradition and culture and engage in conversations that include, rather than exclude brown faces, and to deconstruct the negative portrayal of Aboriginal people, especially women.

I feel that as a nurse researcher I can somehow make a difference for my people. Even though I was not raised Indian, I now feel my life has purpose, that I can use my place of privilege at the university to help. I can, if they allow, build relationships with my relations and advocate, facilitate, and participate in changes that my Aboriginal relations see necessary to improve health and experiences in the health care system. I have come to the realization that I could possibly do something. I remember in a previous study, some of the urban Aboriginal women expressed interest in continuing to be involved in research. They wanted to continue the dialogue and make public foresights they thought could improve Aboriginal people's experiences with health care providers. I thought we could work together, thus my doctoral journey began.

CHAPTER 3: OUR STORIES, OUR TRUTHS

In this chapter I provide a glimpse of the stories shared by the urban Aboriginal women with whom I was honoured to walk alongside and who wanted to continue our relationship and to share their knowledge, experiences and traditions in conversations, as part of my doctoral inquiry. The journey of our work together was captured in sharing experiences and knowledge mostly through traditional Talking Circles. However a great deal was learned before and after the Circles and at other times over the last six years when we gathered to discuss the research process and protocols. Talking Circles are described in detail in the methodology/methods, chapter 5, later in this thesis.

We met before each Talking Circle to eat and socialize. Following supper we went into another room and an Elder opened the Talking Circle with a Traditional prayer. During the Talking Circle the Elder held a rock, that had special meaning to her, as she told a personal story. The person who spoke held the special rock to show that she was the speaker. When she was done speaking she passed on to the next one of us who wanted to speak. In the traditional Talking Circles we followed protocol, which respected each woman as she spoke by not interrupting or talking until she was finished speaking. When the woman was finished speaking, the special rock was passed on to and held by the next speaker. There was complete silence within the Circle as the rock was passed from one speaker to the next. On occasion, when the woman who had just finished speaking appeared upset such as crying, the Elder facilitator asked if the speaker was feeling alright for the Circle discussion to continue. At other times, the speaker was asked a question for clarification only, not to probe a topic further or question what had been stated. Others in the Circle acknowledged what was said in the story being shared by nodding their heads or maintaining eye contact with the speaker.

The Talking Circles lasted from ninety minutes to two hours, after everyone agreed they were satisfied that they were finished telling their stories, and at a reasonable time to take their children home for bedtime. The purpose of the research and the sharing of the opening story were revisited at the each Talking Circle.

3.1 Situating Self in the Talking Circle

As a woman, mother, daughter, sister, nurse, educator, and researcher on a journey learning about who I am and what my place is as an Aboriginal, I remember sitting in the Talking Circles. I listened as each woman told her story, she revealed her joys, pain, memories, and who she is today as an Aboriginal woman, through all she had experienced. For me, the stories, I call truths, filled the empty space that had existed between each of us and within the Circle. The empty space changed from what I thought would be a seemingly comfortable sharing of their health care experiences to profound and disturbing realities of what they faced today and in the past. I had some understanding and knowledge about the history of Aboriginal people but the personal stories clearly made what I had read or heard from others, real.

Within the Talking Circles, I felt like we embraced the woman who told her story by actively listening, not interrupting, not judging, blaming or labelling. There were so many unsolicited life examples of mistreatment and wrongdoing that at times, I felt like the atrocities being described and the substance within the stories were pushing at me and at the edges of the space within Circle in which no more hurt and pain could fill the space that held us safe and together. Hearing the truths, at times they were so profound for me to absorb, it seemed like the woman was shouting, although her voice was barely audible. At other times, the pain and difficulty in remembering and sharing stories were evident in the women's facial expressions; or flooded the Circle with joyous laughter. As each woman told her story, the Circle seemed to fill the air with her words, joys, pain, memories, and insights for health reform and who she is today as an Aboriginal woman through all she had experienced. The truths she spoke reached out to all of us in our Circle as she shared her life experiences and reflections. At times the words were spoken so quietly yet described such profound experiences that I had to sit forward in my chair, straining to hear what was being said and to get nearer to her to show I was there to support her and honour her for sharing her stories.

Listening to each and every word in the story, the lived experience, the painful teachings, life in residential school, violence in the home, on the streets, discrimination in school and being ignored in the health care system, held an indescribable presence within the Circle. It was the utter rawness of sharing their fears, anger, sorrow and urgency to tell others about their lives as Aboriginal women. The intensity and sadness that filled the space of the Circle would barely diminish before the special rock was passed from one storyteller to another. The rock was rubbed and held tight in the storyteller's hand as she shared her thoughts and memories. When it was my turn to hold the rock, I talked about my mom, the shame of being Aboriginal, and not being told I was Aboriginal. As I held the rock, I was surprised how the rock radiated warm heat; but I was immediately comforted by how it felt, as if this rock was holding us together as a group of women exposing our hearts in the Circle.

Several of the women agreed with the stories told and had similar and unique experiences to share. A few talked at length about the injustices faced in residential schools and the public education and health and social service systems. Sharing of stories stopped when everyone felt they had said everything they wanted to say. However, in most of the Circles we had to end them because the children needed to go home to bed. The Talking Circle was always closed with a traditional prayer. This filled the Circle and our hearts with thankfulness, hope, and determination to meet again. The women's stories continue to play over and over again in my head and the tears in my eyes and the pain in my heart remains.

To begin the Circle, Elder Two told one of her stories, one that I had heard before, when she and I were working together on another research project. It changed my life, opened my inner search for meaning and justice and guided me on my journey to embrace my Aboriginality and become an Aboriginal woman. Excerpts of the women's stories are now shared. The name of each woman has been replaced by a pseudonym that was either chosen by the woman or selected to represent Indigenous symbols and meaning.

3.2 Opening Story

The story that opened each of the Talking Circles was one of several stories told by Elder Two, an Aboriginal mother, grandmother, sister, daughter, nurse, and my great friend and mentor. This particular story was specifically chosen by Elder Two because it described a recent health care experience that had extraordinary meaning for her and raised memories of her mother and residential school. Her mother has since passed on, yet the essence of what Elder Two shared is exceptional.

As she sat in her chair among the other women in the Talking Circle, Elder Two spoke:

I'm sitting here wondering, am I doing the right thing, sitting in this emergency waiting room? I am actually very nervous. I wonder - am I going to *have the same experience as I had the last time I came here? And that makes me afraid; because the last time I was here they made me take my clothes off. When someone makes me take my clothes off it makes me feel ashamed, that makes me think that they don't respect me. How come they make me take my clothes off, it is my arm that is the problem.*

I'm thinking about my Mom. She is an Elder of our community and she had the same experience. She was very sick and had to go to the emergency room to see the doctor and the first thing they did was throw a gown at her and say "take your clothes off and tie this in the back." Mom thought, "What? Take all of my clothes off? Then my bottom is going to be sticking out!" Mom was very upset; she said no way is she taking her clothes off. This is the same thing that happened to me, so I wonder - does this happen to everyone?

It ended up that Mom did take her clothes and put the gown on. She had asked the nurse, "what would happen if I don't put the gown on opening in the back?" The nurse said, "if you don't put the gown on then you won't see the doctor." This made Mom even more upset. Mom left without seeing the doctor.

Now I'm thinking, why did Mom feel this way, and why do I feel this way? I guess we have to look at the history of what has happened to us. Going to residential schools has probably created most of the problems for all of us. It has made us shameful. It has made us afraid. We were abused and I guess the result of that is not wanting to take my clothes off – because of sexual abuse, physical abuse, fear, being ashamed I am an Indian. Feeling that I am not a worthwhile person because I am an Indian woman and that the person that is going to check me is probably going to be a man, has created this complexity of feelings.

The events described in this story made me feel shocked, sad and hurt. Before reading the literature about residential schools for this study, I had heard bits in the media, and newspaper, but never really knew much. It seemed colonization continued today to harm, label, and oppress Aboriginal people. While sitting in the Circle, trying to unravel what had just been disclosed by Elder Two, I tried to imagine the impact of this experience on her life and her mother's life. As I struggled to believe this recently happened at a local hospital in the community in which I practice as a nurse, my mind whirled. I had not yet grasped the depth of profoundness of experiences that had been shared when Nigwa stood up to take the rock into her hand. Her voice sounded somewhat unsure and shaky. She looked around the room as she spoke:

3.3 Nigwa

I was told I was a drunken squaw, so I became one. I've been sober for 23 years. I'm not a drunk. I know I'm a Native. It took me a long time to say that. I did not like being a woman. No matter where I went Native woman would be bad. Native woman, all they were good for was one thing – to be raped, tortured, beaten. I got raped when I was 16 years old [crying]. *They were white. The cops came, let them go, and said, "She ain't nothing but a squaw. She ain't going to remember tomorrow. She's drunk." Little do they know, I still remember to this day, what those guys look like. I've hated men all my life.*

Then you go see the doctors or nurses and they say, "How much did you have to drink?" Yeah we drink. Just because I ended up in an abusive relationship huh? They took my oldest son away. They lied. My son is thirty six years old today. I don't know what he looks like. They took him away from me. They said I was a drunk and I was stupid. I didn't know any better. I was eighteen years old when my *son was born. I've been looking for him since. I was still a ward of the courts back then,* [crying]. *Social workers, the doctors, everybody* [said]*, I was psychotic, I had many different personalities. I wasn't. They told me I signed him up for adoption. I didn't sign no adoption papers. I signed papers they told me that,* [crying] *when I got back on my feet I was going to get him back. I've been lied to by everybody out there. That's why I stayed within my shell all these years. I came out of my shell when I turned 50.*

I remember in my growing up I didn't like going to doctors, to nurses. I was always afraid they would find out I got hurt, or how I got hurt [by parents]. *I wasn't supposed to tell.* [When] *I told them* [social workers] *what I went through at home*, [they] *put me in a foster home and I ran away from there because the father was the same way. I told that to the social worker, they called me a liar. Every direction I went out there they called me a liar. And then, when my children were babies, they were always taking them away from me.* [My daughter] *has a bruise* [birthmark]. *They thought I was pinching her. This is when they first got apprehended. She still has her birth mark.*

Nigwa paused, spoke directly to me about difficulty trusting others and then continued to share hurtful school and health care experiences she related to the skin colour herself and family members*:*

It's really hard for me to trust anyone like when I first met you, I wanted to run. It's not because of the color of your skin, it's because you're a younger human being. Always scared of people. I never knew who to trust. I could trust my children and Elders but anyone in between that, I was always petrified of them.

We went to several schools here in British Columbia and it didn't matter what school it was, if it was the Native school or the white school, all the Natives *were put in a corner. I've always wanted to become a teacher because I used to get tired of seeing all these little kids put in a corner because we were told not to learn. My brothers were put in these classes where the teachers call it, "the stupid class." So all my younger siblings ended up the stupid class because none of my teachers took time to set them up and say "you gotta do this, this and this" they just said "you're stupid" and sent you to the other room. I was in that other room all my life* [crying].

I was put in a corner for two days when I was in the maternity ward. They forgot about me, they came in and looked at me. They put me in the same room with both my daughters. Health care professionals need to quit looking at our colour and just listen.

I would not take my children to the doctors. One day I had to take my son to the doctors, I just got him back from the ministry and I didn't want to lose him again. My doctor was away, I got this doctor who didn't know me, and my son was really really sick. That doctor took one look at him and said, "What is your mom doing, beating you?" I wanted to take my son and walk out of there but I wanted to find out why he was sick; why he couldn't stop coughing.

When I got custody of my granddaughters I did it opposite, I used the doctors every time something happened to my granddaughters. I brought them to the doctor's office so that would be in writing what happened to them. Before I was totally petrified of the doctors. Totally petrified they were going to take them. And now they got records of every little owie they have [laughter]. *I don't know where I picked that up but I started using them instead of being afraid of them.*

When I brought my granddaughter to the hospital, we were there two hours and they hadn't done nothing for her. The kid in the next bed already had two shots *for pain. I was asking all these questions and none of the nurses would talk to me. A teacher from the school came in to see how my granddaughter was doing. We had been there three and a half hours I think and I said, "They haven't done X-rays or nothing." The teacher asked the same questions I was asking and the nurse is standing there, talking to her, answering her questions and she's not even related to my granddaughter. She wouldn't give me no answers. I was so furious. That's why I keep saying I wish they would look past the skin you know; a broken bone is a broken bone. It reminded me of when my son hurt himself eighteen years earlier and no answers and someone else asks that is different colour than me and they got answers. It's not different, it's still the same. I kept thinking maybe if my son was white he would have got help; maybe if my granddaughter was white she would have got help. I'm not usually prejudice or anything but this is what I seen when I went into that hospital.*

I've always seen it, with white people. They get called Misses or Mrs. When they go and talk to the Natives they talk to her like she's a little four or five year old, instead of another adult. I've gone through this since I was a little girl, looking after my brother and sisters. I'm still going through it with my granddaughters. They talk to me like I'm still that same deaf-dumb-stupid little girl. I don't know if that's just the way I see it or.

I finally went to a place where they didn't act any different. I went to talk to them about a hearing aide. It was the first time I didn't feel like I was being belittled or discriminated. She sits down and talks to me like a human being. [Laughter] *I looked around, I was so used to be talked to as if I'm deaf-dumb and stupid, because she was talking to me like a normal person. She helped me. She is still trying to help me with my hearing aid. That was the first time in fifty four years* *someone talked to me like I was a human, I mean as a professional, doctors, lawyers.*

At another time in the Circle, Nigwa described a particular incident and articulated ways she had learned to protect herself and her grandchildren over the years, even though she put her own health at risk in order to do so. The meaning of family, protection and not wanting her grandchildren to suffer was evident:

I had a stroke on my fiftieth birthday. I didn't know what was the matter? My mom kept saying go see the doctor I said "No, I can't." I had just gotten custody of my granddaughters. I didn't go to the doctor because I didn't want to lose my granddaughters. I didn't want them to take them away from me. I figured if they found out I had health problems they would come in take them away and put them in a foster home. And I didn't want them separated and I knew from my experience foster homes weren't good. I thought the only safe place for them was with me. I avoided getting help for myself because of fear of losing my granddaughters. Four or five days I had trouble changing my granddaughter and she was, just two. I needed help and I went to see a doctor. [He] *put me on this, put me on that. After, I just kept telling myself I have to be fine, I have to be fine. The girls needed me and I was back to normal again I was able to move.*

I came out of my house when I was fifty. I'm fifty four right now. I stayed locked up because I didn't feel like I belonged anywhere. It is just lately that I walk with my head up. I used to have long hair, I walked like this [bowing her head so her hair fell forward, hiding her face] *and no one seen my face* [crying]. *I couldn't talk to people. I was scared of people. I used to stay quiet all the time. I never thought anything I would say was worth listening to. Then, I don't know it got a lot easier. I say "hi" to people. Try to talk and now and then I do get that scared* *feeling. That fear tries to climb back in and I don't want to talk. And I want to go run and hide again. And I know I don't want to do that anymore. I go home and I sit there and I try to carve. I get so restless. I got so used to coming out this past three years, three and a half years. It's really hard to stay home now. I'm always out and about running around doing this doing that. Talking to people. Catch the bus and I go to my own AA meeting* [laughter]. *I'm glad I did come out of my house. I'm not as hard as a rock or cold as ice. That is ok to feel, it is ok to care, it is ok to, I can't really say I hate anybody anymore.*

Everything I've gone through since, since I've been on my own you know, anyone else would have died. I keep thinking about my past, thinking about my past and I'm so thankful that I quit drinking. Quit doing drugs. I keep thinking there must be a higher power out there somewhere. For me to make it as far as I made it. Cause I know I wouldn't have made it in the condition I was in when I finally sobered up. I was taught not to show anything. I was taught not to talk. Taught not to cry. I was taught how to hate all my life. It wasn't until I had all my children that I learned how to really love and care. They taught me how to love me. It took me a long time to finally say, "I do love me, this is who I am".

The stories shared by Nigwa were so raw; the reality of what she endured shocking. She retold the same stories at two of the Talking Circles. It was apparent that her stories continue to affect her life. I agreed with her, how did she make it as far as she had? How many aspects of her life were affected by or resulted because she was native? She lived through so much violence yet survived and was able to share to help us know what she has suffered through and why she was who she was today. She taught us that no matter her strife she continued to resist and be strong for her children and grand children.

I was overwhelmingly confused and wondered how health, social, education, law enforcement professionals could not be aware of what they do or perpetuate with such clear descriptions of racism and discrimination, stigma, and indifference. The room was silent. There were tears in the eyes of many of us.

A soft mature voice arose breaking the silence, bringing my thoughts back to the Circle. My eyes went toward the sound of the voice to see who was speaking. It was Elder One. She was the most senior woman amongst us in the Circle. In her hand was the special rock. She rubbed it with her thumb as her words filled the quietness of the Circle:

3.4 Elder One

I haven't talked about my [past] *until I went to "trauma"*[1] *a couple of times. I didn't know what the heck trauma was, you know. What more can I do about trauma, I've been in trauma all my life. So what is there to learn? I lived it. So anyway I went to this treatment center. There I learnt all about myself, even to talk about it, and it's a painful thing, because a lot of times I didn't feel like I was accepted no where.*

I've been in the residential school since I was five years old. My mother died when I was born. My father went to the Second World War and left me in the hospital. Yeah, we talk about sexual [abuse] *in the residential school. This is what happened for quite a few years. A priest took advantage of me. I was threatened not to talk about it or anything like that. I was a child. A lot of things happened in those days in school. Never had no education at all. All I was taught in the residential school is to be 'perfect', to be clean, 'pure', to forgive myself. I used to always wonder ,why do I have to forgive myself? For what?*

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[1] A trauma treatment centre for Aboriginal people who went to residential schools.

As Elder One talked about her life in residential school, she described one incident in which it was assumed by her caregivers that she had bugs, and how such acts of racism, labeling and abuse affected her at the time and for the rest of her life:

Coal oil is what they used to put on us [to kill bugs]. *That's a dangerous thing and you know I never even had bugs. Today I get lots of flashbacks where I notice things. I got angry of course, but it's not too long ago, we'll say within about ten, fifteen years. I've been trying not to get that too much in my mind because I begin to think that if I keep that in my mind, it's like a tape recorder, you know, over and over, and the thought and experience is there. Then I begin to talk to the Creator instead. I was so mixed up with the Creator and God, and Jesus and all that - because in the residential school, you go on your hands and knees and pray. That's all I ever did, so that God will make me forget all that, and then not get punished, like the way I was taught, if I was to talk about this sexual abuse. I kept in my mind, always, for many years.*

For a while I lost my children, because you know, all I did was drink, and try to forget that thought that kept going over and over about that priest. I was on the street. That's how I was, never had no home. I was always "dirty" and a "whore", and a "bitch" and everything. I was called all that. But you know the Creator put me on earth for a purpose; this is why we are still here. We have to pass that on. Whether they believe it or not that's fine. There is a loving God that takes care of us, no matter how we suffer…

The reason I am fragile and getting sick is because I still have those things that I'm dealing with that I have to live with, you know. The nurses and doctors, they'll do their best. They need our help. They need a lot of education and understanding, and not from highly educated people, from the way we live every day *to day life – what we have experienced, the hurts that we have, the suffering that we have.*

I know that nobody has **ever** *talked about the residential school. It's just recently that it's coming out. Because some people like me are starting to come out with it and talk about it. This is why I always thought, "nobody will believe me anyway because it hasn't been heard of." Because a lot of us Native people, my ancestors, who are gone, that been in residential school too, my grandmother and my father, they're gone. And yes they drank, that's all we ever knew anyway because of all kinds of hurt and pain we had. There was no way to express it. I've been in mental institutions. I tried to take my life.*

[Last year] *everything was investigated, in Ottawa. I went way down to details on everything when I had that court hearing*[2]*. My lawyer told me I could opt out. I said "No darn way! I'm not opting out. I'm going right through with it. Ottawa is going to know about this, hear about everything! I'm doing this for the ones that are gone. That didn't have a chance to talk. I don't give a damn about the money!" A lot of my people are still suffering from that* [residential schools]. *Yes some of them go on destroy their lives because they were never heard, at all. My ancestors went through the same thing. They never had that chance. They didn't have that voice. That was part of my healing and I'm glad I did.*

Elder One spoke for quite some time about her residential school experience and explained the meaning and healing that came from testifying in Ottawa. At a

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[2] Between 2006-2012, according to the *Indian Residential Schools Settlement Agreement* (IRSSA), the Canadian Federal Government is providing court hearing opportunities for residential school survivors to tell of their experiences and the impact on them and their families. The aim is to educate the Canadian public about the history, and to provide financial compensation for reconciliation by the government and to assist with healing from the trauma (Indian and Northern Affairs Canada, 2010; Truth and Reconciliation Commission of Canada, n.d).

different Circle, she was reminded by what a previous speaker said about a health care experience that frustrated her and shared her experience:

I wanted my daughter to come with me [into the examination room], *this was about a year ago. My own doctor wasn't available at the time. He* [doctor] *said, "This is private" and I said "No it's not private. This is my daughter I want her to be with me." So I never went back there again. I was denied that* [being accompanied and supported] *because of that doctor, whoever he was. I told my* [own] *doctor about that after. I think my doctor went and talked to him at that clinic, but I never went to that clinic again. So I always thought that I'm not listened to in a way and denied in a way - or nobody's going to believe me anyway. So I haven't been really talking about it* [difficulties accessing and receiving health care] *to anybody really.*

Today I can say I have a home. I've worked on myself, did everything. See my doctor all the time. I still have problems with going to other doctors, if I have to, but my doctor has my history, he knows. Now I can go, now the Creator can take me home. I did what I wanted to do. I can live with it now, what I did. I know now I have to be more active I have to talk about it more because a lot of my friends, family, are doing the same thing. They are afraid to talk, but I tell them never be afraid. If nobody believes you, that's fine. Nobody probably believes me too, but that's okay. That's between me and my Creator. My Creator knows – is why I'm still here. He wants me to let it out – the healing that everybody needs to have. Sharing this is what I like, you know this is what I want and I think it is very important. Thank you.

As Elder One told her life story, images surfaced in my mind, as one atrocity after another were revealed. My mind flashed through multiple vividly colored pictures: a little five year old girl; groups of Aboriginal children in residential school; sexual, mental, and spiritual abuse; attempted suicides; mental institutions; being homeless and living on the street; children being taken away; drugs and alcohol misuse to treat the pain; testifying in court; and being labeled. The images crossed a lifespan and were grounded in her initial words, *I've been in trauma all my life.*

She sat with us, shared her story and told us this is what people needed to know, to help them understand the reason why Aboriginal people are how they are today is because of what happened within the residential schools. During the telling of her truths, she and many of us sitting in the Circle looked sad most of the time, with glimpses of nodding heads and occasional bursts of laughter filling the room. The plethora of emotions, thoughts and feelings that emanated from what was said could never be described in words alone.

She revisited these same stories for all of the Talking Circles. The effects of these events in her life are powerful, strong and meaningful. Before sharing at the last Talking Circle, she began to cry and had to leave the Circle. Elder Two accompanied her and they returned in a few minutes. Elder One apologized and expressed that retelling the stories was so very painful that even though she wanted everyone to know what happened in residential school, it was becoming more difficult each time. The week after that Talking Circle, we held a meeting to strategize the next stage of the research. Based on Elder One's difficulty and trauma of sharing her stories over and over again, we discussed other ways that Talking Circles could be used to share experiences with health care professionals, educators, and policy makers, so as not to have our work continue the harm that was done to her.

As the images in my mind continued, the rock was passed on within the Circle. A much younger voice spoke out:

3.5 Ram

My children do know that they are Aboriginal. We don't speak it in our home because my dad was never taught because his father was in the [residential] *schooling and they were to be white and not to be Native. He just decided that he was going to follow what they were doing* [at residential school]. *So my dad was never taught anything about our Aboriginal heritage. So we weren't taught ourselves. But when I got older my dad did tell me that we were Aboriginal.*

My husband is Aboriginal. He has fetal alcohol syndrome and he's struggled his whole life. He was barely surviving on social assistance because he didn't know that there were other things that he could do to help himself. So it's horrible. There is really no help out there. I've gotten actually a lot of help especially with my husband because they look at him, and they just brush him off like "Go away." I've had to go and be an advocate for him, and if I hadn't, it would not get done. It took me a year to get the help that my husband needs.

People are just being pushed through school without actually getting educated properly and learning how to take care of themselves. My son is in school, but he definitely has a writing disability and the school kept pushing him through … he's in Grade 10 and he reads at a Grade 2 level … I had to put him in tutoring which cost two to two hundred and fifty bucks a month. I could only afford that for about 6 months.

… my [other] *son, he is a little darker than his sister. He gets treated differently too when I go places or do things. He's only four, but he's big because his dad's really tall. So it's kind of discriminating almost in that sort of way. My*

daughter is not as Aboriginal looking, she took more of my lighter skin, and my son took his dad's darker skin. I agree with what others have already said, that there is racism and assumptions. When [health care professionals] *look at me they don't think Aboriginal right away. But then when they look at my file and it states on there, then it's like they change and become someone else. They talk to me differently. There is a stigma mark attached to being Aboriginal. People don't see they're doing it or being that way. I don't know if they do it on purpose or not on purpose, or both. But definitely people need to be educated and not make assumptions.*

As Ram spoke, the residential school surfaced again and confirmed what was reported in the literature – family, language, and heritage stolen and denied. What was it like for her father in residential school? Had he been abused? Was it easier for him to be white than native? She made it clear that colour of skin was a barrier for her family, in school and the health care system. What lingered in my mind was how each of her family members had been treated differently based on the darkness of their skin colour. What would that be like for each of them and among them by being treated differently? Had this caused difficulties within the family?

When Ram finished speaking, she handed the rock to a middle aged woman who had reached out her hand for the rock so she could take her turn to speak. Holding the rock, she offered a few memories about her own life as an Aboriginal person and as a teacher at a post secondary institution:

3.6 Quail

I wasn't in the nursing program but there were students that were in some of the courses that I was taking. I could not believe how racist they were. I couldn't believe what I was hearing because I had never been in a situation where racism *was so blatant. I thought to myself, "these young woman are going into nursing with this attitude and they are going be looking after Aboriginal people." My heart just went out to the Aboriginal people, because these people are supposed to be looking after them, going out there and getting their training and not having a heart for it.*

I think Aboriginal people feel more comfortable if you are Aboriginal as a nurse. A lot of Aboriginal people would speak about going to the social workers where they are predominately white and getting discriminated against there. So no matter where they went, whatever resource center they went to, they were being discriminated against.

Aboriginals really do need more support. I never realized how much because I haven't really lived on a reserve. I grew up in a residential school away from my family and I never went back. So where I was working was like a little microcosm where there were Aboriginal people from all across Canada that came and went to school. I was able to see where a lot of the problems were coming from. I found that with the courses I taught, [a] *human growth and development* [course], *there was sections in that course that covered sexual abuse. Every year I was never prepared for it but, after it finished that part of the course, there would be a lot of absences in my class. It never really dawned on me until I talked to them personally what was holding them away. They said they haven't even really resolved that part of their lives until it came up into the course work. They didn't even know that, or they forgotten and it just came up for them.*

I was asked to do a study as to why there were few [Aboriginal] *people* [in post-secondary school], *and it was again brought back to discrimination and racism. So it's everywhere. It's a big job, big job for you young people.*

More trauma through residential schools, education and health care system. Blatant racism and discrimination, and lack of knowledge about Aboriginal people demonstrated in barriers to health care service access and delivery of needed supports. What can or should be done? Will this research help? There are so many complex issues carried on for generations, how to begin seeking answers and solutions to so many questions. I wanted to start to take action to fix the problems but did not know where to start.

The rock had been passed on to another woman in the Circle. She looked down, as if she were speaking to the rock as she rubbed it. She spoke with a tentative voice:

3.7 Bear

Hearing tests. That's what I need. I've been deaf since I was seven. I can lip read very well. I'm a good listener. I didn't get any help with my diabetes until two years ago. I've had it since I was fifteen. I moved from a large city to this area up here, but they didn't believe that I was a diabetic … My doctor [I have now] *is good.*

One of the women who had been caring for the children entered the room and stood at the edge of the Circle. It was Spirit, Bear's sister. Looking at Bear's face, eyes moist with tears, she spoke out:

Bear had a different diabetic nurse than I had … it was very negative. I went in there with her so I could help her understand what the nurse was explaining to her about her diabetes. Because of the deafness in the one ear, if someone is speaking too fast then Bear can't lip read fast enough. So there are some words that the nurse had said to her that she didn't understand. But with me being diabetic, I understand the terms a lot easier, so that I was able to help her out a little better.

A close connection between the sisters was evident and when Spirit interjected for Bear, she seemed to regain her courage to speak again. She looked up, smiled at her sister from across the room, and continued sharing her story,

It seems like there is no proper time [to ask questions]. *You gotta go over what she* [nurse] *has to say to you, then you got to understand within that time limit. Finally it's* [appointment] *up, then* [she says], *"I'll see you in three months time." We walk away with questions. By the time that our next appointment* [comes] *we forget the questions. That's when I will come and see* [the nurse at the Primary Health Centre at the urban Aboriginal center] *to explain to her what was happening and then she would be able to help better and go from there.*

I'm deaf in one ear. I need my sister to come with me to all my doctor's appointments because I don't hear, most of the words [starting to cry again]. *And if I didn't have Spirit come with me, I wouldn't understand anything.*

As a nurse who worked in the area of diabetes for several years, I know the importance of education and family support in diabetes self management. Several issues Bear shared made me question the provision of health care. How could a health care professional not believe a client who states she has diabetes? Why would a health care professional fail to provide support to a client, especially when the complications of diabetes are life threatening? Why were the health care needs of Bear not addressed over the years? Why had she not had a hearing test and been fitted with hearing aids, if necessary? I could feel myself getting upset again about lack of individualized service provision all at the expense of the client. I wanted to help Bear, hear more, ask questions, refer her to health care services, but knew I could not at this time. The Talking Circle continued for the others to tell their stories. Another voice had already started speaking.

One of the women with long thick grey hair, who had been so quiet and seemed to have not moved at all since the Circle started, stood up and reached toward Spirit for the rock. She looked down at it much of the time she spoke:

3.8 Wolf

On our reserve, we have our own health department separate from the Band office. We have people that work on Aboriginal health – alcohol, drugs, mental health and healing. There's probably going to be a lot of healing projects from the residential school [due to the IRSSA, and resurfacing residential school experiences]. *We will be working with the Elders and probably the parents, youth and children. You have to work with everybody, because the residential school has caused a lot of problems for a lot of people. My own mother and sister passed away with cirrhosis of the liver and other brothers and sisters have passed away because of alcohol, or run over by a car, or AIDS. So there's a lot of history around different people.*

My history's in residential school. Before that, I was raised in a family environment, with all my uncles, aunts, grandfathers, grandmothers, everybody, all in one house. But then that changed when my father died. There's a lot of ripples that happened in our lives.

I sobered up about thirty years ago. Then I started having children. I had my first son, but I had one before that, but I miscarried. It was a judgment of one police officer, when I lost the baby. It was in a [large city in British Columbia] *and my water broke. The only thing he could say to me was, "Shame on you for pissing your pants." I told him, I couldn't help it, "I think I'm losing my baby." They called the ambulance for me anyway, so I ended up in hospital. I lost it.*

After that, I had four more boys. One of my sons had to struggle through school and he never completed because he was pushed aside all the time. And a few other students told me he didn't have to do nothing and they'd send him out in the hallway.

I was lucky to have a good doctor. He was very helpful. When my kids got sick, he made sure they went to the hospital, got the right treatment, and were taken care of. He used to speak for his patients if they didn't get their treatment they needed. But now he's retired, I haven't had a doctor or seen a doctor since. I only go if I really need to go, like when my wrist is broken.

I think health care professionals need to go back and learn to be human again; cause that's what it is –becoming human and treating everyone else as humans. Not looking at the color of skin. Forgetting about, you know, their own beliefs and learning who the people really are, because most of what they learnt is from their parents, grandparents and the media. They haven't learnt the truth about us. They just learn by rumor. Just like our tourists that come to my reserve one summer and what they wanted to see was Indian people making teepees, living in teepees, making Indian things. That's what they expected. I told them, "That's not how we live today. We aren't those savages they called us." That's what we were to the people – savages. They have to get to know us, who we really are.

I experienced this [racism and discrimination] *last week with one of my nieces. She was in the hospital. Her baby had seizures. She breastfeeds and takes good care of her baby. She's only sixteen and is a very good mother. Social services got involved. They were accused of being poor parents, and she was alone in there. Her parents weren't there. So I guess she felt attacked.*

We have to learn about our own history because I learned from other people telling me what my mom was like, and that helped me understand why she was like that. And my stepfather too, all the abuse, learning to understand his background helped me to forgive him and let it go. I guess a lot of stuff from my past I've learned to let go. Now I depend on my Creator, cause years ago I wouldn't have said this much [laughter].

I know when I first sobered up I would just sit there and listen. They would ask me to speak I'd say "No!" [laughter]. *I just listen to other people. I have this urge to tell my story now. But I haven't done that yet, so, this is the longest time I have spoken in a long time.*

More about residential schools, being taken away from family; and the "ripples" that occurred – abuse, addiction, and death. Having a health department on the reserve would help provide supports for people as they told their stories about residential school in court hearings. Her experiences were profound, especially how she was treated when she was losing her first child. As I looked around the room while she spoke, there were tears in almost everyone's eyes. Images flashed in my mind and I could not comprehend how these experiences she described impacted her life. Although I felt happy for Wolf that she had a great physician, I was concerned for her health and wondered how long it had been since her last health checkup.

As I sat in my chair, across the room from Wolf, aware of my surroundings, my mind grappled with the atrocities the women had described thus far. They seemed to be common occurrences in their lives. I wondered how this can be changed. What is my role, our role as health care professionals, and human beings, to make this stop and help the healing?

Another one of the women, the one with long black hair, had walked over to get the rock, sat back down and began:

3.9 Eagle

Mom and dad had moved to Thunder Bay. The reason was that our parents believed the little ones weren't going to have a chance on the reserve - we'd have a better education, a better life [*in the city*]. *When were growing up we had a very healthy, heartwarming experience with the doctors and the nurses and I myself going through three cesareans and having two boys and a baby girl, was great.*

Eagle spoke about positive experiences with her family physician then shifted to negative experiences that occurred while working on reserves:

This happened in 1959, at a university women's hospital in eastern Canada, when a young [Aboriginal] *woman, who lived in the remote north, was brought* [flown] *out for a scheduled cesarean section for her second baby. This was terrible I had never ever in my life heard anything like this - it was on the news and in the newspaper. Beautiful baby son, she has. You know what that doctor did to make her scar, pretty? He put beads on her; he sewed beads on this Anishnaabe*[3] *Indian. It was worse than obscene to see these beads sewed on her beautiful, beautiful body. How could you desecrate a body like that? You know, to anybody, you don't do that!*

I was covering these twenty six reserves, going to these different nursing stations and to hear what these nurses and these doctors have to say. It was unreal! I started using one of those recorders and I let them know. This nurse, she said, "I wish all those Indians would just go and die! They don't need anything. They're taking up the air. They're taking space in the hospitals." I said "I've got your job,

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[3] Anishnaabe is the term used for First Peoples in eastern Canada (Alfred, 2005).

and I'm going to take it now [terminate employment]*." I've worked in Ottawa. It doesn't matter where I work but I will not ever, tolerate anything like that! It don't matter what you are.*

Even though the story she shared was not her personal experience, the story for me was a disturbing example of blatant racism, discrimination, and desecration - just for being Aboriginal. What has this done to the hearts and personhood of Aboriginal Peoples? Stories had uncovered local and provincial acts of violence and now in a distance province in Canada. How common are these types of acts in other countries? There was no time to absorb the enormous impact on Aboriginal people in this room and internationally. The rock had been passed to her sister who sat beside her on the couch, in the Circle. She also had long black hair. Her eyes connected with each of ours as she held the rock in her hand and shared her story:

3.10 Annabelle

It's really true. I mean the discrimination and the racism is rampant. Even from my own personal experience. I had to go see a specialist. I'm afraid to make that appointment with him because when I went and first saw him he wasn't very sensitive. He had no personal qualities in saying, "How are you this morning? Is everything okay? It may hurt a little." But nothing like that. He gave some medication for my sinuses and he says to take that. I didn't take it because on the label it says if your nose is bleeding you are not to take that medication. When I went back, he says, "Why aren't you taking it?" I said, "My nose is bleeding and the medication says you're not supposed to take it." He says, "Well, are you

sniffing[4] [Annabelle's emphasis] *too hard?" I looked at him, and he says, "Well come back when it clears up a little bit more."*

He's a specialist he's supposed to know this and when he prescribed that to me and he says, "Are you sniffing too hard?" I was supposed to make an appointment with him two weeks ago and I'm afraid to and I don't want to. I don't know what they are going to do. I don't know what he's going to say. I still haven't gone back, only because the blame was on me. So it's my fault because what he had recommended wasn't working right? He didn't bother asking how sensitive I am to sprays. I'm just sensitive to even use perfume or anything like that. My skin just can't take it.

There is so much racism right there at the door, behind the door and wherever you go. In the healthcare it's ridiculous. Then the affordability, I may be Status but what about those non Status, how are they going to afford to pay for it? It's just, it's huge. For me, a social worker, being scared to go see a specialist and not making that appointment for two weeks. I'm putting my health at risk because of who he is.

I just wanted to say that with bringing in family members in today's world does not work. I have years and years of experience already and they treat you like you don't know anything or don't have the ability or don't have the knowledge of working with your own family; or don't have the understanding of what the healthcare professionals are saying. They treat you as if you are dumb. They don't even believe you when you're telling them about the family member and how they're behaving and that they're sick. You know, whatever is happening with them.

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[4] The word 'sniffing' is used to describe inhalation of solvents. Although this is a health concern in some Aboriginal communities, is has become a generalized stereotype of Aboriginal people (Smylie, 2001).

Because if you spend every day with a family member, you know what is happening with them daily. The healthcare professionals, they don't listen and this is something I've been working with. I've been looking after my mother-in-law for three years and not once has a healthcare professional listened to what I had to say and didn't talk to me directly. They would talk to my mother-in-law but she didn't understand because there are days when she wasn't capable of, understanding what anyone was saying. So they would need to talk to me, but they wouldn't directly speak with me.

It's frustrating. I've lost a lot of respect already with the healthcare professionals only because they just don't care who you are. This is my own personal experience. I don't know what other experiences there are with other people. They don't look at us as persons especially with Aboriginal people they never did. We weren't considered persons until 1960 and even then they thought it was a joke. So I mean, yeah the healthcare system sucks. It does.

Not being considered a person until 1960! Not a person? I could not grasp this truth. This was within my lifetime! Who decided this? For what reason? Just for being an Indian? More stories about racism, being silenced and ignored, treated as dumb, and not being heard or listened were exposed.

Fear of repeated mistreatment by the specialist prevented her from returning for follow-up. Health care choices because of mistreatment were having an impact on her health. How long will she put her health at risk and continue to delay or refuse to return? I had never felt fear because of how I was treated by a health care professional, but I had white skin blonde hair and blue eyes.

My mind was full of negative stories and how they impacted life, health, and happiness. Some seemed to be repeated, on a different date, place, or time, and executed in a variety of ways. I was so overwhelmed, but as I looked around the room, I saw all of the beautiful, wonderful women seated in our Circle. We were taking turns sharing our knowledge, exposing our vulnerabilities, and opening our hearts. There was a closeness I felt with them, no matter how horrible the stories. As I thought about my ancestors and wondered what they had experienced, the rock had been passed on to one of the youngest women in the Circle. She spoke in a quiet voice, almost a whisper:

3.11 Mahoya

I just want to share a story. It was when my baby was born real small. He was born four months early. He was about the size of my hand. He had no nipples. You could see through his skin. He went through heart surgery, hernia repairs, laser eye surgery, four different surgeries and he was ventilated for three months. I know my experience at Children's Hospital was really positive. The staff there was pretty young and they're all up to date. Then after five months he got transferred to the local regional hospital and there's a lot more older nurses there. I don't know; I just didn't feel the same respect there that I did at Children's [hospital].

The one time my great grandma, my native grandma, wanted to see him, but visitors weren't allowed into the nursery, only parents were allowed. She couldn't understand, she said, "Well, I haven't seen my great grandson. Why can't I go in?" and then she started swearing and everything. She was really mad, but the nurses didn't really do anything about it. I felt really bad because I didn't know what I could do. It was a couple weeks later when my white grandparents, my non-native grandparents, came and the nurses let me bring my son to the door for them to see. There is discrimination there.

I'm facing a bit of discrimination with my pediatrician right now. She just makes us feel uncomfortable like we're the worst parents ever because we have our kid in daycare and that every other parent who has a kid with respiratory problems takes their kid out of daycare. She says things to us that just really make us uncomfortable and sometimes I'll leave her office crying because I feel like the worst parent ever. I don't think I should be feeling this way. I've spoken to my GP, my family doctor about her.

During Christmas my son got sick, he was put on antibiotics and he had a reaction. So I called my pediatrician's office and the secretary said, "Oh no this doctor is only seeing your son for his asthma" and I said, "My son doesn't have asthma. I've never been told this before. I thought that she was seeing him for all his complications for his prematurely"…. There's been miscommunication that I can't get a hold of my pediatrician to talk to her about it. I'm trying to get a new pediatrician. Some of my family members feel that it is discrimination.

So that's been my experience so far, and I know from my personal experience having my son in the hospital for so long. I know how to advocate for other parents and other Aboriginals and as an Aboriginal when I'm out there working. I know it's going to be difficult sometimes [as a nurse] *to stand up to doctors or to your boss and upper management about some of these issues, so, I have to learn the strength and I'm glad I'm here listening to your stories. All My Relations.*

Not heard, mistreated, ignored, discriminated, and judged were added to the list of thoughts and images that had surfaced from the other stories. Why was colonization being perpetuated? Has there not been enough suffering already? I remembered the purpose of the research and why we had gathered in the Circle – to find a common vision from which to begin to make positive changes for nonracist and nondiscriminatory health care for the women and their families. The rock was passed on to another young Aboriginal woman who is a nurse:

3.12 Rain

I had done some teaching within this health authority, oh about four years ago, in regards to the health status of our people and trying to teach physicians, nurses, social workers about that history piece. It was something they didn't know. I realized that although I was teaching it, there also needed to be that experience from the Elders, from youth, a whole different perspective. I was speaking from my experience as a First Nation nurse, nursing in a hospital setting or in this health authority. If you look around, there is no diversity. There are very few First Nation nurses, so I am really happy to see more coming up.

I also began to feel that, "Why was I the one? Why was this put on me to educate these healthcare providers?" Because in doing so it will become an Aboriginal issue and [management saying], *"You go deal with the Aboriginal issues and health concerns." I realized that it had to be a collaborative between a health authority. It had to become entrenched in a healthcare system, in a hospital setting, and it had to go way back into the education curriculum where it belonged.*

I think they've [health authority] *got it backwards. And I say that because the years that I spent trying to teach* [cultural safety] *that, for the most part, the people who come, you're preaching to the converted. They're the ones who like to know all this and they're the ones always there. It's the ones who really need it and they don't think they're racist or discriminatory; those are the ones who stay away because they don't think it's important. If it's not mandatory, it's not going to work. And furthermore, I think the regional health authority really needs to have an* *environment that supports cultural safety and cultural sensitivity because its fine for people and workers to come to it, but if the whole structure doesn't support that, in the workplace and in the schools, it's not going to work.*

More issues, more assumptions. What became evident was the reality that these stories were crucial in understanding what had happened and what continues to happen to Canadian Aboriginal women. There was so much wisdom in this Circle, so much life, I felt confirmed that as we continued to talk, remember, dream, hope, and heal, change was possible. Together we could make it happen.

A happy sounding voice broke the heaviness within the Circle. The youngest woman among us, had the rock in her hand. She was smiling – such an uplifting look. It seemed like the Circle was filled with sunshine and warmth:

3.13 Rose

When I went into nursing my grandma was thrilled. She was like "I told you to be a nurse." And so she's pretty excited. For me it was just more of a chance thing. But I find it very rewarding so far and able to connect with the First Nations patients on a different level than other people I find can.

Some youth do not think about going to post-secondary school, because my cousin was thinking about going into nursing and when she told her mother, she said "Oh, don't you think you should go for something else?" Like it's too hard. I find that sometimes families are their own barriers to the younger people going into it, or the younger people underestimate themselves. I was fortunate enough to have a supportive family like my parents and my sister and our Band makes it relatively easy for applying for funding and stuff.

I thought about the importance of family in our lives. Is this not one of the reasons I was doing this work; to learn more about and help my Aboriginal family, all my relations and ancestors, not only those in my immediate family? Is it possible for me, as an Aboriginal woman and nurse, to connect with Aboriginal patients on a different level? I fear I would need to tell them I am Aboriginal because I do not look Native. I was excited with the possibilities that the knowledge I was gaining would guide my nursing practice and personal life and help me teach others.

Spirit reentered the room, and sat on the arm of one of the couches nearest Bear, her sister. Someone else was watching the children in the other room. She began to speak while Rose passed her the rock. Her voice was deep and strong. She seemed to speak with thoughtful determination:

3.14 Spirit

Well you're a native. Once again the nationality aspect with some Aboriginals. You can't tell if they are because they are mixed blood, you know, half white half native. So there is that labeling. You don't look native, why don't you get a native person to speak to the people here in the native center? So you feel once again on the defense. Gotta prove to ourselves that, yes, we are Native and we're proud of it.

I'm trying to learn everything about it because I went through school where I was labeled. I wasn't white, and I wasn't native so I was Chinese or Japanese. In particular, this happened in a P.E. [physical education] *class and they were having competition on who would beat each other in a volleyball game. First the Natives verses the white, the winner would take me on, because they weren't too sure what I was right? Or who I was.*

Most of my growing up I was taken as a boy or a guy and you know plus the way that I was dressed and how I would present myself. I felt that I had to have walls up and I had layers upon layers of clothes that were baggy. I was also into the *baggy style at the time. Everything was all black; black pants, black hat, black shades, you know, and black shirt, everything was black for me. It took a long time for her* [nodding to her sister beside her] *to get me out of black, because that's how I was raised and so plus being labeled as a boy, and built like a guy, then I had to do guys work.*

When I was in [another small town close by]*, I had to be with the men crew doing the yard work or cutting wood, because I was built like a guy. Then I was also being labeled as handicap because I went to a local non-profit facility for people with mental and physical disabilities. There they taught me that I couldn't handle my own money. I couldn't go out shopping for myself, and so my disability cheque was always handled by someone at the facility. Then they would only allow me, like I had to sign a form saying that I received ten or fifteen dollars for that week, and I had to make that last all week. So I felt very belittled there.*

I was labeled so many different things and I was so hard. I had so many walls up that I didn't want to let anybody in because I was afraid of being hurt, verbally, mentally, physically, sexually, whatever. I just didn't want to get hurt anymore you know. That's just some of the ways I was brought up. If I didn't do one thing right, I would get a beating for it. So I would always be cautious about what I was doing, whether it be working with kids.

In everyday chores or even be out downtown, I felt like I had to watch over my shoulder. If someone moved their hand quickly I would jump, and cringe. The worst fear, that I had, was when someone would come up behind me, and touch me, to give me a hug, because that's how my attackers would attack me, was come up from behind scooting me around. My first instinct was to punch first and then ask questions later.

I've had different tools given to me on how I can handle this … there is so many things I wish I could have been taught when I was younger but its just, I just got to learn from my experiences and what I went through, and some are good; some are bad.

I was saddened by what Spirit told us she lived through, just because of her physical appearance of not looking Native or white. People treated her like she did not have an identity. Imagine, having no identity, being isolated, and segregated. Multiple labels were used by others to try to place her in a certain race or culture, as "different" from themselves. The tone of her voice was matter of fact like, but sounded so sad, defeated, and hopeless when she spoke. Her days seemed to be filled with ways to hide and protect herself from abuse. What would it have felt like not being allowed to be independent, manage your own money, have decisions made for you, when you are perfectly capable and had every right? Seeing Spirit interact with the children was heartwarming. She was so kind and gentle with them. How can one comprehend how she had been treated, just because people were not sure what or who she was?

Slowly, one of the younger women tried to sit forward and struggled to get up out of the deep arm chair she sat in. She was visibly pregnant. Spirit took her the rock so she did not have to stand up. The young woman rubbed her swollen tummy and with a smile on her face she spoke to us:

3.15 Nigwa's Daughter

This is my pregnancy number five. My last two pregnancies, the nurses looked at me when I went in with my water broke, "Oh your water didn't break, you're going to have to find somewhere to go" because I'm living in [a small city several kilometers away] *at the time. Well okay, my mom lives here. But it's just the* *way she said it, she's really rude about it, like "are you sure?" And my second daughter that I have, when her water broke and I came in, I made sure I didn't change my clothes until I got here, I didn't care who's car I was in, I was wearing my ucky old yellow clothes. I got here and I changed my clothes and I gave my clothes to the nurse because they did that paper test thing. You know just the whole way she was talking to me. It was the same nurse both times, when I went in. She said the exact same thing to me. They* [nurses] *had complete disbelief that my water broke. They didn't listen. They probably didn't want to hear me.*

When I was in [a larger centre] *with my son when I had him, they kept me in the room I delivered in. I found out after that I was actually supposed to be moved to a different room. I didn't eat until the very next day, when my mom came. She came on the bus from here (several hundred kilometers away) and she, and my ex-spouse at the time, brought me food. It was in this bag and I just started horking it down. But you know they completely forgot about me. I was way in the back of the hospital. You have to go off the elevator and turn left and then turn right and then go way down the hallway and then turn again. It's the exact same room I delivered in before. I was there for a week, in the same room. They didn't move me and the only reason they brought food was because my mom and ex went and reminded all them, "Well, she's hungry, you got to feed her." Mom and my ex were bringing me snacks and food.*

As Nigwa's Daughter talked more about her birthing experiences, it was like she was still in that room way at the back of the hospital. She then began to recollect school memories:

In high school, now my husband is twenty four, he went as far as Grade 11, and right from Grade 8 to 11 he had someone doing all his writing, all his *homework and all that kind of stuff. When I was in grade 6 they tried to tell my mom that I couldn't read and that I was dumb. I proved them wrong. How did he* [teacher] *say? I was reading a novel that even a Grade 12 student couldn't read?* [Looking at her mom across the room and smiling]. *I got out of that reading class.*

When I went to high school ... me and my friend, we both took law… I would do half the work and he would do none …. Midterm grades come out and we'd both get B's or A's ... He never did anything. He should have at least failed it you know. So they [non-native students] *got special treatment still.*

I thought, more examples of being, segregated, ignored, forgotten, discriminated, labeled, mistreated, silenced, prejudged, and lied to, just for being Aboriginal. Another child along the way, she will need to go back to the hospital. What will she encounter? How will she manage? Does she wonder how it will be for her this time? Does she have a plan? I could not ask, could not interrupt, someone else was reaching for the rock.

What keeps her strong, to move on? I could see she was close to her mom because she often looked at her while she talked, was this part of her strength? Many of the women talked about the importance of family. I wondered if knowing what her own mother endured, gave her this strength and courage.

Nigwa's Daughter joined us for two of the Talking Circles. She delivered a healthy baby girl during the study and was less able to meet with us. She came to visit one day six months later to let us see and hold her new baby. I did not get a chance to ask her about the events of her birthing experience.

The Elder who helped plan the study and prepare the Talking Circles spoke several times throughout the Circles. She opened the Talking Circles with a personal story and encouraged the women to start speaking and to speak when there was a quiet period. She seemed to sense how long to allow the space to be silent, when to tell her own stories, and when to ask the speaker a question for clarification or encourage her to share more of their story. This was done in a way that facilitated further dialogue, supported the speaker by showing interest in what she had talked about, without interfering, overtaking the speaking time, or changing the course of what was being said. Elder Two had the rock in her hand. It was her rock that she shared with the group. While she held it she looked at it, rubbed it and commented that the rock is always in her pocket. She explained that she rubbed it often, it helped her find peace just by its warm and smoothness. She also chuckled and said she had used the rock so much over the years that her rubbing had changed the rock from being flat to having a spooned in shape in the middle. She held her head high and spoke in a clear strong voice:

3.16 Elder Two

What I experienced even as a child, a new nurse, a middle aged nurse, an old nurse, is that it hasn't changed. I think that in some instances of racism and prejudice may be a little more subtle now. I used to be always called a "dirty fat Indian" like it's always been assumed that we are dirty for some reason. I don't get that now, but I'll get things that make me feel that way I felt when I was actually told those words in plain English. It will be the attitude of that person, their body language especially their attitude towards me. Like when I started to work as a director [of nursing] *I moved to this town specifically for the job. One of my peers said to me, "We've got two of you here now", and the 'other one' was her dad. I thought, "What do you mean by 'we got two of you here'?" I didn't quite understand why that had to be said and I didn't quite understand why that person said it. Was it positive, was it negative? Was it a joke or what was it?*

As far as working as an Aboriginal nurse, I've had some really wonderful experiences where people have been happy. They will say, "Oh are you really an Indian? You've got blue eyes." But then they'll put their arm up next to me, and say "Oh ya, your skin's brown" and they sort of felt honored in a sense that I was taking care of them. I have had others that have said, "Get the hell out of my room! I'm not having a dirty squaw or Indian!" or "How do I know you haven't been drinking last night?!" When I was a bedside nurse I would just ask for a different assignment. Because in my mind I thought, "no, I don't want to be with them anyway, they didn't want me there so it was best just to part ways for both of us."

I've talked to physicians and they've said, "Well yeah I heard about that residential school, what is it?" And that's all they know. There was one physician that I know in town and he said, "You know, I've been practicing for over thirty years, I've heard this talk about residential schools. What is it? I don't know anything about it?" Even my own physician doesn't really know anything about the history about our people.

I found that the staff I worked with ultimately did come to respect me. They might not have at first, especially if I was the boss. They didn't like that very much, like, "What's this brown skinned person doing there when I should be?" But once they got to know me and I did share experiences with them and explained reasons why [I felt discriminated against]*, then I saw attitudes change. It was because they didn't have the knowledge.*

It's unbelievable the inequities in wages. There is no core funding and you're lucky if you get five years funding or it might be three years or you might be writing a proposal every year. We've been lobbying the government to increase the funding amounts. For example, if you work at an urban Aboriginal health and *social service organization, like I was hired as an RN coordinator, my wages were very low. If you work on the reserve, usually your wages are lower than if you worked in the hospital. If I was a young person and I had a family, I would be looking to get a job at the hospital or in public health or whatever, unless for some reason I had lots of money and I could afford a small salary.*

As far as the local hospital goes, there's they say, an Aboriginal liaison and she's supposed to be for the whole of the health region so that's impossible but that also goes to show. There was an Aboriginal health and wellness plan that was developed in 2002. It was redone last year and one of the recommendations was to have Aboriginal liaisons in the hospitals for our people when we go in there and it hasn't been acted upon and that is now five years later.

I had just so much difficulty in trying to get policy changed when I worked as an Indian nurse. It used to be that any Indian child no matter how old they were, automatically had their hair cut. They used to use lice shampoo because it was assumed that ***ALL*** [Elder Two's emphasis] *Indian children had lice. When I was a student nurse, a long time ago, I could not get that policy changed. I got it changed in the second hospital I worked in. I really had to fight for it because it was not necessary. It is assumed for some reason we all have lice and are dirty. We all don't have lice and we're not all dirty. So it's been up and down and up and down.*

I really honestly and truly feel that it's important for health care professionals somewhere along the way to learn the history, culture, traditions of the Aboriginal people. We are the First People of this country, of this land and so to me, that is really important. If you learn that, you learn to respect people that are different from yourself, that are of a different color. If you can learn to respect and *deal with me, then you will be able to learn to respect and deal with those that are black, yellow, brown, white.*

3.17 Stories and Truths Guide the Research Journey

This chapter exposed a number of stories told by the urban Aboriginal women participants in this study. All of the women were eager to tell their stories and expressed hopefulness that this study would result in improved health care encounters for themselves and their families. They also stated they wanted to teach others about Aboriginal people and their history to gain a better understanding of their lives, through their stories. Using Indigenous Methodology to ground the research, Talking Circles were used as a traditional method for storytelling. The Circles, facilitated by an Elder, beyond doubt, provided a safe space for the women to share their often painful, profound and revealing stories about their experiences of health, social services and educational institutions. Traditional Talking Circle protocol was followed by the women who knew the rules and were copied by those that did not. An unwritten protocol that allowed for flexibility of the Circle was apparent and based on the knowledge and needs of the women present. Indigenous Methodology and methods used for the study will be presented in detail and in relation to the learnings that arose from the research process and Talking Circles in the methodology/methods of this thesis. Exploration and analysis of the meanings that surfaced within the woman's stories, as well as questions that arose while I listened as they spoke, and other questions that arose during the study will be discussed and explored in the findings/discussion chapter later in this thesis. A comprehensive review of the literature is now presented.

CHAPTER 4: EXPLORING THE WRITTEN TERRAIN

In the previous chapter I presented stories from the urban Aboriginal women who participated in this study and the realities they face in their everyday lives. Multiple issues about Aboriginal health and wellbeing and interrelated factors surfaced, and the experiences that they related have historical antecedents that require unraveling. Early in my studies, I was told by one of my Elders, *You cannot understand the present without knowing about the past. The history of our people shape who we are today and who our children will be tomorrow* (Elder Two, personal communication, May 23, 2007). Over time I realized what she told me to do was undertake a serious and difficult quest and to do that meant immersing myself deeply in the literature.

In this chapter, I provide the reader with an overview and critique of 600 sources, dated 1867-2012, of national and international literature that I located through my search of scientific, analytical and conventional qualitative research; Indigenous research; government and media reports; and autobiographies. These sources give a wealth of information about historical, societal, political and cultural factors related to the health of Aboriginal peoples. The central concept that was searched was Aboriginal health. That and relevant synonyms (i.e. Indigenous health) were combined in various permutations with terms such as urban, residential schools, sixties scoop, racism, colonization, decolonization, generational /intergenerational trauma, traditional health practices, health care beliefs and values, Canadian health care system, cultural safety, culturally appropriate, health care experiences (including issues of access), policy development, decision making, self-determination, and empowerment. A second part of the literature search revolved around exploring culturally appropriate research methodologies. The term Aboriginal, and relevant synonyms and categorizations (i.e. Indigenous, First

Nations, Inuit and Métis), were combined with traditional knowledge, methodologies, research methods, and epistemology. A third part explored previously published research on health care provider practices, relationships and inclusion of Aboriginal people in research and involving Aboriginal people in the transfer of knowledge such as the teaching of health care professionals. Again, the term Aboriginal, and relevant synonyms (i.e. Indigenous and First Nations were combined with the key words traditional storytelling, talking circles, learning circles and healing circles.

The interdisciplinary nature of this research is reflected in the breadth of databases that were searched. Library databases that were explored with the above criteria included the Cumulated Index to Nursing and Allied Health (CINAHL), Educational Resources Information Centre (ERIC), Google Scholar, ProQuest Dissertations and Theses, PubMed (MEDLINE), Social Services Abstracts, Social Work Abstracts, and Sociological Abstracts. National, federal, provincial and local government and Indigenous websites were also accessed for reports and publications. The reference lists of research that was retrieved were also analyzed for relevant studies that may have been missed in the original database search. I also used resources from my personal library of Aboriginal and health literature that I collected over the years.

The literature I examined that informed my understanding of urban Aboriginal women's health and life experiences are highlighted. Through my immersion in the literature, I unravelled interconnected underlying issues that impact the health and wellbeing of Aboriginal people and these are presented in this chapter. The literature review is nested in five main areas regarding the health and wellbeing of Aboriginal people in Canada: a) the impact of colonization; b) the

Canadian health care system, c) the state of Aboriginal health in relation to health determinants and factors that influence health inequities between Aboriginal and non-Aboriginal Canadians; d) Aboriginal women's experiences with health care services and the impact of these encounters on their health and wellbeing; and e) Indigenous research with, by and for Aboriginal women that informs health care policy, health care professional practice and service delivery.

References to Indigenous people within this chapter and throughout the thesis are not meant to generalize this population as one homogenous group based on similar histories, health care beliefs, individual experiences, treatment or human suffering or for that matter issues faced by non-Aboriginal people. Rather, the discussion being focused on Aboriginal peoples in Canada, is intended to acknowledge their unique experiences and contributions as distinct people and to illuminate deeply rooted sociopolitical and historical forces that continue to impact their health as colonized people. Being of Aboriginal ancestry is reported as a world-wide issue of concern, and this literature review highlights the plight of Aboriginal people in Canada. This is not to undermine or dismiss concerns or issues that Aboriginal peoples face in other parts of the world. Rather, it acknowledges that the multiplicity of problems encountered by Aboriginal people in Canada mirror those of other Indigenous people in various geographical locales, connecting them in distinct and unique ways.

4.1 The Colonial Terrain

This review of Aboriginal history in Canada is broad and includes an overview of both governmental and Indigenous sources of information from a variety of colonial and Aboriginal perspectives. In this section of the literature review I provide a backdrop or foundation from which to unravel the unique challenges that Aboriginal people face in relation to their history. As I constructed this review of the history of Aboriginal people in Canada, it became obvious that there is both conclusive and inconclusive evidence as well as conflicting accounts. Further, the amount and veracity of information is varied since much of Aboriginal history is oral in nature. The date, migration paths, population and mortality rates of humans that occupy North America is hotly debated and a rapidly changing area of inquiry that includes molecular genetic studies (Waldram, Herring, & Young, 2006), which is beyond the scope of this thesis. The differences in population estimates and dates that follow are recorded according to cited author.

The oral history of North American Aboriginal people maintain they are the original inhabitants of the Americas and did not migrate from somewhere else (Applied History Group, 2001; Roberts, 2012). Scientists, on the other hand suggest, based on the discovery of the first homo sapiens in Africa over 400,000 years ago, that the First Nations peoples of Canada migrated from Asia across the Bering Strait, south of the Arctic Circle, or by trans-oceanic voyages to become the original inhabitants of the Americas (Applied History Group, 2001).

Prior to European settlers coming to North America, including the area that is known as Canada, Indigenous people occupied the land for at least 12,000 years. Population estimates at the time of European settlement, around the 1500s , were 18 million within the North American continent, and 500,000 to over 2 million people in Canada and between 200,000 to 300,000, in British Columbia, the province in which this study was conducted (Chansonneuve, 2005; Royal Commission on Aboriginal Peoples [RCAP]; 1996; Muckle, 2007).

Initially, Indigenous populations were strong and healthy and lived in diverse and complex societies (University of Victoria, n.d.a). They lived by the laws of the

Creator that respected the land and everything in Creation (Castellano, 2004). They believed in collective ownership, peace, harmony, and good relations that embraced principles of gender balance and respect for roles and skills of men and women in community life (Boyer, 2006).

The linguistic and cultural groupings of Aboriginal people in Canada are: Northwestern Coast, Plateau, Plains, Northeastern Woodlands, Eastern Subarctic, Western Subarctic, and Arctic; which make up hundreds of nations, tribes, distinct languages and dialects, religious beliefs, and political leadership systems, with each having unique cultures based on the resources of the area inhabited. For example, the Northwestern Coast people obtained an abundance of food from the ocean while the Prairie people were known for hunting, harvesting and following bison herds. British Columbia is characterized by a range of costal shores, mountainous, and plateau lands and in this region there are 30 separate Aboriginal peoples and ten general cultures identified. (Chansonneuve, 2005). Currently, in British Columbia there are 200 distinct First Nation communities and bands, approximately one third of total number of bands in Canada, which is more than any other province or territory (Province of British Columbia, 2007).

Generally speaking, Aboriginal people as hunters and gatherers travelled seasonally in small groups throughout resource-rich environments to obtain an abundance of healthy food, returning to their permanent villages for the winter season. They were well nourished and ate a low fat highly nutritious diet of wild game, fish, berries, root, and plants. They used sophisticated methods to manage and prevent depletion of these rich resources. Traditional medicines and wholistic health practices and healing techniques were used to maintain health and initially Aboriginal people did not suffer from deadly epidemics. Women who were experienced in birthing practices, more recently known as traditional Aboriginal midwives, assisted with child birth and infant care. Art and culture were key elements of life within their communities and included basket weaving, carving, sculpture, painting, dancing, drumming and storytelling. The responsibility for education of their young was an extended family endeavor which reflected community values and customs, and included development of skills for survival, and rights of passage ceremonies prior to the arrival of Europeans (Muckle, 2007; University of Victoria, n.d.a).

As can be seen from the above description, the First Nations people of Canada fared well prior to settlement by Europeans. But after European settlement and in a typical fashion exemplified throughout the civilized world, white settlement eventually resulted in territorial disagreements and disputes over land and hunting rights and colonization of Aboriginal people ensued, to the persistent detriment of these original inhabitants. The process of colonization, defined as domination over economic, political, social policies of a dependent area or people, is well documented (Archibald, 2006; Moffitt, 2004). Colonization involves a complex national system that positions the colonizer’s race, colour and culture as superior, and those of the colonized, inferior (Adams, 1999). The social process of colonization fails to recognize or value the existence of Indigenous peoples’ culture. Yet, as literature clearly demonstrates, without systems of belief, language and ceremony, it is difficult for Indigenous people to maintain a wholistic and healthy life (Alfred, 2005; Laenui, 2000). Much of the literature reports colonization as a historical event, yet colonization continues and its generational and contemporary effects are apparent today. Literature and research reports over the last several decades identify descriptions of colonization and its aftermath for Indigenous

Peoples globally, such as in: Africa (Turay, 2000); Australia, (Oxfam Australia, 2007); China, Hawaii, United States (Dei, Hall, & Rosenberg, 2000); Haiti (Farmer, 2004); India (Shroff, 2000); New Zealand (Smith, 1999) and Canada (Adams, 1999; Bartlett, 2003, Browne & Smye, 2002; Mitchell & Maracle, 2005; Moffitt, 2004). Various characteristics and permutations of processes of colonization are recognized in history and the discussion that follows presents an overview of colonization in Canada.

The history of European invasion and domination of Indigenous lands and control of Indigenous Peoples in Canada began over 400 years (Applied History Group, 2001) or 500 years ago, according to Adams (1999) and the Royal Commission on Aboriginal Peoples (RCAP) (RCAP, 1996). There are variations in reports that make it difficult to conclusively place these events into a specific time period. For example, encounters with the Inuit people of the Arctic and Europeans have been recorded over a period of 900 years and with First Nations people for 400 years. Reports of the European "discovery" of North America date back to the 10th century, and the settlers of north eastern Canada, the Norsemen of Scandinavia. In the 14th century northern Canada was settled by the British (Martin Frobisher); and eastern Canada was inhabited by Spain (Christopher Columbus), the British (John Cabot), the Portuguese (Cortec-Real), and by the French (Jacques Cartier). In the 15th century, western Canada was settled by the British (Cook) and in the 16th century by Russians, the Spanish, and by the French. The explorers, fishermen, and fur traders from these countries, especially England and France, travelled throughout the country imposing their ways, beliefs and culture. Missionaries travelled westward through the prairie regions to bring Christian doctrine. Populations also migrated northward from what is now known as the United States of America

(Applied History Research Group, 2001; Yazzie, 2000) and eventually European communities were established in all areas of Canada (Roberts, 2012). Initially, many of the Aboriginal peoples in Canada coexisted with Europeans through the establishment of trade networks and European technologies, and reciprocal sharing of knowledge and skills. However, the majority soon faced upheaval and disruption, especially when Europeans, and later Canadians, took over Aboriginal land, culture and families. It is reported that Europeans found Indigenous people as "barbaric", and used them as a slave labour force until Indian slavery was outlawed in the 1830s (Adams, 1999).

The decades from 1700-1900's heralded the endorsed colonization of Aboriginal people by British government through the development and enactment of policies and acts to gain legal power from which to enforce cultural assimilation. For example, in 1763 the Royal Proclamation (RCAP, 1996) was signed by Indian and colonial leaders to regulate trade, settlement, and land purchases between Aboriginal people, the government, explorers, and settlers. This resulted in military control over much of the once occupied Indian land which stripped Indian people's rights to their homeland. Parcels of land were set aside for "Indians only", which became the standard framework for all Canadian reserves that were mandated later in history. The literature provides accounts of the signing of agreements by Indian and European leaders in which promises were made to exchange resources and protect the rights of both parties. However, as noted by Adams (1999), the Indian people with whom these agreements were made believed promises would be kept, but they did not fully understand the language and implications of these agreements. Further, colonizers often failed to adhere to details outlined in the document (Adams, 1999).

The Royal Proclamation led to the signing of several other Canadian government treaty and other agreements in the 1870's to formalize reserved lands and promises of education for Aboriginal children (Adams, 1999; Waldram et al., 2006). The Constitution Act 1867, (formerly called the British North America Act) and the Indian Act of 1876 are examples of colonization in which legislation allowed the federal government to control Indian people and the lands reserved for them (Waldram et al., 2006).

Aboriginal people in Canada were forced to relocate to designated reserves and areas of land that had limited resources and poor sanitation (British Columbia, Provincial Health Officer, 2009). They were segregated to these government assigned lots of land throughout Canada, which were often located in remote and desolate isolated environments or adjacent to or in urban settings, in which their traditional foods gathered through hunting and fishing were unavailable (Adams, 1999). Their freedoms were curtailed and once on reserve they were required to obtain written permission, a pass, from imperial agents (individuals assigned to carry out treaty agreements) to hunt, leave the reserve, or sell their produce. Started in the 1800's, this pass system was never approved in the legislation and therefore not legal, but this enforcement continued well into the mid 1940's. This control is linked to causing a forced dependency on the agent or government for all aspects of sustainability, some of which continues today (Adams, 1999). Isolation on reserves resulted in lack of adequate resources and access to appropriate education and health services necessary to maintain health and wellbeing. Regrettably, being isolated also caused increases in domestic violence against Aboriginal women, children and elders; addictions; unplanned pregnancy; poverty, and harmful environmental conditions such as overcrowded and substandard housing, food insecurity and contaminated water (Alfred, 2005; Health Canada, 2005; Valaskakis, Dion Stout, & Guimond, 2009).

The European invasion was also responsible for the advent of the people known as Métis, Half-breeds who were offspring of First Nations women and French or Scottish fur traders. Initially fur traders settled in the east, but gradually they migrated westward for the fur trade. The Métis used traditional First Nations medicine for healing and were adept at buffalo hunting, the timber trade, and mining. Many had strong ties to the Roman Catholic Church from the Europeans, while others retained aspects of their First Nations spiritual beliefs. Some reports suggest European men joined with First Nations women because in some tribes, women were the owners of land. By marrying a First Nation woman, the individual became entitled to rights to the land (Boyer, 2006).

Gradual establishments of Métis communities that were apart from Indian or European settlements led to intermarrying of Métis women and Métis men and led to the distinct identity of the Métis. However this did not become formally acknowledged until the early 18th Century. It is noteworthy that because they were not acknowledged by the Canadian government as white, First Nations, or as a unique Aboriginal group (until fairly recently), they were stripped of their hunting and trapping rights and became impoverished (Chansonneuve, 2005). Yet, similar to other Aboriginal groups in Canada, the Métis have their own language, music, dance, and culture shaped by a mixed blend of European, Celtic and First Nations traditions. Currently, they are largely based in western Canada, with a strong presence in British Columbia (Province of British Columbia, 2007).

Over time increasing government control and enforced silencing of Aboriginal people occurred through the deliberate and legislated suppression of languages, disintegration of cultures and familial social structures, all of which is clearly documented in literature (Boyer 2006; Wardman, Clement & Quantz, 2005). In particular, the residential school system, established in the 1840s by churches, was formally sanctioned by the Indian Act of 1876 (Constitution Act, 1867). Commonly described today as a system of assimilation and cultural genocide, the Indian Act of 1876 allowed the Minister of Indian Affairs to control education of Aboriginal people and forcibly remove children aged seven to fifteen years, although some were as young as five, from their families and send them to schools commonly located in distant isolated communities (Chansonneuve, 2005; Heritage Community Foundation, 2002; Okanagan Indian Band, 2009). Residential schools, with the main remit of assimilating Aboriginal children, were more common in western Canada and are reported to have operated until 1969. However, a few of these church-run schools remained open until the mid 1990s (Roberts, 2012).

It is estimated that over time 105,000 to 107,000 First Nation, Métis and Inuit children attended residential school. The majority of children were First Nations children and 5% were Inuit. However, it is difficult to confirm the number of Métis children enrolled because they were either recorded as Half Breed or not at all. Being of mixed blood they were treated as outsiders in residential schools by First Nations children and non-Aboriginal workers alike, even though they endured the same hardships while in residential school (Chansonneuve, 2005). Aboriginal children were forbidden to speak their own language or practice their normal traditions and beliefs which are important to maintain health and wellbeing. Parents were often not allowed to visit their children, rupturing the bond between parent and child. These losses affected the child's self-identity and severed connectedness to their families and communities (Boyer, 2006; Brant Castellano, Archibald, &

DeGagné, 2008; Heritage Community Foundation, 2002; Indian Residential School Survivors Society, 2006).

The majority of research and personal reports about residential schools describe un-scrutinized access to children by colonizers, which resulted in physical, spiritual, mental and sexual abuse of thousands who were left without voice or recourse toward their abusers (Chansonneuve 2005; Dion Stout, & Kipling, 2003; Fournier & Crey, 1997; Wesley-Esquimaux 2009; Wesley-Esquimaux, & Smolewski, 2004). Tens of thousands of children died without notification to family or siblings attending the school, and they remain buried in unmarked graves near residential schools (“Protesters Storm Church”, 2010). Such acts ought to arouse moral indignation, yet to this day the voice of the dominant culture remains silent regarding the consequences that such acts have had on Indigenous peoples. Forced relocation of Aboriginal children into white mainstream society is a phenomenon that is not unique to Canada. Within the same era, residential boarding and mission schools existed in the United States, and in Australia, the children who attended residential school, known as the Stolen Generation, shared common trauma and abusive experiences by colonizers with the intent to assimilate Indigenous children into the dominant culture and society (Laenui, 2000).

While the residential school system was in place, the Canadian government continued to control, “civilize”, and assimilate Aboriginal children between 1960 and the mid 1980s by what is referred to as the “Sixties Scoop”. In this time period thousands of Aboriginal children were apprehended from their birth families and placed in foster care with white families. Forced removal of Aboriginal children and placement into non-Aboriginal environments often denied them their Aboriginal culture and customs. Living in a community within dominant white society resulted in the children being subjected to acts of societal racism, multiple acts of abuse and trauma which consequently damaged their self-identity and wellbeing (Alston-O'Connor, 2010; Sinclair, 2007, 2008).

Lest we become complacent and think of acts of assimilation as something of the dim dark past, it is clear that they continue to this day. Currently there are more Aboriginal children in foster care in Canada than at the peak of the residential school period (Ball, 2008), and the number of Aboriginal children in care far exceeds that of white children. Even though there have been attempts by the Canadian government to reconcile and compensate residential school survivors, the lingering effects of residential school and foster care remain and are carried down through the generations. Many Aboriginal people have testified that they feel inferior and shameful about their identity, heritage, language, and bodies, and many have difficulty maintaining their wellbeing (Chansonneuve, 2005; Sinclair, 2007; Wesley-Esquimaux & Smolewski, 2004). The sum total of colonizing effects clearly impoverished the Aboriginal people of Canada and sent clear messages to them that they were an inferior race or class of people.

By the mid 1900's the survival of Aboriginal history and culture was challenged by several levels of colonization through government law, agreements and land claims that continue to be challenged today. Changes to the Indian Act in 1951 allowed Indian people to leave the reserve without permission of the Indian agent, sell their own produce, attend provincial schools and publically organize off reserve (Prince Albert Grand Council, 2008). Yet, First Nations people in Canada have continually struggled for justice. Nationalist anti-racist movements which began in the 1960s formally challenged the Canadian government and led to Aboriginal communities redefining themselves away from a colonized position, to reclaiming their history, culture and sense of nationhood, and this continues today (Adams, 1999). These efforts resulted in First Nations people finally being granted the right to be Canadian citizens and vote federally in 1960. This led to the formation of status and treaty groups united into one lobbying group, the *National Indian Brotherhood*, in 1968, which became the Assembly of First Nations in 1982, to protect national treaty and human rights (Prince Albert Grand Council, 2008). The *White Paper on Indian Policy* released in 1969 by the government called for the abolition of treaty agreements, the Indian Act and other relationships with First Nations peoples. The intent of this policy was for the complete assimilation of First Nation people into Canadian society, thereby eliminating their status as Indians and all negotiated government Indian agreements that had been agreed on and passed (Chansonneuve, 2005). In response, the *Brotherhood* successfully lobbied the government and defeated the White Paper. More recently, based on lobbying from Aboriginal groups, the government funded the Aboriginal Healing Foundation in 1998 in response to the RCAP for residential school survivors to assist with healing. Furthermore, the Indian Residential Schools Settlement Agreement in 2005 was also federally funded from the call for action to acknowledge each survivor's experience (Chansonneuve, 2005: Roberts, 2012).

Aboriginal people are remarkably resilient and strong in response to the historical and structural practices of oppression, and continue to vigorously pursue their rights. Since the 1970's the Native Women's Association of Canada was developed to promote the wellbeing of women through a variety of political initiatives and support services (Native Women's Association of Canada, 2007e). This group worked with the United Nations claim in 1981 to demonstrate that the Indian Act discriminated against First Nations women and was in violation of international law because the Indian Act denied them their Indian status and entitlements when they married a non-Aboriginal man (Department of Indian Affairs and Northern Development, 1995). Their work led to a resolution to eliminate this discriminatory clause within the Act and to establish Bill C-31, which restored their right to maintain Indian status no matter whom they married. Amendments to the Indian Act are ongoing and positive in many ways for Aboriginal peoples in Canada, however, these amendments are fraught with barriers and limitations regarding exactly who is entitled to the changes. For example, a recent amendment to the Act, Bill C-3 *Gender Equity in Indian Registration Act* was instituted January 31, 2011 to ensure eligible grandchildren of women who lost status by marrying a non-Indian man can apply for Indian status. Eligibility criteria include having at least one parent registered under the Indian Act and being born after 1951 (Indian and Northern Affairs Canada, 2011). Children of Aboriginal women who lived in common-law relationships before 1951 will not be allowed to pass on their Indian status to their children, nor will the children born to Aboriginal women in which paternity is unknown or unstated be entitled to Indian status even though their mother is registered (National Women’s Association of Canada, 2011).

Changes in government acts and categorization of Aboriginal people in Canada influence transformations of identity, rights and survival and have resulted in rural-urban migration patterns among Indigenous people. The land that was designated centuries ago is now considered home because of the strong sense of connection to this ancestral land and has special meaning physically and spiritually, however, life on reserve remains challenging through attempts by government to improve relationships and conditions on reserve. Individuals move off reserve and move to larger rural or urban settings due to lack of employment, housing for marriage and family formation, and educational opportunities. Many return back to reserve because they are unsuccessful in finding employment, unable to adjust to city life and lack access to affordable housing. Living on reserve for some is commonly viewed as a better quality of life for raising families without the distraction of city life of crime and being disconnected from the support of extended family members (Kirmayer, Tait, & Simpson, 2009). On the other hand, there are several problems for people who live on reserve that will be discussed later in this chapter.

Ongoing amendments to the Constitution Act to protect treaty rights and to include Aboriginal people in future changes to the Act; and the RCAP funded by the government are also attempts to improve relationships (Chansonneuve, 2005). Aboriginal people have not stood still waiting for such improvements and are moving ahead in reclaiming and relearning their traditional language, knowledge, voice, and vision (Battiste & Henderson, 2000). Among them are a variety of famous and accomplished Aboriginal people who have reached several national and international achievements. For example, the current 28th Lieutenant Governor of British Columbia, Honorable Steven Point (Government of British Columbia, 2007); well known large screen film actor Chief Dan George and Academy award winner Graham Green; singer activist, Buffy Sainte-Marie; Canadian Aboriginal Group of Seven artists including Daphne Odjig and Alexander Young Jackson; Métis leader and hero, Louis Riel; and National Hockey League player and coach, Brian Trotteir, are all Aboriginal people (National Aboriginal Achievement Foundation, 2011).

Even though literature representing the history of Indigenous people is plentiful and discusses colonization and achievement, the majority fails to describe the aftermath of colonialism that continues to harm and oppress Indigenous people in Canada and throughout the world. Again regrettably, colonization continues to inform current racist attitudes and stereotyping of Aboriginal Peoples (Thomas & Green, 2007).

4.2 The Canadian Health Care System

The Canadian health care system involves a complicated combination of financial arrangements between ten provinces and three territories and First Nations communities (Soroka, 2007; Waldram et al., 2006). Prior to the 1867 Constitution Act provinces were responsible for the establishment and maintenance of hospitals, asylums, charities, and the federal government had jurisdiction over marine hospitals and quarantines (Health Canada, 2007a). The Act outlined the availability of health care through federal and provincial funding with stipulations that the federal government would ensure direct services to Aboriginal populations, veterans, and military personnel and the provincial governments for health care delivery for other Canadians (Betker & Bewick, 2012). Various sharing arrangements for federal/provincial/territorial sharing of health care costs and delivery evolved and it was not until 1957 that the *Hospital Insurance and Diagnostic Services Act* mandated provincial funding to provide universal care – medical and hospital treatment for every resident. Community care such as health promotion and prevention efforts were not included. The federal government passed the *Medical Care Act* in 1966, in which Canadians were given the right to reasonable access to medically necessary hospital and physician services, on a government /provincial/territorial prepaid basis (Chenier, 2002). By 1977, this cost-sharing was replaced with block funding in which provinces took control from the federal government of insured health services (Madore, 2003). Canadian health care reform is documented in several reports, a few of the most notable historically that continue to shape current health care are:

- The *Lalonde Report* in 1974 led to the reconceptualization of health promotion, primary care, and hospital and community care (Lalonde, 1974);
- The signing of the international *Declaration of Alma Ata* (World Health Organization, 1978) ensured primary health care for all Canadians. Hence, essential health care was made universally accessible to individuals and families in their community at a cost that was affordable and which used methods and technologies that were practical, scientifically sound and socially acceptable;
- The policy document *Achieving Health for All: A Framework for Health Promotion* was enacted in 1986 and had a strong focus on health for disadvantaged groups, chronic disease management and coping; and the prevention of disease and injury (Epp, 1986);
- The *Ottawa Charter* was developed in 1986, to enable people to increase control over and to improve their health, through health promotion practices (World Health Organization, 1986).

These important improvements to health care reform have resulted in the initiation of health promotion policy and resource allocation, and the establishment of the Public Health Care Agency of Canada in 2004 (Betker, & Bewick, 2012) and the *10 Year Plan to Strengthen Health Care* (Health Canada, 2004) in Canada. The recommendations contained within these documents call for increased access to care and reduced wait times for health care. They also address other fundamental issues such as allocation of human resources; Aboriginal health; home care; primary health care; prescription drug coverage; northern health care services; medical equipment; and prevention and health promotion (Health Canada, 2007a).

The current health care system, based on the Canada Health Act of 1984, stipulates that all Canadian citizens are entitled to health care that is publically administered and accountable to the provincial government. The Act further stipulates that care is to be comprehensive and portable, and will cover hospital, surgical and dental services after three months of residency with no extra costs being levied for out of province care. Additionally, there are no user fees. The health care system includes a variety of services and provides for insurance coverage schemes. For example, hospitals and clinics provide a wide range of services that include emergency management, diagnostic tests and inpatient and outpatient services. Public and private sectors operate long-term care facilities; palliative and respite care and specialty medical, surgical and support services, vision care, prescription drug coverage, medical equipment or appliances. Services of podiatrists and chiropractors are available, some of which are subsidized by the government or insurance companies (Health Canada, 2007a). Within the province of British Columbia an exception is noted and citizens pay a fixed health care monthly insurance premium and there are user fees for some health care services such as physiotherapy and eye examinations, which are either waived or reduced for those with low income (Betker & Bewick, 2012; Canada Health Act, 1985).

Approximately 1.6 million people in Canada work in the health care industry. The health care team includes a variety of health care professionals, physicians, nurses, and other health care providers and health support staff, such as clerical and cleaning staff. Physicians are paid through fee-for service schedules, salaries or blended payments negotiated with the provincial and territorial governments. They work in multiple settings, mainly hospitals and private practices based in the community. Nurses and other health care professionals are generally paid salaries through negotiations with unions or their employers. Nurses, the largest group of health care professionals in Canada, work primarily in acute care settings but also work within community health and public health care service delivery. Dentists work in private practice and their services are not covered under the publically funded health care system. Rather, their services are purchased through extended care insurance or included in employer benefit programs. Other health care professionals include optometrists, laboratory and medical technicians, pharmacists, physiotherapists, psychologists, speech therapists, and audiologists (Health Canada, 2007a).

In 2008, Canada's health care spending was 10.4% of the gross domestic product, in comparison to 16% in the United States, and 8.5% in Australia in 2007 (Organization for Economic Co-operation and Development, 2010). Research indicates that increased spending on health care is not necessarily a predictor of better health. For example, Canada reported better health outcomes than the United States despite its 16% GDP commitment. More recently the combination of publicly funded not-for-profit and largely privately delivered health care system in Canada has proven to have favorable health outcomes and cost-effectiveness (Starfield, 2010). On the whole, Canadians support the health care system and agree it is one of the top priorities for ongoing funding and sustainability.

For Aboriginal people in Canada, colonization not only forced assimilation and cultural genocide through the education system and in the child welfare system, it also caused problems for them within the Canadian health care system. A discussion of the health care services available to Aboriginal people in Canada helps explain their current health status and access issues. As previously stated, prior to the European invasion of North America, First Nations people were mainly healthy and managed their health wholistically using traditional medicines and healing practices. The management of health care for Aboriginal people in Canada is complicated with numerous accounts of differing provision amongst First Nations, Métis, and Inuit people. As Drees (2010) notes, "Aboriginal perspectives on the history of formal health care in Aboriginal communities are, to date, scarce" (p. 141).

Groups of explorers and expedition companies that came to Canada, often included at least one physician who at times offered health care for First Nations people. In the early years of colonization, Aboriginal people shared their health practice with colonizers to help them survive in this new land. For example, they taught them to eat spruce tree bark to prevent scurvy, and First Nations women experienced in birthing practices commonly provided maternal child care for many Euro-Canadian women (Waldram et al., 2006). Unfortunately, for the white population illness and epidemics rapidly increased mortality rates and physicians were less able to tend to the health of Aboriginal people due to the need to concentrate on the care of their own people, who lived mainly on ships or trading posts and in populated areas in which trading occurred. Over time European contact decimated the Aboriginal population especially through the introduction of foreign infectious diseases. A variety of controversial reports are noted in literature, with some authors suggesting that the introduction of epidemics was purposeful genocide by colonizers to hasten extermination of Aboriginal people. For example, Waldram and colleagues (2006) list several authors who have generated a large body of literature that reports epidemics were planned and executed plots by Europeans for the destruction of Aboriginal societies. The Aboriginal population in Canada, plummeted by 40 to 90% by the late 1800's due to diseases, such as small pox and tuberculosis (Chansonneuve, 2005; Indian and Northern Affairs Canada, 2006). It took over 400 hundred years for the birth rate to exceed the death rate of Aboriginal people in Canada (Gerlach, 2007).

In the midst of reported attempts to wipe out the Aboriginal people of Canada, it is also reported that prior to the confederation of Canada in 1867, established missions provided health care for Aboriginal people who lived close to the trading posts. Missions were the first to build and staff hospitals throughout Canada. For example, the first such hospital built in 1639, located in the eastern province of Quebec, was operated by an order of Hospital Nuns, the Ursulines. Many orders of nuns continued to manage and staff hospitals until fairly recently (Waldram et al., 2006).

Government run medical services for Aboriginal people at the beginning of the 20th century were virtually absent. Waldram et al. (2006) report the Canadian government as disinterested in the health of First Nations people, even though it is stated with the Constitution that they are responsible for their wellbeing. In fact, these authors describe one of the most controversial areas within multiple treaty agreements is the right to free, comprehensive health care for Indians. The Canadian government denies this promise though some Indian groups state this was part of the treaty agreement. The details of these discussions are complicated and outside the scope of this thesis, however, the degree of disagreements continues to impact Aboriginal people today.

In the late 1800's health provision for Indian people had not been organized and bands were required to pay for medical service such as treatment by local physicians and hospital care on a fee-for-service basis (Waldram et al., 2006). In the 1900s the health and social status of Aboriginal people was so appalling that the Department of Indian Affairs hired a physician to lead improvements in health care provision (RCAP, 1996). For over 40 years, health care services for Aboriginal people were provided by government agencies, missionaries, military officers, and volunteers until the government mandated that physicians and nurses take over their care (Health Council of Canada, 2005). Between 1945 and 1970's the Indian Health Services in Canada formed state operated health care systems for Aboriginal communities and provided for training of Aboriginal health care staff to deal with the plague of tuberculosis that was destroying Aboriginal communities. Consequently nursing stations, health centres and small regional hospitals were located in small and remote regions. Unless Aboriginal people lived close by however, they had to relocate to access health care services and many never returned home (Health Council of Canada, 2005). This served to fracture communities and separate Aboriginal people from those whom they loved. Adding to the difficulty accessing services, Western health care practices were the norm and health care providers were mostly non-native. Thus, health care decision making was hierarchical and done without significant participation of Aboriginal people (Drees, 2010).

The Indian Health Policy of 1979 acknowledged the federal government's legal and traditional responsibilities for Aboriginal populations and agreed to work with them to address access issues and health disparities (Health Canada, 2007b). Whereas the key concerns for the federal government aimed at addressing socio-economic, cultural, and environmental influences on health in First Nation communities, the provincial and private services focused on diagnostic, treatment, acute, chronic, and rehabilitative services. First Nation and Inuit populations demanded the right to take control over their own health care provision, and starting in 1989 the federal government approved the gradual fiscal transfer of Indian health services to the communities requesting to manage their own health care services (Health Canada, 2007d). Consequently, many First Nations and Inuit communities in three of the ten provinces including British Columbia and three territories manage all or in part health care services in their community. The main government operated health services for First Nations, Inuit, and Métis is the First Nations Inuit Health Branch (FNIHB), a federal regionally managed branch of Health Canada that is responsible for Aboriginal health care delivery in seven regions across Canada and supports the delivery of public health and health promotion through community-based health services. Community programs include: primary care nursing, communicable disease, addiction, environmental health and chronic disease services. Today Métis and Inuit people who do not live on reserve have access to the same health care insurance coverage as non-Aboriginal Canadian citizens from mainstream services. The Non-Insured Health Benefits program (NIHB) pays for services that are not covered by the Canada Health Act for all status Indians in Canada who live on and off reserve, and includes medications, dental care, vision care, assistive devices, short-term crises care, mental health services and medical transportation to travel to distant urban areas for services not available within the local community (Health Canada, 2007c). As can be seen through this dialogue, a number of significant initiatives have been implemented to rectify health related disparities for the Aboriginal people of Canada, however, as will be discussed later, the health of Aboriginal people in Canada continues to be significantly worse than non-Aboriginal citizens.

Remote isolated communities of less than 200 Aboriginal people often only have access to a lay community health care worker, who consults with a community nurse in a neighboring community as needed. Because of the low density of population, nurses rather than physicians manage nursing stations and provide expanded nursing services that include primary care, public health, physician and pharmacy replacement services on a 24 hour, 7 day a week basis. Throughout Canada, there are currently 675 nurses and 22 physicians, mostly non-Aboriginal, working in 74 nursing stations and over 223 Health Centres. Physicians may visit regularly or occasionally depending on the size of the community (Health Canada, 2008a). Without these services, Aboriginal people who live in isolated areas of Canada would not have access to health care in their communities. All First Nations people also have access to mainstream provincially and territorially funded health services under the Canada Health Act of 1984.

Ironically, although Canadian health care is known internationally for its universal and equitable service provision, several problems exist including inconsistent access to and provision of health care services, and insurance coverage (Health Canada, 2011). In literature it is highlighted that provision and insurance coverage is inequitable between regions and subgroups of the Aboriginal community, which is linked to poverty and ill-health (Madore, 2003). Differences in health status are linked to unequal provision of health care services, low access to services, and differing insurance entitlements that exist between Aboriginal and non-Aboriginal Canadians, and Aboriginal individuals and communities (Tjepkema, 2002; Young, 2003). For example, categorization of Aboriginal people and their entitlements, another aspect of the Indian Act, enforces policies that interfere with accessibility to and coverage of health care services (MacDonald, 2009; Waldram et al., 2006). To illustrate this point, the Indian Act determines which individual or group has the right to Indian-specific federally funded health care programs and services, individualized health and social services, or no services at all (Lavoie, Forget, & Browne, 2010).

Geographical location and Aboriginal categorization as status or non-status Indian determines the level of access to health care services and government health care insurance coverage. Métis people, that is those who are born of Aboriginal and non-Aboriginal parents, are not entitled to Indian-specific health services from the federal government because they are not registered Indians (Health Canada, 2007a). FNIB provides key programs and health care insurance coverage to status people, but not to Métis or non-Status Indians (Haworth-Brockman, Bent, & Havelock, 2009; Health Canada, 2008b). For Aboriginal people initiatives to transfer the control and fiscal regulation of health care services to Aboriginal communities, has historically been delayed through a lack of coordination by the federal and provincial governments (MacMillan, MacMillan, Offord, & Dingle, 1996). Reasons given for delays are described by authors such as Lavoie et al. (2010) and Waldram et al. (2006), and will not be further discussed in this chapter.

Health care services exist for many Aboriginal people who live in urban areas rather than on-reserve where they qualify for health care services. Urban Aboriginal people can access mainstream services and a variety of Aboriginal health and social service centres located in larger urban settings. For example, Friendship Centres began to be established in the mid-1950s to organize specialized services for increasing numbers of Aboriginal people as they moved from reserve to major cities and transitioned into metropolitan areas. Friendship Centres are an example of community-based, Aboriginal-controlled services aimed at improving the quality of life for Aboriginal people who live in, or are travelling through, urban areas in Canada. Many of the programs provided by Friendship Centres are aimed at addressing some of the problems that arise from inequities in health and wellness care access and services for Aboriginal people. They provide culturally appropriate programs and referral services related to health and social well-being, housing, education, employment, recreation, and cultural preservation (National Association of Friendship Centres, 2010). Initially funded mainly by volunteers, fund raising initiatives and small grants by provincial and federal governments, over the years Friendship Centres demonstrated their vital role in the community in providing services and maintained well established relationships with municipal, provincial and federal governments. More recently the administration of funding these Centres has shifted from the government to the National Association of Friendship Centres. There are currently 120 Friendship Centres providing services for urban Aboriginal people and some non-Aboriginal people in major centres throughout Canada (National Association of Friendship Centres, 2010).

Even though Friendship Centres provide services for Aboriginal people who have emigrated from different locations across Canada, it is important to note that health and social services provided through Friendship Centres are quite different from multidisciplinary services offered in the mainstream system. Friendship Centres are not funded or mandated to provide such extensive services and commonly have insufficient funding and resources, such as staff, to meet the demand for culturally appropriate services of the Aboriginal population (Evans, Sookraj, Berg, & the Okanagan Urban Aboriginal Health Research Collective [OUAHRC], 2006). In addition, the funding of individual Friendship Centres requires continuous seeking of mostly short term grants from municipal, provincial and federal initiatives to meet the needs of the consumer.

Although there may appear to be an abundance of health care services for Aboriginal people, Canada is a vast country. A number of significant initiatives have been implemented to rectify health related disparities for the Aboriginal people of Canada. However, this complicated multijurisdictional health care system for Aboriginal people makes it difficult for them to access appropriate health care services and receive health care coverage which they are entitled to. This is evident in the FHS national survey report of 2008 that found one in five First Nations adults experienced problems accessing health care services due to wait lists and having to rely on non-insured health benefits. Women, in particular, experienced more difficulties accessing health care due to long waiting lists, unavailability of health care professionals, reliance on travel arrangements and prohibitive costs for health care services (The First Nations Information Governance Centre, 2010). The funding, delivery and effectiveness of health care provision for Aboriginal people is plentiful in the literature with outcomes evident in the statistical reports of their poor health as compared to non-Aboriginal Canadians.

4.3 The Health of Indigenous Peoples in Canada

Health assessments of populations draw from information collected through census, vital registration, health surveys, health services utilization data and surveillance systems (Smylie & Anderson, 2006). This information provides evidence of the health of populations and is used by governments to prioritize health care policy, services and programs, locally, provincially or nationally. Notwithstanding, the majority of literature and statistical reporting provides noteworthy evidence that Aboriginal people are generally in poorer health than the rest of the Canadian population (Reading, 2009; Statistics Canada, 2006c; Tjepkema, Wilkins, Senécal, Guimond, & Penney, 2009; Waldram et al., 2006). For example, Young (2003) completed a systematic review of research reports about Canadian Aboriginal people, indexed in Medline during 1992-2001, and found that the health of Aboriginal Canadians was significantly worse than the rest of the Canadian population.

The deplorable health status of Aboriginal people in Canada is a highly controversial issue that has been identified and discussed for decades with little improvement. When compared to the non-Aboriginal Canadian population, the lifespan for Aboriginal people is shorter by approximately 7.5 years for men, and 5 years for women (Health Canada, 2000). Even though the numbers of Aboriginal seniors over the age of 60 is fairly small in Aboriginal communities, just over 3%, they now live longer and have doubled in numbers between 1996 and 2006, compared to a 24% increase of non-Aboriginal seniors that make up almost 9% of the Canadian population (First Nations Information Governance Centre, 2010). This should clearly flag a need to be vigilant about their quality of life and the prevalence of chronic diseases (Waldram et al., 2006), particularly arthritis, high blood pressure, and obesity (Tjepkema, 2002). Heart disease is 1. 5 times higher, and Type 2 diabetes 3 to 5 times higher in the Aboriginal population, than the non-Indigenous population (Health Canada, 2006b). Death rates from cervical cancer, digestive system diseases, cirrhosis of the liver, motor vehicle collisions, accidental poisonings, accidental falls, and suicides are almost twice that of non-Aboriginal Canadians (UBC Division of Aboriginal People's Health, 2008). Aboriginal people are also reported as having a greater burden of physical and mental disease (Dion

Stout, Kipling & Stout, 2001; Dion Stout & Downey, 2006; Kirmayer & Valaskakis, 2009; RCAP, 1996; Wardman et al., 2005).

The health statistics for Aboriginal people are alarming and repeated calls for urgent action must be considered seriously, given the reported growth rate of the Aboriginal population. Between 1996 and 2006, there was an increase of 45% in the Aboriginal population compared to 8% in the non-Aboriginal population. According to several health and vital statistical reports, the Aboriginal population in Canada increased from almost 3% in 1991, to 4% in 2006 nationally. Locally in British Columbia this population increased from 2.8% in 1996 to 4.4% in 2006 to 5% in 2008 (Division of Aboriginal People's Health, 2008). The Métis experienced the greatest increase in the past decade with a 91% increase; Inuit by 26%; and First Nations by 29% (Statistics Canada, 2008b).

Aboriginal people are much younger than the non-Aboriginal population, with a median age of 26 years compared to 40 years for non-Aboriginal people. Children and youth under the age of 25 make up almost 50% of the Aboriginal population, compared to 31% non-Aboriginal. Within this young population the birth rate is also increasing (Statistics Canada, 2008a). Off-reserve communities are among the largest and fastest growing Aboriginal communities in Canada with 75% of First Nations people and 69% of Métis living in urban areas (Statistics Canada, 2008b). Factors that may account for this growth include high birth rates, an increased number of individuals that identify themselves as an Aboriginal person and improvement in the collection of health and census data on Indian reserves since 1996 (Statistics Canada, 2008a).

Over the last decade and a half there have been several inquiries, initiatives and promises by the Canadian federal, provincial and territorial governments that have explored the provision of appropriate and wholistic services for Aboriginal people with the aim of improving their overall health and socioeconomic status. The RCAP undertook a five year national inquiry in which the Canadian government and Aboriginal people mutually identified issues and recommended priority action plans to shift power and control from the federal government to Aboriginal self-government and the return of Aboriginal land to Aboriginal people (RCAP, 1996). These initiatives aimed to support revival of the social, economic, cultural, and health status of Aboriginal peoples and their communities, in particular to improve housing, health, education and employment. Subsequently, a five year review of the progress of the action plans was undertaken by the Assembly of First Nations, the national organization representing First Nations citizens in Canada (Assembly of First Nations, n.d.). They found the Canadian government had progressed little in addressing the agreed upon recommendations and issued a failing RCAP Report Card (Assembly of First Nations, 2006). In general, five years after implementing the mutually agreed plan, few initiatives have been completed. First Nations communities continue to live in poverty and the gap in living conditions between non-Aboriginal and Aboriginal Canadian people astoundingly increased rather than decreased.

Since the RCAP (1996), other initiatives to address and reduce health inequities for Aboriginal people have taken place. The Romanow Report (Romanow, 2002), the Kelowna Accord (Patterson, 2006) and the local health authority (Interior Health, 2006, 2010) have developed action plans aimed to improve the health status and outcomes of Aboriginal people. However, many programs developed are derived from Western perspectives, with several directed to Aboriginal communities on reserves, and not urban populations (Tjepkema, 2002).

The programs that have been mounted to date have failed to address the root causes and structural issues that contribute to socio-economic gaps among the Aboriginal population (Assembly of First Nations, 2006; Young, 2003). Anderson, Smylie, Anderson, Sinclair, and Crengle (2006) propose this may be due to the fact that funding of initiatives is often short-term or are program based and thus unable to address underlying issues or provide necessary ongoing services. In addition, Browne (2005) and Dion Stout and Downey (2006) suggest health challenges faced by Aboriginal people, especially urban Aboriginal populations, are not commonly known or understood by non-Aboriginal people, adding to the gaps in service provision.

Within literature even though there are indicators that Aboriginal people suffer poor health, there is limited information that ranks health inequities and disparities for off-reserve non status and status people residing in urban settings. It is difficult to collate information that is reported to develop a clear picture of the health status and related issues regarding the health of this urban Aboriginal population in Canada because health surveys categorize Aboriginal people inconsistently. This difficulty is recognized and identified by several Aboriginal health researchers and scholars, who suggest that comparing and analyzing health reports is problematic when data sets and criteria for inclusion or exclusion in the health assessment are inconsistent (Smylie & Anderson, 2006). For example, in one survey First Nations people were referred to as on-reserve populations only, while another survey included all Aboriginal people no matter where they resided and regardless of their Indian status or categorization (Browne, McDonald, & Elliot, 2009; Reading & Wien, 2009). In his exploration of health research, Young (2003) identified a severe underrepresentation of Métis, urban Aboriginal people, and almost no representation of children and women, which is a significant gap in health profiling data.

In general, statistical reports and researchers present a grim health outlook for Aboriginal as compared to non-Aboriginal people; however, in this discussion it must not be inferred or assumed that all Aboriginal people in Canada are unhealthy or that they can equally be compared to non-Aboriginal people given the complex historical, political, and socioeconomic differences. For example, the Aboriginal Peoples Survey 2001 (O'Donnell & Tait, 2003; Reading, 2009) reported 56% of off-reserve Aboriginal people aged 15 or older reported their health as excellent or very good. Minimal difference was noted in 2002, with 61.4% of the general Canadian population including Aboriginal people who self-reported their health as excellent or very good (Health Canada, 2002).

Although there are multiple inconsistencies in the collection and reporting of health data and attempts by government and communities to improve health access and service delivery, it is clear in the literature that major inequities and disparities between Aboriginal and non-Aboriginal people in Canada remain. Difficulties in identifying and comparing the health of Aboriginal and non-Aboriginal people in Canada may be due, as reported above, to failure to generate reliable statistics; but it may also be related to failure to make adjustments based on the broader contexts that affect Aboriginal people's health (Raphael, 2004). Health is simply not a result of an individual's genetics, culture, or lifestyle choices. Indigenous people, in particular are often inappropriately referred to as a culturally homogeneous group who share similar health and wellness beliefs, concerns and practices, this is not the case. An examination of broader and intersecting socioeconomic factors impacting Aboriginal health and wellness reported in the literature follows.

4.4 Roots to Health and Wellbeing

Recently federal, provincial, and territorial governments have shown increased interest in Canadian communities and populations marked with major disparities in health status. In particular, all levels of government report a need to address and lessen gaps in health inequalities between Aboriginal Canadians and the rest of the Canadian population (British Columbia Provincial Health Officer, 2009; Health Canada, 2005; Health Council of Canada, 2007a; Raphael, 2004; Romanow, 2002). Numerous initiatives are aimed at socio-economic and environmental factors that determine the health of individual and groups (Health Canada, 2005). These factors are known as social determinants of health and include income, housing, education, early life, employment, personal health practices and coping skills, health care services, gender, culture, and Aboriginal status, all of which influence the ability of individuals and communities to remain healthy or become ill (Raphael, 2004; Romanow, 2002). The interrelated interactions between these factors affect health. For example, individual and community socio-economic challenges are common factors that influence inequities in health among populations (Benoit, & Nuernberger, 2006; Glouberman & Millar, 2003).

Reading (2011) takes the social determinants discussion further, and contends there are three differing levels of determinants that impact health – proximal, intermediate and distal determinants. She uses the high prevalence of obesity and diabetes in Aboriginal peoples as an example to illustrate confounding factors. Proximal determinants are those closely related to behaviour and lifestyle, such as eating unhealthy food. Most health initiatives would direct healthy eating health promotion initiatives and programs at this level and fail to explore deeper the reasons why someone is not eating healthily. The inquiry stops at this level and improvements to health are expected. However, intermediate determinants of health consider the cause of illness and in the case of obesity and diabetes, unhealthy eating could be the result of poor access or lack of financial resources needed to obtain healthy food. Healthy fresh food is more costly and less available in isolated communities and this leaves minimal options, if any, other than the consumption of cheaper processed foods that are more readily available, resulting in weight gain. Living in an isolated community is related to distal determinants of health, in which the roots of the initial example of unhealthy eating are further uncovered. Individuals who live on reserve as a result of colonial segregation are subsequently often denied access to traditional healthy foods, leading to food insecurity, poor dietary intake, obesity and finally the development of diabetes (Reading, 2011; Reading & Wien, 2009). Consideration of the distal determinants of health requires different health care strategies and interventions than the more common proximal and intermediate focused programs for effective outcomes to occur.

As previously discussed, for Aboriginal people there are specific compounding social and historic factors such as being segregated in residential schools and suffering abuse that intersect with and impact health differently and more significantly than for non-Aboriginal people. For instance, culture, poverty, unemployment, poorer education (Flaskerud & Winslow, 1998; Heritage Community Foundation, 2002; Reid, 2004), discrimination (Brunen, 2000), racism (Smye, Rameka, & Willis, 2006; Reading, 2011) race, power, systemic inequalities, social injustice (Greenwood, 2006) and being Aboriginal (Cass, 2004), have been identified fairly recently as having an impact on the health of Aboriginal people and this is evident in the literature. Tjepkema (2002) found that low socio-economic status and diseases related to smoking and obesity are more prevalent for Aboriginal people off-reserve than on-reserve and more prevalent than for non-Aboriginal people. According to the First Nations Regional Longitudinal Health Survey (RHS) in 2008, the only First Nation governed national health survey, fewer First Nations adults who live in isolated communities complete high school and reported lower income which leads to living in housing that requires major repairs (First Nations Information Governance Centre, 2010).

In Canada, Mitchell and Maracle (2005) identify that the health status of Canada’s Aboriginal people is similar to “people living in economically, disadvantaged and underdeveloped countries” (p. 14). They link gross differences in health between Aboriginal and non-Aboriginal people with the systemic impact of colonization, through the loss of culture, and historical and intergenerational trauma. Consequences of acts of colonization on Aboriginal people are devastating. This is not unique to Canada, as the loss of one’s cultural identity, land, resources, political autonomy, and spiritual freedom, causes poor health and consequential devastation of the world’s Indigenous Peoples everywhere (Adams, 1999; Archibald, 2006; Smye, et al., 2006). The lingering effects of colonization from forced segregation on reserves; forced removal of children from their home to residential schools; placement of Aboriginal children into foster care; and sizeable health and social disparities are shameful realities for many Aboriginal people worldwide. (Frohlich, Ross, & Richmond, 2006; Sinclair, 2007; Wardman et al., 2005).

Factors that intersect and determine the health of Aboriginal people is evident in much of the literature. For example, and as previously acknowledged, the legacy of residential schools has been identified by Aboriginal people as a significant contributing factor to their poorer health status (Canadian Institute for Health Information, 2004; Heritage Community Foundation, 2002; RCAP, 1996).

The RHS 2002/2003 reported 50% of Aboriginal people over the age of fifty who attended residential schools identified that their experiences negatively affected their health and wellbeing (First Nations Centre, 2005). Residential schools often had insufficient health care facilities, inadequate diets and poor sanitation, leading to the spread of disease, suffering, near starvation and the death of up to as many as fifty percent of the children in the schools (Boyer, 2006; Brant Castellano et al., 2008).

Government legislation perpetuates historical colonial policies, services, and practices that are viewed as racist by many Aboriginal people and scholars. To further understand the underlying social injustice and poor health of Aboriginal people in Canada, Reading (2011) states there is a fundamental belief within the Canadian governmental system that Aboriginal people are inherently different and this difference makes them unable to ever succeed in life. Reading clearly associates health and social inequities and disparities of Aboriginal people to distal determinants bound in governmental and societal and social exclusion. Moffitt (2004) and Smith, Varcoe and Edwards (2005) argue that health promotion and illness prevention initiatives to curb chronic health conditions and maintain quality of life that use colonialist health practices fail to acknowledge the underlying causes of Aboriginal health disparities. They recommend health care policy be based on the experiences of Aboriginal people and inclusion of their voice in changes that are directed towards creating equitable health and social conditions.

Sadly little has changed over the years. O’Neil (1989) reports health care professional practices are grounded in taken-for-granted middle class values of paternalism, power inequities, and cultural misunderstandings. In O’Neil’s research, Inuit patients described their health care encounters as racist. O’Neil maintains Aboriginal people as colonized are marginalized within the dominant colonial structure and have difficulty attaining good health and accessing health services. According to the literature, this may be due to the fact that the Canadian health care system process of decision making and service provision practices are based on a paternalistic biomedical system in which health care professionals such as physicians hold great power and influence patients' health care choices or tell patients what to do (Wittmann-Price, 2004). Farmer (2004) and Tester (2007) give evidence that ongoing colonial practices enacted through political, economic and social structures are ignorant of or disregard unique values and beliefs and marginalize individuals and groups, including Indigenous Peoples. As a result they frequently encounter limited access to basic services because of discriminatory policies, limited economic resources and placement of populations in rural or remote geographic locations. Marginalization and social isolation of individuals prevents them from speaking out about their health concerns. Being silenced or ignored when one tries to voice concerns pushes individuals to the margins of society, where they remain disempowered, silent and face additional racism and discrimination (Farmer, 2004; Fiske & Browne, 2006).

Allen (2006) agreed that Western health care systems are set up for the dominant culture, in which white is considered the norm and from which all else is measured and framed. Using this gaze enables differences in health status to be attributed to skin colour rather than other complex factors such poverty, lack of access to services or as a consequence of racist health care practices. Drevdahl, Phillips, and Taylor (2006) explained that some scientists assume, although unintentionally, that differences in health or disease are actually biological rather than consequential to social, political, and economic factors. These underlying factors are compounded in relation to the health of Aboriginal women, which is next discussed.

4.5 Aboriginal Women's Health

The health of Aboriginal women is influenced by racist and discriminatory societal views of gender and race that excludes them from the dominant society and positions of power and privilege. This is seen differently today when viewed through the lens of underlying factors that determine health. Canadian Aboriginal women continue to be oppressed because of gender and race discrimination within contemporary colonization. An extreme example of Canadian governmental cumulative colonization, patriarchal oppression and structural racism was the forced sterilization of many Aboriginal women that continued to occur until the early 1970s. Intent on erasing the inferior Aboriginal race, the government deemed Aboriginal women were incapable of raising their children and enacted a national program of forced sterilization for women, especially if they had been diagnosed with any sort of mental health challenge (Boyer, 2006; Browne & Fiske, 2001). Problems faced by Canadian Aboriginal women are reported as severe and this sets them apart from the country's non-Aboriginal female population (Dion Stout et al., 2001). Boyer (2006) reviewed the history of laws, legislation, and policies that impact the current health of Aboriginal women in Canada. She concluded that had Aboriginal women's rights been protected they would have a similar health status to the rest of the Canadian population. Further, she linked the Indian Act, residential schools, forced sterilization laws, and mental health to institutional laws, legislation and policies created and centered on male values that "have had a long-lasting negative effect on the health of Aboriginal women … attacking the essence of

Aboriginal women as caregivers, nurturers and equal members of the community" (p.7).

For urban Aboriginal people, especially women who are marginalized, not only are their health needs under-reported in the literature (Giddings, 2005a), but what is known about the current health status of Canadian Aboriginal women repeatedly highlights major inequities and discrepancies compared to other Canadian women (Armstrong, 2005; Browne & Fiske, 2001; Cass, 2004; Health Canada, 2005; Young, 2003).

Aboriginal women face multiple barriers within the health care system that impact their health care decision making and have implications for their health (Anderson, Dyck, & Lynam, 1997; Browne & Smye, 2002; Fiske & Browne, 2006; Kurtz, Nyberg, Van Den Tillaart, Mills, & Okanagan Urban Aboriginal Health Research Collective [OUAHRC], 2008; Moffitt, 2004). Lord and Mandell (1995) assert "Aboriginal women must deal with discrimination based on gender, class, and race" (p 39). Whereas women of the dominant white culture may face class and gender issues, they rarely face racial discrimination.

Many issues relevant to Aboriginal women are reported in literature. For example, the population of Aboriginal women and girls is growing by nearly 15% and this growth rate is higher than non-Aboriginal women and girls in Canada. Aboriginal women are overrepresented in statistics reporting poverty rates, violence, abuse, single parenting, and imprisonment (Chartrand, & McKay, 2006; Dion Stout, et al., 2001; Statistics Canada, 2007b). Canadian Aboriginal women are commonly subjected to domestic, sexual, and other types of violence (Amnesty International, 2004), and are twice as likely to experience emotional abuse from a partner than non-Aboriginal women (Statistics Canada, 2007b). They are the sole support person for their family yet they live in poverty and receive a lower income than Aboriginal males, who receive a lower income than non-Aboriginal people (Native Women's Association of Canada, 2002, 2007d).

When compared to Aboriginal males, they are more likely to attain higher education levels, yet they earn less overall income (Roberts, 2012). Aboriginal women's income is $5,000-$10,000 less per year than other women in Canada and the unemployment rates of Aboriginal women is twice that of non-Aboriginal women (Statistics Canada, 2007b).

They are at higher risk of alcohol and substance abuse; are over medicalized and prescribed anti-depressant drugs; have higher rates of cervical cancer (at six times the national non-Aboriginal average); have higher rates of AIDs and make up 50% of new HIV cases. Additionally, they have up to a ten times higher rate of sexually transmitted infections than the national average; and become mothers earlier, with 50% under the age of 25 years compared to 28% for non-Aboriginal mothers (Native Women's Association of Canada, 2004).

According to the 2002/2003 FHS (First Nations Centre, 2005), First Nations women reported barriers and problems with accessing health care services. They are diagnosed with diabetes earlier than the general population, usually between 20 to 34 years of age, are frequently obese or morbidly obese; have higher rates of arthritis, allergies, hypertension, asthma, stomach/intestinal problems, rheumatism, and osteoporosis; or feel blue, sad, or depressed for two or more weeks within the previous year. Twenty percent attended residential school and stated this affected their health negatively. However, they reported they had support systems in place in case of need and the majority talked to family and friends rather than their family physician.

The National Women's Association of Canada (2002) reported to all levels of the Canadian government and urged immediate attention be given to assess Aboriginal women's health concerns. Aboriginal women who participated in the inquiry "emphasized the toxic role played by racism and sexism in undermining their health and wellbeing, together with the detrimental effects of poverty, unemployment, and culturally inappropriate or inaccessible heath services" (p.11). Despite these damning claims, five years later, not much had changed:

> Indigenous women, because of continuing oppression, abuse, discrimination, and poor socio-economic status, are more apt to experience illness and diseases associated with these conditions, including diabetes, certain cancers, cardiovascular diseases, disabilities, additions, sexually transmitted diseases (including HIV/AIDS) and depression. (National Women's Association of Canada, 2007c, p. 12)

Underlying the lack of change is the history of colonialism within the health care system. Allen (2006) stated that when white is seen as dominant, and the *right* way, stereotypes related to specific cultural characteristics portrayed in colonial history, such as alcoholism or homelessness, are commonly generalized to all Aboriginal people, making it difficult for health care providers to assume this is not so. This is not surprising, because as Browne (2005) suggests, stereotypes of Aboriginal people originate in public history and linger within a dominant social perspective in which most health and nursing education literature is framed.

Research studies report that even though health care professionals believe their relationships with and treatment of clients are culturally appropriate, they are often unaware that their practices unintentionally demonstrate discriminatory attitudes and are described as such by their clients (Hunter, Logan, Barton, &

Goulet, 2004; Johnson et al., 2004). Browne and Varcoe (2006) recommend that health care providers need to realize that the attitudes reflected in their practice are often influenced by racism, discrimination, colonial, historical and political climate, and this has a noticeable effect on patients. Browne (2005) and Tang and Browne (2008) reported health care providers in a large Canadian city stated they treat all patients equally regardless of their social, cultural, or political status. However, this was not demonstrated in their interactions with female Aboriginal patients. There was a disconnect between the nurses' descriptions of their own practice and the observations reported by researchers regarding how they actually practiced when observed. Wilson (2006) highlighted problems with the current "one size fits all" (p. xi) biomedical health care system of health and nursing service delivery. By treating all patients the same, the health care provider fails to acknowledge the uniqueness of human beings thereby ignoring individual needs, beliefs, and desires.

Some minority women have little trust in the health care system because of disempowering interactions with health care professionals. They often believe they will encounter racism if they seek treatment. They report feeling unwelcome in the health care system and are therefore discouraged from using mainstream health services or from returning for care (Browne & Fiske, 2001; Canales, 2004b; Cassidy et al., 1995; Dodgson & Struthers, 2005; Johnson, et al., 2004). Interestingly, exclusion also causes negative influences on health and wellness (Anderson, 2000; Reading & Wien, 2009; Reid, 2004). A prevailing ethos of racism creates problems for some women, especially those who feel marginalized and vulnerable. As the health care decision spokesperson for the family, Aboriginal women are responsible for negotiating health care services in environments that are paternalistic and racist and in which their *Nativeness* labels them as Other and keeps them excluded from the dominant culture in which health care is framed and delivered (Anderson, 2000; Barrios & Egan, 2002; Johnson et al., 2004). Browne and Varcoe (2006) describe Othering as racialization, in which Aboriginal women are labeled because of their physical characteristics or race. Consequently they receive treatment that projects negative stereotypes and labels Aboriginal Peoples, practices commonly enacted by dominant society. Being treated disrespectfully affects how women view themselves in relation to others, in particular health care providers, who mostly belong to the dominant society (Allen, 2006). Brunen (2000) found that Aboriginal women who have difficulty accessing adequate and appropriate health care and are treated poorly "may ultimately end up in far worse condition than where they started … result[ing] in a devastating snowball effect in families, communities and societies as a whole" (p. 13). Canadian Aboriginal women report being talked down to and treated as a number. They also report that they do not receive adequate health assessments and feel inferior, unimportant, or stupid when voicing a particular health care concern. As a result of disempowering interactions, they have little trust in the health care system, feel unwelcome and are discouraged from seeking health care in the future to avoid facing racist and discriminatory care (Browne & Fiske, 2001; Dodgson & Struthers, 2005; Kurtz, et al., 2008).

A report on the health and health indicators for Aboriginal women by Dion Stout et al. (2001) illuminates the reality that, although there has been public recognition of injustices committed against Aboriginal people in Canada, "marginalization and prejudice remain very much present in the daily lives of many community members, while the effects of this marginalization make themselves manifest in any number of ways" (p. 12).

Reports exist of health care professionals missing severe health symptoms or critically misjudging patients because they lack knowledge of Aboriginal people and/or have racist/discriminatory attitudes. Indifference to the welfare of Aboriginal people perpetuates the problems many Aboriginal women face when dealing with, or choosing to avoid the mainstream health care system. Brunen (2000) described her own experiences as an Aboriginal woman accessing Canadian health care, as being dismissed, belittled, degraded, and misunderstood. She wondered if she was *good enough* to access health care, and if she would ever find a doctor she could trust. McCall, Browne, and Reimer-Kirkham's (2009) research provides insight into the poor and unjust treatment that Aboriginal women who are multiply marginalized by the stigma of living with HIV/AIDS receive. They expressed their interactions with health care professionals "were fraught with discriminatory and judgmental behaviour" (p. 1779).

Numerous other research studies reveal that health care professionals unintentionally or intentionally silence the voices of Indigenous people, thus deepening marginalization, discrimination, and stigma that many Indigenous people have experienced over the last several hundred years (Browne, 1995; Browne, Smye, & Varcoe, 2005; Reid, 2004). Health care professionals, who lack knowledge about the history of Aboriginal people, particularly residential schools, foster care, and the generational effects of colonization, have limited ability to understand and contextualize how their everyday routines and rituals are structured within a dominant system that fails to acknowledge or be sensitive to lingering historical trauma and contemporary racism. Dion Stout and colleagues (2001) state there are numerous studies that provide evidence of difficulties for Aboriginal women in accessing mainstream health care for health and social services, which fail to consider underlying reasons why women chose not to use the services, such as "racism, cultural insensitivity and lack of Aboriginal personnel" (p. 26) whom they can trust. When Aboriginal women refuse to seek health care services or re-enter the health care system to avoid discrimination, not only is their health compromised, but the health of their families is also at risk. Health care systems perpetuate the beliefs, values, and attitudes held by mainstream society and Aboriginal women suffer (Brunen, 2000).

Richmond (2007) suggests health care provision should be built on the attributes of Aboriginal health and cultural identity within a historical, cultural, sociopolitical context based on the strengths and social supports necessary to reach and maintain the health of Aboriginal people. Smye et al.(2006) recommend the development of "tools or frameworks that will help nurses and other health care providers to situate patients experiences in the larger context of mediating sociopolitical, economic and historical forces" (p. 146) to respectfully make sense and understand difference. Literature provides evidence and direction for creating safe opportunities for the sharing of voices of Aboriginal women, as well as ways for health care professionals to work respectfully with marginalized groups and to form an increased awareness of the lived experiences of those who are othered. These concepts are next explored.

4.6 Indigenous Research, Policy, and Practice

In the following discussion I present concepts in the literature that are becoming increasingly acknowledged, such as the inclusion of Aboriginal people, particularly women, in culturally safe research. It is believed that such inclusion facilitates their representation and voice in changing health care policy and health professional practice, leading to improved health outcomes. Further, inclusion of

Aboriginal people in research fosters relationships between individuals, health care providers, and communities (First Nations Centre, 2005), which can unravel the distal roots of Aboriginal health and social issues, and potentially improve health outcomes and experiences through enacting changes to health research, policy and practice (Reading, 2011).

Including Aboriginal people in all levels of the research process and policy development requires the researcher to be aware of and utilize research methodologies and methods that are acceptable and appropriate to Aboriginal peoples and communities (Smith, 1999). In order to include the voices of Aboriginal people, researchers and health care policy makers recommend working with Aboriginal people and becoming aware of and understanding local Aboriginal knowledge, health and wellness beliefs, values, and issues to build a foundation from which to inform research, policy and practice (First Nations Centre, 2007). Baker (2010) advises that the inclusion of voices of Aboriginal people is necessary at all levels of government and health care policy decision making and stipulates that intersectoral collaboration will improve Aboriginal health and wellbeing and decrease disparities. However, invitations to include Aboriginal people at any level of research or formal decision making may meet with resistance, because, as this literature review demonstrates, historically Aboriginal people in Canada have been marginalized in mainstream society. Canadian Aboriginal people, who have been recipients of acts of cruelty and degradation, may naturally be wary of suggestions that their voice is now valued, as history demonstrates that governmental and legislative promises have been broken countless times over the generations. Nevertheless, for the health and welfare of Aboriginal people to improve it is imperative to build a foundation of trust with them, which begins with acknowledging their history of colonization and the impacts that colonial health care practices have on Aboriginal health to this day (Boyer, 2006).

Canadian scholars argue that Aboriginal women are a valuable resource for the Indigenous community, Indigenous and mainstream health care professionals, and policy-makers. Browne and Fiske's (2001) research with First Nations women and Bartlett, Iwasaki, Gottlieb, Hall, & Mannell's (2007) work with urban First Nations and Métis women accessing mainstream health services highlight Aboriginal women as experts ideally placed to inform health care providers and policy-makers about health care gaps and inequities within their own communities. Indigenous research that is conducted in unison with Aboriginal women helps to develop respectful inquiry that reflects their beliefs and values and promotes their health and wellness. Acoose, Blunderfield, Dell, and Desjarlais (2009) attest that research by, for, and with Aboriginal women enables them to find their voice and share experiential stories, which results in improved wellness, and inspires other women to participate in studies as a means of beginning their own healing journey.

Maori scholar Denise Wilson (2008) reported the significance of using a Maori centered approach when conducting research with Indigenous women to explore their interactions with mainstream health care and discovered what was most important for their health and wellbeing. This author noted that by including the women's cultural beliefs and practices in the plan for health care interventions, these interventions became more culturally relevant and acceptable for the women. Further, Canadian researchers Meadow, Lagendyk, Thurston, and Eisener (2003) wrote about the challenges as non-Aboriginal researchers of conducting Aboriginal research and found that including urban Aboriginal women in qualitative health research helped them to understand factors that contributed to the women's health.

Their inclusion of Aboriginal women as research assistants enabled the researchers to become familiar with the community. Further, their engagement in community activities and collaborative committee work helped them gain acceptance at the community level.

Fortunately, the climate in which research is being carried out today is slowly changing, as increasingly researchers acknowledge and understand the importance of including Aboriginal women within their research design. One such researcher is Bronwyn Fredericks (2003, 2008), an Australian Aboriginal woman researcher. Fredericks disclosed her experiences of researching with Aboriginal women for their benefit. Through the research process, new ways were created for others to see Aboriginal women; for Aboriginal women to have and share their voices; and for the women, including the researcher, to more fully understand themselves as they developed the research process. Learning to construct valid research methodologies and to navigate through the requirements and limitations of academia is not without its challenges. However, as the research of Fredericks highlights, bridging with culturally situated women's ways helped to build a better understanding of the research process and lessen the Aboriginal women's previously held historical negativity about research.

Dickson and Green (2001) echoed the importance of including Aboriginal women, as co-researchers, in a women's health assessment research project. The women who participated in this research stated they experienced more equitable power relations and reduced previous negative impressions of researchers – between researchers and participants, and peers and colleagues. Their research report was written largely in the words of the women and the data analysis and presentations were repeatedly revised by them. The research process and findings were reported as empowering, health promoting, participatory, and fostered power-sharing.

Smylie et al. (2004) recommend that knowledge generated from Aboriginal research should be transferred to practice after being developed and evaluated within the context and relevance of the community in which it is conducted. Reading (2002) also strongly advises the transfer of knowledge generated in Aboriginal research be transferred to health care professionals and practice as important facets to inform and potentially change health policy.

In spite of several local provincial and national initiatives aimed at improving the health of Aboriginal people in Canada over the last several years major social and economic inequities remain. These inequalities might be due to minimal reports in the literature that report health research and policy that has been Aboriginal led or partnered. This does not discount the plethora of work that has been done, but raises an imperative for research, policy and practice processes that are culturally safe, community-based, and which embrace Indigenous perspectives (Smith, 2005b).

Browne and Fiske (2001) attempted to better understand the First Nations people's encounters with mainstream health care providers and concluded that cultural safety education and practice was paramount to reducing "racism, inequity, and marginalization to ethnocentrism, lifestyle choice, and cultural differences" (p. 143). Other authors echo the need for cultural safety education of health care providers to improve access and awareness of health services for Aboriginal people (Kurtz, et al., 2008; National Aboriginal Health Organization, 2008a; Papps, 2005: Wardman, et al., 2005; Wepa, 2005).

The founding work of Ramsden (1992, 1996), a Maori nurse who recognized the impact of power imbalances between nurses and patients stressed the importance of educating nurses to become aware of colonial history and its impact on Indigenous peoples. The concept of cultural safety originates from political discourse of nursing education in New Zealand (Ramsden, 2002) and draws attention to colonial health care practices. Cultural safety philosophy provides a deeper understanding beyond cultural awareness that acknowledges difference, and cultural sensitivity that respects difference, to cultural competence in which cultural awareness and sensitivity is reflected in nursing practice skills, knowledge and attitudes. Smye, Josewski, and Kendall (2009) describe that cultural safety focuses on the "social, structural and power inequities that underpin health inequalities/disparities" (p. ii) and the need to shift power differentials inclusive of social, historic and political factors that shape health care and health within Aboriginal and multicultural contexts.

The practice of cultural safety is often not part of post-colonial health care settings. New Zealand, the recognized leader in this area, is setting the climate regarding the importance and impact of cultural safety (Nursing Council of New Zealand, 2005),and their work has drawn the attention of health care and education systems in Canada, New Zealand, Hawaii, Australia, and Taiwan. Cultural safety provides guidance for learners to understand within a socio-political context that culture is more than cultural practices and traditions. Cultural safety encourages health care professionals to challenge unequal power relationships at the individual, family, community, and societal level. Since the publication of Ramsden's (1992, 1996) seminal work on cultural safety, the tenets of cultural safety in health care practice have been considered and written about in several health and social disciplines, for example, Wepa, a social worker in New Zealand and Dion Stout, Browne, Smye, and Varcoe, nurses in Canada, to name a few.

Even though New Zealand and Canada have colonial histories, their histories are quite different, hence, the cultural safety model developed by and used in New Zealand cannot necessarily be replicated in Canada. The New Zealand model can however, draw attention to health inequities in Canada and help shape cultural safe practices within a Canadian context. By understanding cultural safety, health care professionals can begin to address inequities in health care through respectful relationship building with Aboriginal people thereby improving access and experiences within the health care system (University of Victoria, n.d.b). Hunter and colleagues (2004) suggest cultural safety concepts included in educational curricula across the social and health professional disciplines and throughout community organizations and agencies "can only enhance health outcomes" (p. 279). The literature also identifies a need for health care professionals to receive some level of cultural safety education and training. One such recommendation is the development of an Aboriginal specific cultural safety curriculum for health care professionals, which may help to improve the overall health of Aboriginal peoples (Kurtz et al., 2008; Okanagan Urban Aboriginal Health Research Collective, 2009).

Today in Canada, cultural safety concepts are being included in the education and training of health care administrators, providers and educators; according to the National Aboriginal Health Organization, the Canadian Association of Schools of Nursing, Canadian Nurses Association, Association of Faculties of Medicine in Canada, Indigenous Physicians Association of Canada and the Aboriginal Nurses Association of Canada (Aboriginal Nurses Association of Canada, 2009; Indigenous Physicians Association of Canada & Association of

Faculties of Medicine of Canada, 2009). This includes adoption of cultural safety within several disciplines including; nursing, medicine, occupational and physical therapy, social work, sociology, anthropology, education, pharmacy, and health (Smye et al., 2009). For many disciplines, cultural education is a requirement for program accreditation and approvals.

The task now is for health care professionals to understand and apply the principles of cultural safety to their practice, so that a more sensitive approach is evident in Indigenous people's experiences. This would prevent what Browne and Smye (2002) found in their analysis of health discourses related to cervical cancer in Aboriginal women, where researchers and health professionals blamed health inequities on "culture" thus ignoring the complexities of barriers to health care for Aboriginal women (and women from other marginalized groups). Browne and Smye highlighted the importance of acknowledging intersecting factors of culture, history, and socio-political relations that shape and impact women's health concerns and access to health care. Smith et al. (2005) agreed that "care should be based on the priorities and experiences of the women and families themselves" (p.44). Providing culturally safe practice would ensure this.

4.7 Final Reflections of the Written Terrain

The goal of this literature review was to provide a critique of a variety of literatures in ways that provided understanding about the plight of Aboriginal peoples in Canada. Hence, in this chapter I exposed issues that impact on the health and wellbeing of Aboriginal people, and in particular urban Aboriginal women. Historical and current social and political accounts of the Canadian health care system were highlighted and the health profile of Aboriginal people and its relation to the determinants of health was provided. Major health inequities and discrepancies between Aboriginal and non-Aboriginal Canadians were identified and Aboriginal women's experiences with health care services and the impact of these encounters on their health and wellbeing were highlighted. Discussion ensued about inconsistencies in collection and interpretation of Aboriginal health statistics, and Aboriginal health policy and strategies were presented. The chapter concludes with some dialogue about Indigenous research with, by and for Aboriginal women, for health care policy and service delivery.

From this discussion, it is evident that there needs to be improvements to research and policy direction to address the real problems of Aboriginal health and to enable improvements to health care delivery. Changes to health policy that are meaningful for Indigenous people must be directed to the realities of their unique life experience as individuals, families, and communities and viewed within the multiple contexts (historical and spiritual) in which they live (Smye et al., 2006) and reflect a deep understanding of intersecting factors that affect Aboriginal women's lives and health.

The literature reviewed makes it evident that there are multiple factors contributing to the poorer heath of Indigenous people globally. Canadian urban Aboriginal women, who are the custodians of health for their people, expressed their desire to inform the world that:

> Aboriginal people in all areas – urban, rural and remote – are desperately in need of positive measures to address the disadvantage they face, including appropriate health care services. Political will is urgently needed to provide adequate resources to address this desperate need. (National Aboriginal Community Controlled Health Organization, 2001, p. 40)

As this literature review demonstrates, the role of the Aboriginal woman is indispensible in relation to the wellbeing of her family. Her voice and involvement in decisions related to health care is instrumental to improving health outcomes and decreasing gaps in health between Aboriginal people and other Canadians. Critical questions central to improved care and health care experiences were discussed in the review and included the exploration of systemic racism as a main barrier to the attainment of Aboriginal health and wellbeing, within the context of the distal social determinants of health that include the roots of health issues. A broad overview of ways researchers are beginning to engage in health research and partnerships with Aboriginal people was discussed. Finally, current health care provider practices and in particular, cultural safety aspects were explored for the ways in which they can improve health care provision.

Although some literature in this critique is, according to Western academic standards dated, and it is acknowledged that some authors' work are used repeatedly to illustrate points, I felt that these 'seminal' works of wise Indigenous women and scholars were important to include and inform the discourse. The works that are highlighted in this literature review provided initial teachings for me about the lives of Indigenous people globally, particularly when I first started my journey of Indigenous research over seven years ago. The work of these women and the profound impact that their stories and reports of research had on me, compelled me to embark on doctoral studies with a focus on the health of Indigenous women and to use Indigenous research as a pathway to help improve the health of Aboriginal people in general. Wisdom is timeless and the works and stories of the Indigenous women referred to in exploring the written terrain will remain relevant for me for all time. Indigenous research methodologies and methods will be discussed in great detail in the following chapter.

CHAPTER 5: WALKING THE BORDERLANDS: EMBRACING INDIGENOUS METHODOLOGIES

5.1 Situating the Research Journey

In this chapter I present an in-depth discussion about the research methodology and methods used in this community-based collaborative study, but more importantly, I share insights and realities of successfully embracing an Indigenous approach while in the midst of academia. I provide the reader with details of my research journey specific to the research methodology developed for this study, and I do so in a non-traditional way, one that is consistent with Aboriginal storytelling by being non-linear, personal, and in the first person. In some instances I use the term *we* and *our* when I write in relation to working with the women who joined the study, and those who co-lead the research process.

The study is grounded in an Indigenous perspective and in this chapter I critique theory or “book learning” about Indigenous knowledge, research methodologies and methods. I uncover many discoveries and insights I had about difficulties I encountered while trying to remain true to Indigenous knowledge and methodologies, whilst simultaneously forging new pathways for knowledge generation that adhered to University research protocols and my ethics proposal. The methodology I embraced was a living process, not a static framework, model, or flowchart that listed step by step things I needed to do along the way. Rather, the study and methodology were developed, monitored, implemented and evaluated by myself in collaboration with my doctoral supervisors, community Elders and mentors, the research Advisory Committee, and Steering Group whose composition is later described.

As stated earlier in this thesis, the overall purpose of this two stage study was to more fully understand the experiences and contexts of urban Aboriginal women when they sought health care and to work with them to explore their collective visions for how health care services could be reformed to provide sensitive, respectful and non-discriminatory health care. Stage 1: Urban Aboriginal women, who participated in previous research with Aboriginal researchers including myself, along with additional urban Aboriginal women and Elders were invited to join the study. The invitation was accepted by fourteen women who participated in as many of the Talking Circles as their time and commitments allowed. The women who participated in this stage of the study were invited to form a Steering Group to co-lead the next stage. Four women indicated that they wished to undertake this role. Stage 2: Following analysis of the information gathered in stage 1, the Steering Group was to invite members from professional groups such as social workers, medical doctors, health professional educators, policy makers, and others whom they identified as important to join future Talking Circles. The intent was that these participants would engage in dialogue about their visions for change to health care. However, due to challenges identified during Stage 1 this did not occur. The reasons why and the alternate strategy used will be presented later in the chapter when both stages of the research are discussed in detail.

The language used in this chapter is purposeful to facilitate a more general understanding for people in the community and in academia who have understandings of their unique worldviews. I use minimal academic terminology and language, and focus on Indigenous knowledge, beliefs, and values. This approach provides the academic community with an overview of Indigenous perspectives and the Aboriginal community a glimpse of academic protocols. For other Aboriginal people like me, who did not grow up embedded in our Aboriginal culture, this chapter provides a means to learn about traditional Aboriginal culture, beliefs, values and knowledge and how this knowledge can be used to craft a research methodology.

5.2 Traversing the Borderlands of Indigenous and Eurocentric Worldviews

Even though this research was situated in an Indigenous worldview, Eurocentric worldviews were not ignored or forgotten. Rather, I describe a rigorous yet delicate, thoughtful, and intimate journey in which the interweaving of literature, Aboriginal and Western learning and relationships enabled me to traverse the boundaries between bicultural worldviews. I literally had to step back and forth between the Western worldview that I was familiar with, because I was raised white, and the Indigenous worldview that was less well-known to me. This resulted in a continuous shifting and reconstruction of worldviews – white woman, nurse and academic, while claiming my Aboriginality and at times I felt alone and vulnerable in my journey. It was a welcome relief when I read the works of Anzuldúa (2007), Baskin (2005), and Wiber and Kearney (2006) in which they acknowledged their own experience with living and researching in the borderlands. They found relevance and strength from constructing new knowledge that allowed both Western and Indigenous ways of knowing to create a safe space in which academic and Indigenous communities could work together. There are several other Indigenous scholars, referred to in the following pages, who were specifically chosen for their literary reflection of Indigenous knowledge, ways of knowing, and research. Their extensive work taught, guided and challenged my thinking and actions as I worked within these borderlands.

As researchers, one of the earliest decisions we make when we consider undertaking research is choosing the study methodology. Often in academia, we use methodologies that fit our research interests in which the ‘subjects’ are ‘researched’.

As a qualitative researcher, I was familiar with critical feminist inquiry and institutional ethnography from other research studies that I had undertaken; and used these approaches to inform and alter my perspectives. However, in my quest to find a research methodology that would be acceptable for the conduct of this study, I also reviewed narrative inquiry, post-colonial, post-structural, gender analysis and white studies perspectives. During the search for and critique of appropriate research methodologies, I used the teachings of Indigenous scholars to help me deeply understand the impact of Western research processes and found they often have within them large systems of oppression that interfere with or fail to recognize methodologies that decolonize such practices (Jiménez-Estrada, 2005). Thus early on I decided that these research approaches would not be suitable for the conduct of this study.

Research methodologies that I felt most closely aligned to the philosophical stances that I wanted to adopt for undertaking this study were participatory action research, storytelling, and phenomenology, in that they give voice to those who participate in the research. However, as Makokis (2008) points out, they too are grounded in Western research discourse. In the end I felt none of these research approaches provided a ‘best fit’ approach for a doctoral study that focused on the wellbeing of urban Aboriginal women and they were subsequently discarded.

Although an Indigenous approach to research can draw from both interpretative and critical/emancipatory theories, it does not easily fit into pre-existing Western paradigms of research, because it is grounded in Indigenous ways of knowing and theory. Several Western methodologies foster colonizing research practice that neglects to maintain crucial components of Indigenous research methodologies that require long lasting relational commitment to the Aboriginal community, and respects their culture, ethical protocol, values and behaviours. This unintentional or intentional neglect has resulted in one of the most important concerns of Indigenous people – the protection of Indigenous knowledge.

Porsanger (2004), a Saami scholar, describes Western research which starts with a research problem or a research question, leads to investigation or experiments that discover and interpret facts. This methodological view often takes for granted that a link exists between being ‘Indigenous’ and having ‘problems’. Further, Cook-Lynn (1998), a Crow Creek Sioux scholar, and Mihesuah (1998) an Oklahoma Choctaw, argue that colonizing research not only stereotypes Indigenous people as the ‘problem’ but often misrepresents Indigenous stories, depending on the questions asked by the researcher whose interests are being served in the research; why the stories are being told; and who records, interprets, writes and publishes the stories. Unveiling the context from which this knowledge is translated or made public, is imperative for change to occur (Estey, Kmetic, & Reading, 2008).

As Brown and Strega (2005b), anti-oppressive Canadian scholars suggest, Indigenous research is aligned with critical and anti-oppressive approaches that see research as an emancipatory commitment to empower a position of resistance. While some Western research approaches embrace emancipatory empowerment, within Indigenous research, the messy complexities of life on the margins, which in traditional social science research have been silenced, distorted, devalued, and ignored by the academy, can move towards the centre in which Indigenous knowledge is acknowledged and understood as critical to social justice. Research cannot challenge dominance and subordination unless current research paradigms such as positivism are challenged and traditional Western methodologies sensitized and diversified. Indigenous research empowers resistance that is different from private empowerment of an individual's own assertiveness or feeling of being more powerful. Rather it challenges power relations and systemic oppressions with the intent "to individually and collectively chang[e] the conditions of our lives and the lives of those on the margins" (Brown & Strega, 2005b, p. 10). With a decolonizing Aboriginal perspective by asking whose interests are being served (Smith, 1999) within the research processes, existing relations of dominance and subordination can be challenged and offer political action for change.

Smith (1999) a Maori scholar states the term 'research' within the Indigenous context stirs up silence, bad memories and distrust, and is "one of the dirtiest words in the indigenous vocabulary" (p. 1). It is one of the ways in which the worst extremes of colonization remain in the history of colonized people around the world and continues to be a significant struggle "between the interests and ways of knowing of the West and the interests and ways of resisting the Other" (p. 2). Kovach (2005) and Smith (1999) suggest that Indigenous research should be developed and lead by Indigenous scholars, researchers, and community members in order to be authentic and for non-Indigenous scholars, researchers, and community members to be included to continue to develop their understanding of Indigenous knowledge and theories. Indigenous people must be the ones to plan, implement and evaluate solutions to the complex issues within Indigenous communities.

Whilst undertaking my literature review and learning more about Aboriginal colonization, the pre-colonial equalitarian system of women and men, and the importance of Aboriginal ways of knowing, I felt drawn to using a research methodology that respected and provided the richness and depth of an authentic Aboriginal perspective that I yearned for, and in which I could position myself and remain true to a deeply embedded Aboriginal journey. As I continued to reflect on how I wanted to achieve my dream to undertake research, not **for** Aboriginal women but **with** them, I finally turned to Indigenous Methodologies on the suggestion of my supervisors. As I read about Indigenous Methodologies I wondered if there was risk involved in using this approach for my research. Would I find it too difficult to meet the demands of two worlds, – one which acknowledged that Indigenous research must stand outside Western dominant culture and colonizing paradigms of research; and the other which placed Indigenous research, researchers, and the researched within an objectified gaze of the Western research academy, which ultimately has the responsibility to define what constitutes acceptable research?

Early on colleagues suggested that using Indigenous Methodologies could cause further marginalization of Indigenous people because of perceptions within the research academy that Indigenous research and researchers were not legitimate. I was also aware that naming or labeling the inquiry, as Indigenous research risked criticism by those steeped in traditional Western research frameworks that Indigenous research was ‘soft’ and ‘second rate,’ similar to positivist views of qualitative paradigms. However, the acknowledgement of Indigenous research as academically sound is changing as Canadian research funding agencies are recognizing the importance and effectiveness of Indigenous communities in transforming the nature of Indigenous research (Evans et al., 2006). Some centres, such as the Canadian Institutes of Heath Research and Institute for Aboriginal Peoples’ Health have formed Aboriginal Health Research Networks throughout Canada to advance a national approach to improve and promote the health of Aboriginal peoples in Canada through “research, knowledge translation and capacity building ... by respect for community research priorities and Indigenous knowledge, values and cultures” (Canadian Institutes of Health Research, 2010, para. 2).

From past and current experiences of undertaking research with Aboriginal communities I had some knowledge about Indigenous cultural protocols and processes. I also had several conversations with Elders, Aboriginal community members, Indigenous scholars and my doctoral supervisors, before formally starting this work. I also learned from other extraordinary people I met and worked with along the way. My understanding of Indigenous people's history, ways of knowing, and ethical practices of research with Aboriginal people flourished as the result of my deep self-generated desire to know and understand more about my own people and from being in relationships with other Aboriginal peoples. Critique of the literature, autobiographies, dissertations, books, and other relevant reading, deepened my understanding of Indigenous knowledge, ways of knowing and doing.

Indigenous knowledge is used by Indigenous people to make sense of life in today's world and spans across cultures, histories, and geographical spaces that go beyond the physical world, and leads to a 'self-generating' path to infinite unforeseen realms of knowing (Dei et al., 2000). These knowledge systems connect human beings to other living beings, environments, and the Creator and maintain the life of Aboriginal people (Weber-Pillwax, 2004). There is no one definition of Indigenous knowledge or Indigenous ways of knowing because it is a wholistic perspective in which arts, sciences, religion, or philosophies are not separated (Brown & Strega, 2005b). Battiste and Henderson (2000) do however, provide a glimpse of what it includes, as a "cumulative body of knowledge and beliefs, handed down through generations of cultural transmission, about the relationship of living beings (including humans) with one another and with their environment" (p. 42).

As I understood, Indigenous knowledge was more than what one knows about life, the earth, and the cosmos; in the sense that it is purposeful, practical, intuitive and quiet in nature. It focuses on multiple ways of knowing (verbal and non-verbal); language and place; values; holistic nature; and metaphysical teachings from dreams, visions, ceremonies; and emphasizes relationships between the person and these entities (Dei et al., 2000; Ermine, 1995; Jiménez-Estrada, 2005; Kovach, 2005, 2009). Key perspectives used in an Indigenous approach, such as decolonizing, spiritual, and cosmos, shift the gaze from a Western science and colonial perspective to methodologies that “privilege Indigenous knowledge, voices, experiences, reflections, and analyses of their social, material and spiritual conditions” (Rigney, in Smith, 2005b, p. 87) and in doing so, increase the presence, visibility, and voice of Indigenous people (Brown & Strega, 2005; Kovach, 2005; Smith, 1999).

The values of Aboriginal philosophy such as wholeness, interconnectedness, kinship, and connectedness to my ancestors guided me in realizing learning comes from a multitude of places. The knowledge and enlightenment discovered along my research journey changed my perspectives of the world. Some time ago, I wrote in my research journal that I did not think my personal story was relevant or ‘academic’ enough to include in a methodology chapter. However, as I learned more about Indigenous knowledge and methodologies, I began to understand the importance of sharing one’s journey of Indigenous research because for me it affected my spiritual and emotional life as an individual and a researcher. I found myself shifting within multiple identities, as Aboriginal –Métis woman, doctoral student, educator, nurse, and research academic while traversing two worldviews. This remains challenging, but over time, it became easier as I developed a deep awareness that I cannot separate my Aboriginal self from my analytical academic self, my professional nurse self, or even my white self.

5.3 Indigenous Methodologies Insights and Guides

As I struggled between academic protocols and Indigenous perspectives, I devoted much attention to situate this research in an Indigenous paradigm that included historical, political, and cultural texts to provide a "space for further dialogue within a framework that privileges the Indigenous presence, that uses 'the words' (such as colonialism, decolonization, self-determination), and that acknowledges our continuing existence" (Smith, 1999, p. 6). I concluded, in order to open a *space* for the urban Aboriginal women participants to tell their personal and collective stories about their experiences with Western health care services and together formulate strategies for change in a safe environment, an Indigenous Methodology was needed (Brown & Strega, 2005b; Smith, 1999).

Historically, scientific research of the world's Indigenous people has been linked to colonization. However, this research aimed to decolonize research and in doing so required a new methodology that was developed locally, and was ethical, culturally appropriate and critically evaluated (Porsanger, 2004; Smith, 1999, 2005b).

Indigenous Methodologies are informed by ways of knowing that are common among many tribes around the world, yet also unique as local and tribal constructed philosophies, adding another layer of complexity that makes it extremely difficult to define Indigenous ways of knowing. Attempting to do so would fail to reveal the vastness and complexity of meanings that make up the foundation of tribal knowledge for Indigenous people globally. I realized the importance of including local knowledge and ways of knowing and doing in Indigenous research processes, as well as understanding the global significance of using decolonizing methodologies for Indigenous research with and by Indigenous people. Seminal work of scholars, both Indigenous and non-Indigenous, from Canada, New Zealand, Australia, United States, Mexico, Africa and Norway, was reviewed to highlight global understandings and representations of Indigenous research knowledge.

Decolonizing research, such as Indigenous Methodologies, are crucial in the development of new ways to reclaim control over our Indigenous ways of knowing and to reinstate ancestral teachings, values and goals lost as colonized people (Laenui, 2000). This requires a "long-term process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power" (Smith, 1999, p. 98) in which First Nations people have the right to self-determination through principles of "ownership, control, access and possession" of research in order to transform change for and by Aboriginal people (Schnarch, 2004, p. 94). In Canada, self-determination of First Nations people requires the use of Ownership, Control, Access and Possession (OCAP) research principles to ensure the community or group involved in the research has ownership of traditional collective knowledge; has the right to control research processes including all stages of a particular research project – from conception to completion which impact them; has access to research information readily available; and the data is available no matter who holds possession. Although these principles originated from a First Nations perspective, they are relevant and applicable to Métis, Inuit and Indigenous peoples internationally (First Nations Centre, 2007; Schnarch, 2004).

In order for ownership of knowledge to occur, Porsanger (2004) and Smith (1999) state when Indigenous Methodologies are used for research, the new methodology coming from the research must be developed locally and ethically and be culturally appropriate and critically evaluated. For example, in Kaupapa Maori research, the researcher becomes part of the community that is the location of the inquiry. Therefore, decisions about how the research proceeds and how the findings are distributed are done so in collaboration with the community. In addition, there is a deep commitment on the part of the researcher to build relationships between kin, extended family, individuals, ancestors, spirits, and the environment. These aspects of wholistic connectedness play a central role in the research methodology (Bishop, 1999; Porsanger, 2004), and continue after the research is finished (Grant & Giddings, 2002). Thus it can be seen that this type of research focuses on the group rather than the researcher (Bishop, 1999). With these understandings in mind, I embraced an Indigenous "set of beliefs about the world and about gaining knowledge that goes together to guide [my] actions as to how [I was] going to go about doing [the] research" (Wilson, 2001, p. 175).

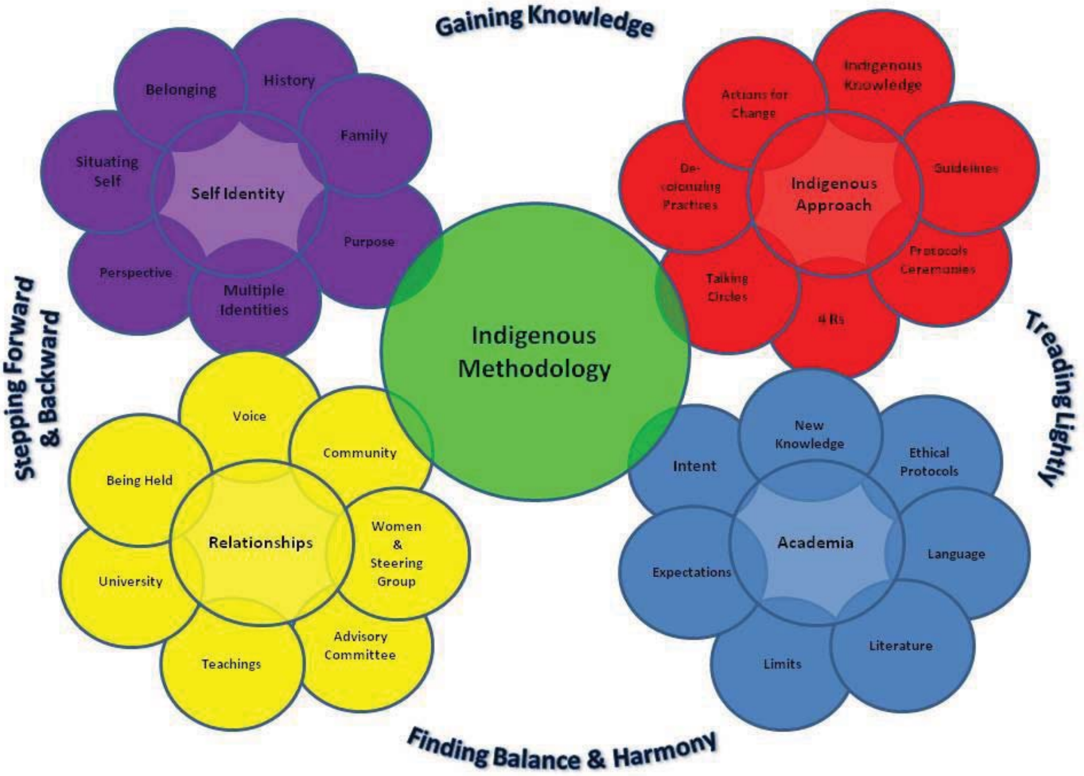
5.4 Constructing Indigenous Methodology: Urban Aboriginal Terrain

Many Indigenous scholars suggest Indigenous Methodologies and research methods cannot be defined, because there are no consistent and generalized frameworks from which to plan, organize, and activate the research process. Kovach (2005) states Indigenous Methodologies start by defining an Indigenous agenda based on Indigenous epistemology and building reciprocal relationships between the researcher and the researched, "including and consulting indigenous peoples, not as objects but rather as participants, to predict possible negative outcomes, to share and protect knowledge, to use appropriate language and form in order to communicate results back to the people…" (pp. 112-113), which is frequently done through traditional storytelling. Indigenous Methodologies seek a global view of Indigenous knowledge and ways of knowing that acknowledges similarities and uniqueness among individuals, families, groups, tribes or nations in their relational connectedness to the earth, cosmos, people, spirits, and all innate entities.

In this doctoral study, the Indigenous methodology consisted of developing ongoing respectful reciprocal relationality shaped by Indigenous peoples' perspectives, voices and ways of knowing and doing, using their ethics, protocols, and methods for all aspects of the research. At the same time, I observed university protocols and created a research methodology that echoed ancient teachings and ensured Indigenous voice and representation were present in each and every step of the process while at the same time meeting the academic requirements of the research study and academic degree – from research topic formation to dissemination of the study findings. At the conclusion of this research I will continue ongoing work with and for the future of our people.

The journey map, Figure 1: *Creating an Indigenous Methodology* visually captures the compilation of teachings, knowing, guidelines and other entities that shaped this Indigenous methodological journey. The circles illustrate the multiple interconnected paths along the journey, and the intricate and deeply interconnected meanings and emancipatory events that evolved along the way.

FIGURE 1: Creating an Indigenous Methodology



There are four multiple circle illustrations intersecting with Indigenous Methodology as the core. They are interrelated and fluid entities, not always peacefully coexisting but committed to embracing balance and harmony. This map illustrates a non-linear and fluid journey of discovery in which the entities within the circles shift back and forth allowing some to be more present than others at different times of the journey while others are suspended in time. Yet all are alive in their connectedness to each other and the universe.

The components of the ***Self Identity*** circle illustrate pathway entities before and during my doctoral journey and that will continue in my journey of life. The detail of this personal journey was initially described in chapter 2 of this thesis in which I described my life as a blue-eyed blonde girl/woman. My personal journey is expanded in this chapter in the sense that through my engagement in this research I deconstructed my old identity to find my own history as an Aboriginal person and the history of many other Indigenous peoples. My previous white family now includes brown faces. These discoveries affected my perspectives about life and the world as I began to reflect on my intent or purpose for wanting to engage in Indigenous research. I realized I had multiple subjectivities that interfaced with my Aboriginality, some of which challenged my core identity as an academic, scholar, and researcher.

In order to move forward, I purposefully positioned myself within an Indigenous perspective. I situated myself as an Aboriginal person which enabled me to authentically find, explore and understand my new self-identity. Gradually what emerged was a real sense of great belonging in my Aboriginal family and a willingness to embrace my Aboriginality whatever challenges or successes I faced. Gaining knowledge helped to build my identity as I traversed the borderlands of Indigenous and academic perspectives while at the same time building and nurturing relationships within both worldviews. Importantly for me, my children have been secondary beneficiaries of my journey of becoming, as they too have embraced their Aboriginal heritage and have become proud to claim their ancestry.

The ***Indigenous Approach*** circle visually portrays several pathways I explored to find a critically reflective perspective from which to embrace an Indigenous epistemology when conducting this research, and to live a life as an urban Aboriginal person. Each of these circle pathways: Indigenous knowledge; guidelines for Indigenous research; the 4Rs of Aboriginal research locally; Talking Circles; decolonizing perspectives; actions that arose from the research are detailed in this chapter. The ***Academia*** circle pathways are also discussed in this chapter to highlight the hierarchal and linear realities of the academy in which specific ethical protocols, language, and Western ways of research are understood. At times I was challenged and felt limited by the constraints of academia and the impact this had on the conduct of this research. I was aware of both academic and Indigenous expectations that others had of me and I of them in relation to the intent of the research process, and how we would generate and share new knowledge that evolved from the study.

The ***Relationships*** circle represents the significance of opening pathway spaces for all voices and communities involved in this research to offer insights that were relevant within the context of their lives. Within my relationships I was committed and accountable to the women, Advisory Committee, and Steering Group to ensure their teaching and collective vision led the way for change. I also navigated relationships within the university. Being held and holding others within the interconnected relationships helped keep the journey safe for me and those with whom I was in relation. This required treading lightly and stepping forward and backward at times as I continually reframed my identity and became aware of how I represented both Indigenous people and those in academia.

As stated earlier in this chapter, historically, Indigenous research has been for the benefit of the researcher. Smith (1999) reclaims Indigenous research as a tool for survival for healing and self-determination by “satisfying a need to know and a need to extend the boundaries of existing knowledge through a process of systematic inquiry” (p. 170). The integral part of Indigenous Methodologies is the inclusion of cultural protocols, values and behaviours that are ethical, respectful and useful. These factors are embedded in Indigenous research through reflexivity and are part of the research design, final results of the study and in the process of sharing the results with the people. Ways of reporting back and sharing knowledge at health conferences or in schools must be grounded in a language that is understood, such as through formal ceremonies.

My research journey was intense, and I am now embedded in Indigenous knowledge and epistemological worldviews that embrace decolonizing research methodologies. Using Indigenous Methodology as a research approach enabled me to construct a unique methodology that suited the urban community and generated further Indigenous knowledge. Finally, I felt that the knowledge I gained would contribute to informing research paradigms by adding to the body of knowledge of Indigenous ways of being for Indigenous people's needs. I therefore, finally felt confident using Indigenous Methodology for my doctoral work because it embraced several guidelines suggested by scholars who were familiar with using an Indigenous approach that emerged from the community and enabled the research process to unfold and thus shape its own methods (Kovach, 2005; Wilson, 2001). It enabled me to work collaboratively with the urban women and Elders, incorporating Indigenous ways of knowing into cultural protocols, values, traditions and behaviours which were integral to each part of methodology (Evans et. al., 2009; Smith, 1999, 2005b). I was also guided by the teachings of Smith (1999), Kovach (2005) and Kirkness and Barnhardt (1991).

Smith (1999) provides questions to increase awareness of the philosophical intent and keep a cross-cultural perspective thorough out the Indigenous research. She states the researcher needs to continually ask who owns the research, who will design it, carry it out, write about it, and how will the results be distributed?

These questions helped to keep me within an Indigenous methodological perspective as I made sure to include the perspective of the women as the centre of the research while maintaining ongoing discussion with my supervisors, Elders, the Advisory Committee, Steering Group and other Indigenous scholars. At times, this took a fair bit of time waiting for the next Advisory Committee meeting and the Steering Group gathering to ensure that everyone was kept up to date and supported the progress of the study. Kovach (2005) suggests when a researcher engages in Indigenous research there are three key themes of Indigenous ways that must inform the researcher's practices: *relational, collective* and *methods*. Relationships of all life forms that are respectful are *relational* and in life, we only take what is needed and then give back and offer thanks. For me, building relationships with the women was the foundation of the research and these relationships were built in a very sensitive and respectful manner. I was introduced to the women by the Aboriginal Elder who invited them to the project and whom they trusted. Therefore they were willing to trust me. However, at times I did not always reach my goal of being respectful and occasionally I needed to admit I was on a journey as I struggled with my academic self or said or did something that was unintentionally relationally disrespectful . I am grateful to the women who were forgiving and my eager and willing teachers.

The underpinning of Indigenous research acknowledges Indigenous cultural systems as almost instinctive in knowing that we must take care of each other and are accountable to each other, our communities, clans and nations. This *collective* is the "reciprocity and accountability … that creates a sense of belonging, place and home" (Kovach, 2005, p. 30). Belonging to a collective required diligence in ensuring that a Western research approach was not used to define the research question, determine participants, choose the methodology or direct the sharing of study findings. *Methods* used in Indigenous Methodologies acknowledge alternate ways of knowing such as insights generated from dreams and storytelling and researchers need to be cognizant of ethical issues such as how much of the research to reveal and who benefits from the research. Methods are nested in Indigenous ways of knowing and cultural practices and are directed by community members participating in or potentially affected by the research.

Kovach (2005) closely ties these key themes of Indigenous ways to four key assertions of Indigenous epistemology, which lead to a deepened understanding and sensitivity that shaped my Indigenous research journey. These include *experiences, Indigenous methods*, *receptivity* and *relationship,* and *collectivity*. For example, it is important to: a) recognize life *experiences* and *Indigenous methods,* such as storytelling, as a legitimate way of knowing and the foundation from which teachings are transferred from generation to generation; b) acknowledge *receptivity* and *relationship* between researcher and participant as a natural part of the methodology to build trust and understanding; and c) understand *collectivity* is a way of knowing in which reciprocity to the community, all life forms, the human world, spirit, and ecosystem are honoured. For me this also included our collectively constructed vision that arose from the women's recommendations for changes in the health care system. Through active involvement in all parts of the research process individual perceptions were validated within the community dialogue and reflected in the generated knowledge informed by experiences and relationships together. These assertions guided my journey in walking amidst Indigenous traditions and methodologies and academic protocols for the research.

This doctoral study was grounded in Kirkness and Barnhardt's (1991) "4 Rs" of research *respect, relevance, reciprocity,* and *responsibility.* The 4R's provided me with a foundation from which to position myself as a researcher and position the research process as I worked with the women and community members: *Respect,* the "reciprocal, shared, constantly interchanging principle which is expressed through all aspects of social conduct" (Smith, 1999, p. 120), underpinned the formation of relationships and valuing of the diverse knowledge of Aboriginal people in relation to health, wellness and community. By acknowledging *Relevance* of the research process and all it entailed, I was reminded that this research was grounded in the Aboriginal people's culture and community. This naturally lead to ensuring *Reciprocity* in which the research approach included a continual giving back more to the community than was taken during the research. By recognizing my *Responsibility* as a researcher*,* an ethos of empowerment of the people involved in the research through their active and rigorous engagement, participation, and leadership was emphasized.

The 4Rs also helped me learn a great deal from the women I was privileged to work with and understand their beliefs, values and ways of knowing. The women I worked with confirmed much of what I had read in the literature. They also taught me about their own Indigenous ways of knowing, generating and teaching of knowledge through the use of metaphors and symbols, the Medicine Wheel and Seven Generations Teachings.

I was aware of the Medicine Wheel from a 'book learning' perspective and assumed all Aboriginal people believed in this quadrant circle and that all Medicine Wheels were the same. However, what I learned from the women was that not all Medicine Wheels were the same in colour, direction, and meaning; however, they helped me understand more fully how the concepts within the Medicine Wheel were applied to daily life. Aboriginal scholars and traditional teachers use similar stories and metaphors such as trees (Brown, Lane, Bopp, & Bopp, 1984: Jiménez-Estrada, 2005; Steinhauer, 1999), spider webs (Cohen, 2001), flowers (Lavellee, 2009), to describe and develop research models (Marsden, 2004) as a means to unveil their research process and research findings. When engaging in Indigenous research and in understanding health and wellness, many authors stress the importance of understanding the meaning of ancient symbols such as the circle, hoop, or wheel in relation to spirituality, health, ceremony, family structure, gatherings, song, dance, and the life cycle of the total universe (Pewewardy, 1999).

For example, some North and South American Indians use the Medicine Wheel to teach Aboriginal knowledge and measure wholistic wellness within a humanistic approach (Brant Castellano, 2002; Dapice, 2006; Monture, 2000). Balance in life and the universe is maintained and challenged through the cycle of life according to sets of four core components represented in four quadrants – spiritual, emotional, physical and mental self; four cardinal directions – west, north, east, south; four healing medicines – tobacco, sage, sweet grass, cedar; four human races – white, black, yellow, red; and four elements – earth, air, water, fire; within the universal circle of life in which all things are interconnected, related, powerful, and synchronized (Chansonneuve, 2005; Pewewardy, 1999).

The Medicine Wheel is also reported as a circle that teaches Aboriginal people about the importance of community, where each person is expected to provide support in all relationships; to work in teams; and to share gifts based on the four quadrants to create balance in their life and within society as a whole (Brant Castellano, 2002; Twigg & Hengen, 2009).

Some Indigenous people live with the understanding that Indigenous ways of being are guided by the Seven Generations Teachings that are based on the cyclic concept of knowing that what one does today, whether positive or negative, impacts the next seven generations; and what happened seven generations ago, impacts us today. These teachings influence present individual and community lives and connectedness to all life forms and wholistic well-being (Lavellee & Poole, 2010).

Most of the women who participated in this research embraced the Medicine Wheel and Seven Generations Teachings although they may have had slightly different meanings in the deeper understanding of their specific tribal teachings. The women also taught me through example, the meaning of relationships, and family and how to position myself within an Indigenous perspective, using these teachings as a foundation.

This learning was crucial and enabled me to understand the relevance of wholistic interrelatedness as the core to Indigenous knowledge and ways of being from which all other values and views within and beyond the physical world emanate. With this foundational knowledge, I was more open to fully explore, understand, and embrace Indigenous ways and research methodologies. For example, to ensure the research was culturally-based and relevant to the urban Aboriginal women who were involved in the study, I kept in constant contact with them, the Elders, and the Advisory Committee, and Steering Group. We remained in contact by phone, email and face-to-face at gatherings. They guided the research process and taught me their values, beliefs and protocols while I taught them the academic protocols and ethical guideline parameters I needed to respect. I was also guided by scholars who offered their teachings from their own research journeys, and my doctoral supervisors.

I found that the teachings of the Indigenous scholars helped me realize the importance of my past and current research and that Indigenous knowledge, philosophy, and worldviews were very complex and very different from Western thinking. The seriousness of engaging in Indigenous research is eloquently captured by Timmins (2001/2002) who described Indigenous research as a spiritual contract. For me this was a huge commitment and responsibility. Following this foundation enabled me to develop, shape and hold space for Indigenous knowledge and to create a research method for the journey. However, I admit that keeping Indigenous knowledge, voice, and representation at the core of the research while working and living within a colonized system was challenging. I found that I continually had to be aware to ensure the research focused on the goals and processes of decolonization and self-determination (Baskin, 2005) and transformation for the women who joined the study. Thus, gaining a deeper understanding of Indigenous knowledge and ways of being was crucial.

5.5 Finding Our Way in Indigenous Knowledge

As I learned about Indigenous Methodologies, I realized I needed to learn much more about Indigenous knowing to understand the essences and true teachings about language, beliefs, values, customs, and traditions that inform and impact Indigenous people's lives. Indigenous Methodologies, conceptualized as plural, honours numerous tribal beliefs, theories and methods. Indigenous knowledge is wholistic and generated from individual, group, and tribal values, ideas, realities, and experience and has been written about by Indigenous scholars around the world. These worldviews are extensively discussed in the Literature Review section of this thesis and for this section suffice to say that they informed my understanding of ancient Aboriginal ways and the methods that I used to interact with the women who participated in this study, which are next described.

For this research I developed a relationship with urban Aboriginal women who lived in a community that was geographically close to where I lived. In part my decision to involve this particular community was based on the fact that these women participated in my previous research and at the conclusion indicated that if any further health related research was done they wanted to be involved. These women welcomed me and provided the place for our Talking Circles and most gatherings. Gatherings included meetings with the women, Advisory Committee and Steering Group. The study was guided by at least one Elder, from the beginning and through all aspects of the study. The Advisory Committee included members who are Aboriginal and experts in Indigenous research, education and culture and they oversaw Stage 1 of the research along with my supervisors. The Steering Group consisted of women who participated in the study who wanted to take on a collaborative leadership role and be more intimately involved in the research.

5.6 Talking Circles: Holding a Sacred Place to Speak

After coming to an in-depth understanding of Indigenous ways of knowing and methodologies, I explored a variety of "data collection" methods and selected Talking Circles as a way to hold a sacred place for the women to speak. Indigenous knowing, as was revealed in the Literature Review, is non-linear and relational and "includes a way of knowing that is fluid and experiential, derived from teachings transmitted from generation to generation by storytelling; each story is alive with the nuances and wisdom of the storyteller" (Brown & Strega, 2005a, p. 27). The Talking Circle is an ancient customary cultural technique used to encourage people to tell their stories, construct collective decisions, to solve problems, and carry out group processes (Becker, Affonso, Blue Horse Beard, 2006; Loppie, 2007; Struthers, Hodge, Geishirt-Cantrell, & De Cora, 2003). They create culturally appropriate, supportive, confidential and culturally safe environments for traditional storytelling, to teach culture, traditions, and history and health education and promotion (Cesario, 2001; Hodge, Fredericks, & Rodriguez, 1996; Hodge, Pasqua, Marquez, & Geishirt-Cantrell, 2002).

Talking Circles are grounded within the importance of relationships and sharing life stories. Wilson (2001) suggests storytelling is a personal narrative that fosters a strong relationship between the listener and the story teller as the exchange of telling, listening, and reflecting on what is heard and what is being said keeps the listener engaged. Storytelling complements the oral tradition of Aboriginal culture in which the purpose of sharing knowledge is not to create stories, but to convey them (Bird, Wiles, Okalik, Kilabuk, & Egeland; 2009;Marsden, 2004). This oral tradition complements Makokis (2008) who eloquently captured what I was looking for as a method by saying Talking Circles are crucial in "uncovering and transforming stories into teaching empowerment" (p. 45). Thus, Talking Circles were best suited to this study as they are a common practice of Aboriginal tradition (Baskin, 2005) and a way for the women to talk for change.

There are variations of ceremonial protocol within the Talking Circle depending on who is in the Circle or the purpose of the Circle. Talking Circles have been common for generations and recently the significance of Talking Circles in Indigenous research has increased. As a word of caution, researchers who are considering using Talking Circles must do so cautiously as they are considered sacred. Sensitive and traumatic experiences are often revealed in the Circle, therefore, those who use Talking Circles must be knowledgeable about the protocols such as ensuring an Elder or other experienced Talking Circle facilitator is present for all Talking Circles. Additionally, the researcher must build into the research process appropriate means to assist individuals who are retraumatised through telling their stories.

The reason I selected Talking Circles as a means for the women to tell their stories is because they foster deeply profound and intimate sharing of life experiences and knowledge (Weber-Pillwax, 2004). Additionally, they generate a large amount of information, perhaps even more than what may be needed or is intended for the aim of research that highlights encounters with the health care system and relevant recommendations for change (Steinhauer, 1999). Lavellee (2009) states sharing circles, a type of Talking Circles, are similar to focus groups but they incorporate cultural protocols. Although this is somewhat true, I am uncomfortable with this description and concur with Wilson (2001) that focus groups are not synonymous with Talking Circles. Focus groups center on a particular content, whether forthcoming from dominant or synergistic elements within the group, whereas Talking Circles focus on information that comes through and out of the speaker's heart, relations and connectedness with those present in the Talking Circle (Wilson, 2001). For me, it was clear that Talking Circles are positioned from the perspective of Indigenous knowledge, and history, with Indigenous people at the centre, whereas focus groups, all though well-intended for the best interests of participants, consist of research content that often places the researcher intent at the centre.

Storytelling guides many paths of teachings and learning in the acquisition and creation of knowledge (Weber-Pillwax, 2004). In our Talking Circles, stories provided meaning and background, and allowed reflection about an experience. It was in the Circles and gatherings that the women taught me about their ways of knowing and meaning of the Medicine Wheel, the Seven Sacred Teachings, and other ceremonies and customs. These metaphors and symbols prompted me to more fully embrace their meanings within my own understanding of the ways of knowing and helped me embed the 4Rs through out the research process.

5.7 Remaining True to Academic and Indigenous Ethical Practices

The researcher is responsible and accountable to ensure the research must benefit the community (Weber-Pillwax, 2004, 2007) and "[i]n the world of Aboriginal knowledge, a discussion of ethics cannot be limited to devising a set of rules to guide researcher behaviour in a defined task" (Brant Castellano, 2004, p. 103). Indigenous ethics therefore includes knowing that researcher behaviour and perspective is nested within Indigenous people's own being, values and understanding of place, and spiritual reality in which limiting risk and enhancing benefits for Aboriginal people's lives is relevant. When it finally came time to undertake my doctoral research, I had several concerns as I moved along the varied paths of my journey. I discussed most of the challenges with those I was working with but I also used my reflective journal to surface some of my concerns. Here is one excerpt from one of several journal entries I wrote as I traversed the borderlands:

> *I am struggling with language and the difference between academic language and meaning and Indigenous language and meaning. I do not want to use works that are colonizing. Words are interpreted in the literal sense by most Indigenous Peoples. In the academic world "data" is usually objective and scientific such as facts, figures, statistics, records, numbers and information from subjects. In Indigenous Methodologies, it is knowledge and experiences and although it could include scientific measures, information is usually shared through storytelling, visions, and oral history. The women's stories were never considered as an object – "the*

> *data" – their stories and lives were used to identify the study findings. However, both academic and Indigenous ways of obtaining information in the end provide insights and some understanding of the information or knowledge gained. How it is made public needs to be appropriate to both worldviews, which is my experience of the work that I am doing.*
>
> *How is data collected – I thought about the word collect. What does it mean? How could it be interpreted? Collect – get something from someone, put together, pick up, take away. To me this had a colonial undertone; and for this study I called data collection, the gathering stories, or teachings and/or knowledge. Academic methods Interviews/Focus groups/surveys are often interpreted as the researcher asking questions and the subject providing answers – it's like picking particular fruit from the tree for the interests of the research not necessarily the interests of the individuals or community. Who has control over what is 'collected' and 'disseminated'? Depends what is asked and how. In Talking Circles the person speaking, or as in our work, the group of urban Aboriginal women, have control over what they want to reveal and the direction of what they wanted to divulge by holding the special rock. The next speaker then directs the path of the sharing by talking about their own experiences and knowledge. They do not have to address formulated questions as in a focus group, often resulting in richer 'data' by sharing control and power of what is being 'collected'.*

When it came time for data analysis I again struggled to ensure authenticity with an Indigenous worldview and doing what was necessary to remain within the standards of the university while honouring the wisdom of the women and sharing stories, knowledge and wisdom in a culturally safe way. Again, I used my journal to reflect on what I was struggling with and to find clarity in how to progress:

> *Analysis – what does this mean? How can I analyze other people's lives? How can I be sure that my interpretation honours the women's stories as their knowledge that they own. I do not want to be disrespectful, especially because I know Indigenous women continue to be objectified and brutalized through colonization. What they revealed in the Talking circles were their intimate life experiences, teaching, and recommendations for change. How will I 'disseminate' the insights from this work? How do I translate and transfer the positive aspects of their lives when there are so many shocking and awful stories? How do I keep or hold their successes, wisdom, and collective insights to improve health in the foreground as study findings? I know it is best to keep within Indigenous Methodologies and have the women involved in every part of the research process. We will just continue to work together….and I will continue to ensure I respect the ethical protocols of the community, the university, and national and international guidelines.*

In view of the fact that the study involved research with Aboriginal people of Canada, University of British Columbia Okanagan human ethics approval was obtained to ensure the Canadian Institutes of Health Research *CIHR Guidelines for Health Research Involving Aboriginal People* (Canadian Institutes of Health Research, 2007) and, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 1998, 2010**),** in particular Chapter 9, *Research Involving Aboriginal Peoples in Canada,* and the *Ownership, Control, Access and*

Possession guidelines (First Nations Centre, 2007; Schnarch, 2004) were used to inform the ethical protocols throughout the study. As well, the work of Ermine, Sinclair, and Jeffery (2004) provided clarity and direction for research involving Indigenous peoples. Guidelines assist researchers and institutions to carry out ethical, culturally competent and mutually beneficial research that acknowledge the unique status of Aboriginal peoples in Canada and value respect for human dignity, welfare and justice. They recognize Indigenous knowledge worldviews and affirm Aboriginal rights to ensure a balance in the relationship between researchers and participants to conserve and develop tribal knowledge. These guidelines also provide support and guidance to Aboriginal people to ensure self-determination and to inform Aboriginal ethics and protocols in this study.

Deakin University Human Ethics Research ethical approval also required that specific ethical considerations needed to be addressed when working with Aboriginal Peoples. These included consultation and negotiation processes between Aboriginal peoples and the researcher throughout the research process such as: clearly specifying research aims, anticipated outcomes and priorities of the research; obtaining community and individual consent to participate; providing ongoing advice and monitoring of ethical standards; honouring values and processes of the community; negotiating access to and/or control of the research results; including Aboriginal peoples in the development and implementation of the research; ensuring community satisfaction and benefit of the research for the community; demonstrating understanding and respect of Aboriginal knowledge, culture, heritage, beliefs and values; acknowledging cultural property rights; and the contribution of Aboriginal peoples to the research. For this research, these considerations were addressed by ongoing consultation with and support of the Advisory Board comprised of local Elders, Aboriginal centre board members and staff, students, Aboriginal scholars, mentors, and faculty and service providers who guided the research process from the very beginning. Each step of the process from the selection of an Indigenous methodological approach, research process, research questions, location of the study, methods to gather information, invitation to join the study, consent forms, review of study information, and academic and Indigenous research ethics and protocols were reviewed by doctoral supervisors, Elders and the Advisory Committee.

5.8 Inviting Women to the Sacred Circle

This study was geographically located in a small urban community within the interior of British Columbia. The research was undertaken in partnership with a centrally located non-profit Aboriginal agency, from which written support for the project was obtained. This agency Centre provided numerous individual, child youth adult and family programs and services for the urban Aboriginal population. Following Deakin University Human Research Ethics approval (Appendix A) we moved into Stage 1 of the study. A well known and respected urban Aboriginal woman, Elder Two, who worked in Aboriginal health care in the local urban community, and was involved in the design of this research study, agreed to contact the women she knew who had participated in a previous health research study and who expressed interest in joining similar research studies. Since she knew the women, we thought it would be an easy process for her to invite them to join the study. However she had great difficulty finding the women. Some had moved; some did not have telephones and had not visited the agency for her to tell them face to face about the project; others were not interested in joining and others were not home, or did not return her phone calls. She decided to invite other urban

Aboriginal women she thought would be interested in joining the study. Traditionally, respect and caring for family, extended family, friends, and community are part of everyday life and when an important event or opportunity in the community happens, who is appropriate to invite is at the discretion of the inviter. Thus the Elder invited women she thought would be interested in finding out more about the study.

Women interested in participating received an information package at a session held at the Aboriginal Centre, containing a Letter of Participation (Appendix B), and a Plain Language Statement (Appendix C), in which details of the study and researcher contact information was included. Elder Two invited them to attend at a time suitable for them, to meet with me and her to talk about the study and answer any questions. Women who did not receive a preliminary information package were given one on arrival and were given time to read over the information. The women were told we would provide child care and financial support for transportation and we would also provide supper for them and their children, so they could more easily attend the information session and Talking Circles.

In all, we joined together for four Talking Circles at the urban Aboriginal Centre with seven to fourteen urban Aboriginal women between the ages of twenty three and seventy one years at each Circle. We used the Centre because the women were familiar with it and it was culturally safe, private and conveniently centralized in the community for easy access. Because Elder Two worked at the Centre, she made arrangements with the Executive Director of the Centre for approval to use the space for project gatherings and Talking Circles.

As the women came to the information session gathering, we introduced ourselves, sat together in the kitchen and talked about daily life. Some of the women worked together at the Centre and others attended the Centre. Many had known each other for years and were familiar with each other's families and intimate details of their lives. When it came time to eat, one of the women, Elder One, said a prayer of thanks for the food. This time of sharing a meal together and socializing is important for Aboriginal people. For me it also was the first step in building trusting relationships with the women. Over the several months of getting together, our relationships evolved from me not being known to the women and the women questioning the intent of the study, to freely cuddling the children, hugging each other at the beginning and end of the gatherings and Talking Circles, and driving the women home at night. There was always a lot of laughter, teasing and sharing of personal everyday life events.

After eating, Elder Two explained the project, and asked if there were any questions. Each woman was given a consent form to read and sign. After a few minutes, I was aware that some of the women were looking around not really reading the form. I asked if it was okay to read the consent form aloud. They all agreed. As I read the document I became more and more uncomfortable with the language in the consent form – academic, unfriendly and certainly not culturally appropriate. I was surprised and embarrassed. I had worked diligently with my supervisors and Elder Two to develop and review the forms, checking the details for accuracy and clarity of language. I wanted to ensure the language on the form was friendly and relational because I knew the relationship between the 'researcher' and the community was crucial in Indigenous work. I also tried to use words that would not be interpreted as implying power over individuals or be discriminatory in nature. But these intentions were futile because the forms were not easy for the women to read and understand without discussion.

The consent forms were discussed later with Elder Two and a few of the women who joined the fist Talking Circle. We concluded that because it had the university logo and looked very official and legal, it was threatening to the women. From a historical perspective Aboriginal people were forced to sign official documents to give up their land, status, or for the government to take away their children into foster care. They were threatened through legal processes that ensured loss of control, loss of their voice, and which often resulted in punishment. Secondly, some of the women had minimal education as is discussed in chapter 6 of this thesis. Others found the academic language difficult to understand. Even though there was some (perhaps embarrassed) laughter from the women about the forms, I worked with Elder Two to provide details and clarification. The main question or comments raised were related to the fact that some of the women were involved in other research but nothing had come of the work. Therefore they wanted to know how this study was going to be 'different'. I described my commitment to them to widely disseminate their stories and recommendations in a variety of forums and using a variety of ways. Elder Two promised she would ensure the research would not 'sit on a shelf' somewhere and never seen again.

We also advised that after the first Talking Circle they were free to invite other women, by word of mouth, whom they thought might be interested in joining the next Talking Circles. Each time a new member joined a Circle, she met with me and Elder Two privately to discuss the project and for her to sign the consent form if she had not already done so prior to the gathering. We referred to the consent form as we explained the Circles would be audio taped and transcribed, and they would receive a copy of their transcripts so they could confirm that what they said was accurately transferred to writing. They were advised they could choose a fake name so their identity would remain anonymous and confidential. We had some discussion about this because a few of the women wanted to use their real name so it would be made public who divulged specific information and recommendations for change. We explained the ethical protocol to use a fake name was for their protection as per the consent form.

Subsequently the women signed the consent forms. Since this experience, I have researched ways to develop consent forms using clearer and more appropriate language that is also more culturally appropriate yet would meet human ethics board approvals. I add this to a list of improvements for 'next time' as an Aboriginal researcher who is accountable in two worlds – academic and Aboriginal – and working with my relations. It is ironic that a consent form called a *Plain Language Statement* was eight pages long and not so plain considering the perspective from which the women were situated – that is within an Indigenous worldview.

Following supper, the children went into the playroom with the hired child care persons who were Aboriginal and known to the children. Because the children were familiar with the playroom, they were excited to have this time to play with each other. The women went into the adjoining room which was set up in a similar fashion to a home living room with couches, chairs, rocking chairs, and stools. Prior to each Talking Circle, we prepared the room for the Talking Circle sacred ceremony. This included arranging the chairs and couches in a circle. On the floor in the middle of the circle, we placed a traditional Indian blanket, a traditional hand carved wood Talking Stick, handmade deer and elk hide Aboriginal drums, pine and fir tree cones from local trees, cedar boughs and evergreen branches, and a candle. This helped place the circle in a more wholistic space by bringing nature and spirit into the Circle with us.

To begin the Circle, we all stood up and Elder One opened the Talking Circle with a Traditional prayer. When we sat down Elder Two formally introduced herself, and then we all introduced ourselves – Aboriginal family, geographic area, our work, or other details of our family. We also offered thoughts about our *place* in the Circle, and why we were there. The Aboriginal facilitator of the Talking Circle, Elder Two, showed the women the rock in her hand and explained the special meaning it had for her. She told the women the person holding the rock was the speaker and everyone else was to listen and not interrupt until the woman was finished talking. She then started the Circle by sharing two personal experiences with the local Emergency Department. As she spoke about her health care experiences, she reflected about the impact of colonization in relation to the treatment she received. Based on the two research questions, she then asked the women in the Circle to share their experiences with health care, and their ideas for changes to health care policy.

The women took turns telling their stories, each holding the special rock as they spoke. We all respected the protocol of listening and not interrupting when someone was speaking and honouring what each person had to say. At times, Elder Two, as Talking Circle facilitator, would ask a question after the woman finished speaking and this allowed others to also ask questions. There were very few questions asked and the way in which they were asked was for clarification, or to ask the woman if she was okay, not to probe deeper or to redirect the discussion. This is common in Talking Circles, as it is considered rude or inappropriate to challenge what someone said. Rather a nod of the head or silent acknowledgement of some sort that what the person disclosed was worthwhile is acceptable (Loppie, 2004).

The Talking Circles were planned to continue for about ninety minutes to two hours, after everyone agreed they were finished talking and were satisfied. While everyone had some idea of how long Talking Circles would last before we started, we usually had to end the Circles before we were finished because as one of the women said, *We could talk all night.* Flip chart notes were taken by me at the request of the women during the Talking Circles because they wanted to see, in writing, their recommendations for change and how they best saw their ideas for change occurring. The purpose of the research and themes from each Talking Circle were revisited at each Talking Circle. At the end of each Talking Circle we made a commitment to the group that we would be at the next circle. We also talked about the type of food to bring to the next Circle and once one of the women brought Bannock, delicious homemade traditional Aboriginal bread that she had made.

Early in the research process, four of the women expressed a desire to continue in a leadership role and through consensus of the whole group of women they formed the Steering Group that was to oversee the rest of the project. In Stage 2 of the study we had originally planned to invite health professionals, educators and policy makers to new Talking Circles where the women in the Steering Group would retell their stories and their visions for respectful, non-racist, non-discriminatory health care for Aboriginal people. It was hoped that within these Talking Circles action strategies could be devised and that the people invited to join the Talking Circle would be in positions of influence so that the action strategies could be implemented. However, following Stage 1 of the research, the Steering Group decided to modify Stage 2, which will be shortly discussed.

In our Talking Circles an Elder facilitated and ensured safety for members and provided immediate support in case anyone became stressed. This was extremely important especially because many of the stories told were emotional and difficult to reveal. At times when a woman became upset, Elder Two moved from her chair to sit beside the woman who was speaking and rubbed her back gently, as a way to show support and acknowledge her difficulty in sharing intimate details of her experiences. However, during the research project there was only one incident in which the Talking Circle was interrupted as support was employed. During the fourth Talking Circle, it became noticeable that Elder One was having an especially difficult time retelling her profound and painful stories that she had described at the previous three Circles. Elder Two accompanied her out of the Circle so she could debrief. When they returned, both Elders explained the difficulty in retelling the stories and reopening memories and revealed that speaking about pain of the past repeatedly was like being re-traumatized. We decided that to continue to Stage 2 as we had originally conceptualized would further traumatize the women.

We also realized health care professionals would most likely not be able to join a four hour gathering outside of their work hours and with increased workload and shortages of staff, their employer would not allow them to do so during the workday. In addition, with only small groups joining a Talking Circle, it would take several Circles to communicate the collective vision for health care reform. After lengthy discussion, the Steering Group decided unanimously that the knowledge generated through the Talking Circles could reach larger numbers of people by presenting at national and international conferences, at the university, and within the wider community. We resolved to pursue this direction as our reconceptualized Stage 2.

The Talking Circle protocol required intensive listening with minimal interruption and limitations in posing questions and probing for more information.

Through my participation I gained profound insight into the stories, strengths and capabilities of the women. I also gained in-depth knowledge of them as women as a consequence of interacting with them outside the Talking Circles. We met for gatherings in which we talked about the research project, ideas to move ahead, what needed to be done, other business, and life in general. We also met for coffee, lunch, and at each other's homes. I realized relationships were imperative in Indigenous work and life, but I never realized how meaningful and deep the relationships would be and that they would develop into friendships and family relationships that continue for many of us. One of the most important life lessons I learned is that when using an Indigenous Methodology, founded in Indigenous knowing, the researcher is able to go beyond the boundaries that are imposed in other types of research approaches, which are often cited as limitations in other forms of qualitative research. However, a challenge remains for all researchers to ensure what transpires within the research process meets academic and Indigenous ethical approvals.

5.9 Freeing the Teachings within the Women's Collective Vision

There is no doubt that the women's stories and ideas for the research process shaped the research journey. I worked in collaboration with my doctoral supervisors, the Advisory Committee, the women, and the Steering Group. Following the aims of the study the urban Aboriginal women's stories were explored to identify storylines, threads and connectedness. This was extremely challenging for me as I walk in the academic world, in which I am used to qualitative data analysis - categorizing, thematic analysis, coding and the like. Because an Indigenous Methodology is developed as part of the research process, I had to let the stories *speak* for themselves and not conveniently slot them into groups or sets of themes.

Each of the four Talking Circle digital audiotapes were transcribed verbatim by me. I reviewed them several times by re-listening to the digital audiotape while at the same time reading the transcription. The intricate reading and rereading, and listening to the audio tapes, helped ensure none of the women's stories were lost during transcription or misrepresented. There were a few words that were in an Aboriginal language which I later had to ask the speaker to explain the meaning and teach me the spelling. Once I was sure the transcripts were accurate, I created a transcript for each woman specific to her contribution to the Talking Circle. Elder Two informed all of the women of multiple dates and times that I would be available at the Aboriginal Centre or Youth Centre to meet with each of them to read the transcript for accuracy and to ensure they were comfortable in sharing what they said in the Talking Circle(s) in which they participated. Although all were invited to read their transcript, not all chose to do so. Those that read their transcript agreed with what was written and did not suggest any changes be made.

Each individual transcript was then meticulously combed to distil into one whole story the various contributions that each woman made across the Talking Circles in which they participated. By using this technique I ensured that each woman had one story that was a compilation of everything they shared and each compiled story was named after the woman using her pseudonym. This technique ensured each woman's teachings were clear and concise. For example, Elder Two's story about her experience in the Emergency Department was disclosed in all four of the Talking Circles, as were Elder One's residential school experiences. As I read and reread, and reflected on each woman's distilled story, the first rough draft of ideas, thoughts, issues, and realities that surfaced were drawn, as a scribble of sorts, on a piece of paper which provides a visual trail of my analysis activities (Appendix D). From the Scribble work, I then visually mapped the storylines and threads on power point documents to create mind maps, one for each woman that provided a visual image of each woman's storylines within the whole story (Appendix E). The colours chosen for each woman had meaning to me, as I used specific colours that I felt best suited the woman.

In the end each woman had a clear and concise story that captured what she said in the Talking Circles. These stories were told in Chapter 3 Our Stories, Our Truths. As I read and reread each woman's distilled story, and after several reiterations, I moved back and forth within one woman's story singly and could see threads that crossed some or all of the other woman's story thread. I was able to discover individual stories and threads, of teachings within each woman's whole story.

I call the woman's stories teachings because the Talking Circle method that I used enabled me to learn in depth from the women who participated in this research, almost as if I was embraced in their arms. Indeed the women, through their stories, taught everyone in the Circle. My supervisors were intimately involved and worked with me throughout this detailed work with the stories (data analysis, in the academic world), ensuring I did not miss important teachings and ensured the stories I distilled were faithful to the original stories the women shared. This was very time consuming. I spent several months embedded in the women's stories going back and forth, and reflecting on them to let their storylines appear. The women's stories were complicated and so very private. What evolved were complex compelling stories within each woman's whole story, some unique to only one woman, others similar and interwoven among the women's stories in similarity or understanding. I then visually mapped the storylines and threads on power point documents to form mind maps.

5.10 Finding One's Place and Never Going Back

Initially, as a new Aboriginal researcher, I was fearful at the commencement of analysis that I would misrepresent the women's words and in doing so dilute or disregard the relevance and significance of their teaching. However, my fears lessened each time I re-listened to the Talking Circle audiotapes and re-heard the women's voices, re-read the Talking Circle transcripts, distilled each woman's story, reviewed my field notes, and learned from numerous conversations with the women. I was able to delve into an intimate thoughtfulness about each woman's words because I knew and trusted the Talking Circle process which shared teachings within the Indigenous community, in particular, how people are affected by colonization, and how they foster sharing, healing and cultural reclamation. Most importantly, I came to understand the importance of respect – respect in all of my relations. At the beginning when first considering the women's stories, I knew I could not speak for them and especially about a community of which I was not part. This would show deep disrespect towards the women as I did not have the knowledge or experience to speak on their behalf. However, over time, as we grew closer together in respectful and reciprocal relationships, they welcomed me into their community, and some embraced me, and clearly told me that they loved me as a family member. They remain my family and friends and we continue to seek out opportunities to tell and teach our vision and work together for Aboriginal people. They have given me permission to share their stories and insights they offered from joining the research study.

The Circle helped offer new opportunities to understand one’s self and others within the context of the issues in their lives (Dancing to Eagle Spirit Society, 2008). For me, I am changed, I feel I am now an Aboriginal woman in my own right even though I do not have similar memories and experiences that many of the women had of - loss, abuse and pain, but I really believe that anyone who listens, really listens to the women’s stories will be changed.

In summary, the search for a meaningful and appropriate methodology that honoured Indigenous ways of being and knowing was personally and academically driven. In selecting Indigenous Methodologies, a living methodology, the blending of book learning and experiential learning fostered the development of a relevant and locally developed specific Indigenous methodology. Four foundational entities critical in Creating An Indigenous Methodology, were grounded in *gaining knowledge* by exploring and understanding multiple worldviews, *treading lightly*, and *finding balance and harmony* within the places of opportunity that arose by *stepping forward and backward* within the borderlands of Western and Indigenous worldviews. These entities, fluid and shifting pathways within the research journey, led to changes in my personal *Self-Identity*, as an Aboriginal woman and researcher; understanding of the importance of staying true to an *Indigenous Approach* through Indigenous knowledge, guidelines, protocols, and ceremonies, such as Talking Circles; facing constraints and challenges of ethical protocols, language, and expectation of *Academia* in the quest for new knowledge; and finding ways in which to build and nurture respectful relationships to enrich opportunities for research within the borderlands of Western and Indigenous worldviews, evolved as the methodology was created and enacted.

Revealing the teachings, meanings and collective vision that arose through the created research methodology and methods will now be presented by returning to the women's stories that were shared in the Talking Circles.

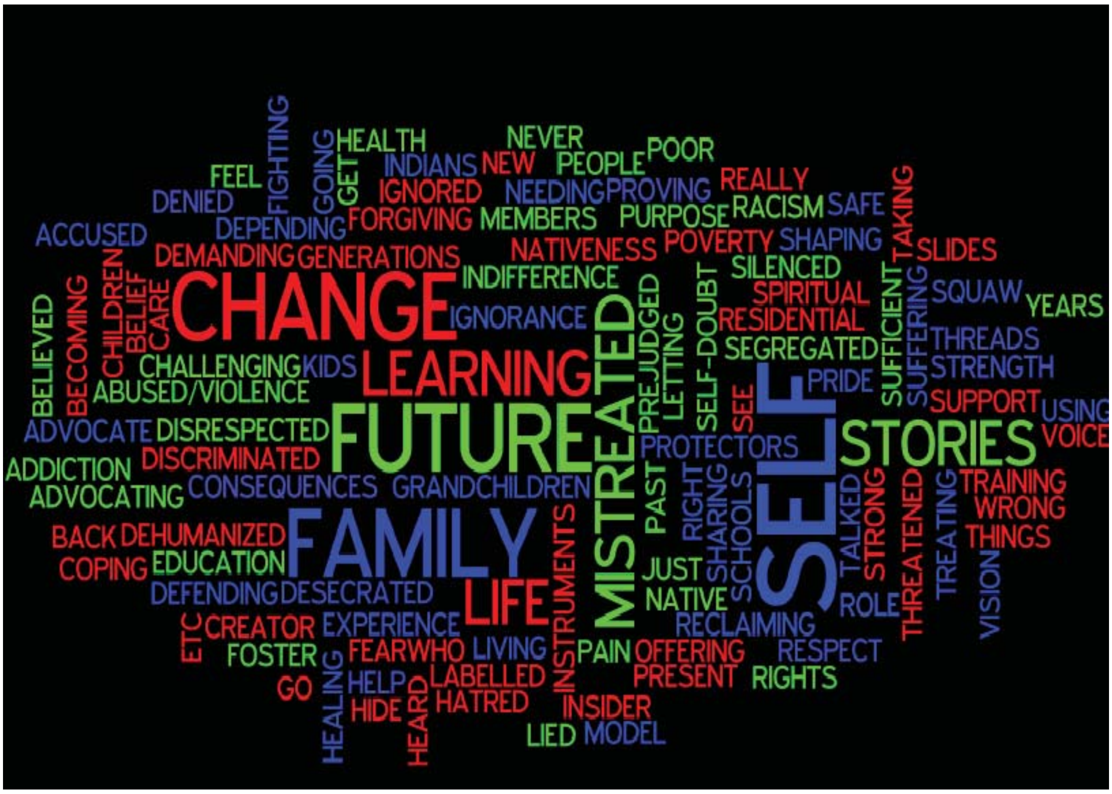
CHAPTER 6: TEACHINGS IN OUR CIRCLE

In this chapter I provide an interpretation of the meaning and impact of everyday life experiences for the urban Aboriginal women who participated in the Talking Circles of this study, in a way that engages a thought provoking dialogue. I present the women's stories authentically, illuminating their significance. Staying true to an Indigenous paradigm to gain new understandings and knowledge, this chapter extends the research circle by sharing aspects of the women's stories. It identifies pertinent literature that enables the reader to raise their own questions, develop their own insights, and draw tentative conclusions. The chapter commences with descriptions about the effects of colonization and this section is called Life in the Aftermath – Residential Schools and Foster Care. These realities are the historical contexts that shaped the lives of the women who told their stories in this research. The chapter then progresses to presentation of the storylines that were identified through a thoughtful and respectful process of analysis, which are: Just Because We're Indian (Experiences); Fighting All Our Lives (Consequences); Who We Really Are (Reclaiming Our Lives); and Shaping Our Future (Woman Warriors). Throughout the presentation of the findings critical analysis of salient literature relevant to these storylines is presented. Finally, the summary of the chapter is presented.

It is important to understand the impact that historical and current colonizing practices have on Indigenous people generally and Indigenous women in particular - how Aboriginal women are positioned in society; and the impact that colonization continues to have on their lives. There is wide diversity among Indigenous women yet they share a common historical and relational experience that connects them as colonized, while at the same time distinguishes them from colonizers, and continues to separate and segregate them from the majority of women. Throughout history, patriarchal Eurocentric Western society justifies oppression and domination of Indigenous people (Henderson, 2000a), which is sadly evident in the stories of the women who participated in this research.

I draw the reader's attention to ‘Wordle’ below and trust it will have a strong impact and set an emotional climate for the reading of this chapter. Every word that appears here was extracted from the transcripts of the Talking Circles. The Wordle isn't pretty – it contains shameful words that describe acts which regrettably affect the lives of Aboriginal people in Canada today and provides insights into the *places* from which the women’s lives continue to be impacted to this day.

Wordle:



Running through the blood of the women in this study are the horrors and memories of the genocide of their people; the forced removal from their land and relocation to residential schools; their exclusion from society in general and from decision-making regarding their position in society today. Not every woman who engaged in this research was sent to residential school, placed in foster care, or had their children taken away, yet all were impacted in some way by these historical occurrences. Providing an opportunity for sharing their collective voice triggered memories of many unresolved traumatic incidents. While numerous issues related to the abhorrent treatment of Aboriginal people are being addressed at various governmental levels, the heinous acts perpetuated on lives of Aboriginal people of Canada that were described by the women who revealed their stories, have left a lingering residual effect.

The women joined in the Talking Circles and participated in the study as a telling/taking action strategy. In telling about their health care experiences they also expressed their vision for health care reform. In addition, they recommended actions for change in current health care practices that would help improve their future health care experiences and those of other Aboriginal people in their communities.

6.1 Life in the Aftermath – Residential Schools and Foster Care

The day-to-day lives of Aboriginal women are often filled with racism, silencing and discrimination (Kurtz, et al., 2008). Colonization, the Indian Act, residential schools, federal and provincial laws, policies and regulations subject Aboriginal women to “a lifetime of violence, poverty, and degradation [and] have created the crisis in Aboriginal women’s health today” (Boyer, 2006, p. 19). Aboriginal women, who were once politically, socially, and economically powerful (Mihesuah, 1998), and who held status in their communities, are portrayed as “drunken squaw, dirty Indian, easy and lazy” by colonizers (Anderson, 2000, p. 99

in Moffitt, 2004). This negative portrayal pushes Aboriginal women to the margins of society, perpetuating an oppressed position, which impacts on their health.

The majority of the Aboriginal women who engaged in this research spoke about events they remembered that remained difficult and traumatic. Those that went to, or had family members that attended residential school, talked about lingering inter-generational effects that still impact their parents, themselves, and their children. They described multiple traumas from living in residential schools and foster homes and how these events continue to affect them personally as well as the health and healing of Aboriginal people in Canada generally. Some of the losses they reported are not unique and have been identified in the work of Mussel (n.d) and Wesley-Esquimaux and Smolewski (2004) to name a few. What is important to note is that the generational aftermath of colonization is echoed in the women's stories and still persists today.

The women talked directly about the negative effects that residential school had on their families. Wolf and Elder One talked about ill health and deaths of family members due to ongoing trauma and inability to heal the wounds of the past. In particular, Elder One frankly admitted she used drugs and alcohol to numb the pain and memories of abuse, depression, fixation on trauma and poor emotional tolerance. She was adamant that there was a link between her poor health, and the affects of residential school: *The reason I am fragile and getting sick is because I still have those things that I'm dealing with that I have to live with, you know. A lot of people are still suffering … nobody talks about it.*

Of all the women, Elder One spoke in the most detail regarding the effects of being disconnected from her family and her people, through being forced to live in a residential school. She expressed:

> *You go on your hand and knees and pray. That's all I ever did, so that God would make me forget all that, and then not get punished, like the way I was taught, if I talked about the sexual abuse* [I experienced from that priest] … *I kept it in my mind, always, always for many years … That tape recorder keeps going ….*

Later, Elder One's eyes were filled with tears and her voice wavered when she shared the same story that she had told previously in other Talking Circles. When she spoke, it was like what she relayed happened yesterday. She divulged not only some of her own experiences as a young girl, but also as a witness to abuse and deaths of other children: *a lot of things happened in those days in school. My brother, I had a brother, and he got killed in a residential school, by a* [Roman Catholic] *Brother.*

When Elder One sought help through mainstream Western medicine, the root causes of her problems were not acknowledged. Instead she was repeatedly prescribed anti-depressant medications and admitted to psychiatric facilities. As was seen through the stories of the women who participated in this research, multiple traumas such as breaking families apart, being subjected to ongoing abuse and not having the same rights as non-Aboriginal citizens continues. Non-resolution of the complex issues that they brought to the Talking Circles inhibited their healing and profoundly shaped their lives. As Wolf stated:

> *The residential school has caused a lot of problems for a lot of people. My mother, my own mother passed away with cirrhosis of the liver. My sister just passed away, cirrhosis of the liver, not too long ago. I've had other brothers and sisters that have passed away because of alcohol … So there's a lot of history around different people.*

Although Quail did not detail her experiences of living in residential school, it was evident through her dialogue that this was a difficult time in her life. She said:

> *I grew up in residential school, away from my family, and I never went back. So where I was working … there were Aboriginal people* [students] *from all across Canada. I was able to see where a lot of problems were coming from.*

The women talked about decisions their parents made to move from the reserve to the city to keep their children safe from being taken and being placed in residential school, and to have more opportunities in life. The effects of living in residential school were again emphasized, when the women revealed with great sadness how their parent's decision to relocate often prevented them from going back home or maintaining connections to family, land and culture. For example, Eagle talked about moving away from community, because *our parents believed the little ones weren't going to have a chance on the reserve. We'd have a better education, a better life.*

The severe losses that were described in the Talking Circles affected several aspects of the women's lives. These losses were related to wellbeing, family members, self-esteem, home, and spirituality. They not only described their losses, but they also talked about the consequences and suffering that occurred in their lives, particularly the trauma of being placed in foster care and the loss of their children.

Nigwa's story of her loss of her children was heartbreaking. She alleged:

> *They* [social services] *took my oldest son away. They lied. My son is thirty six years old today. I don't know what he looks like. They took him away from me. They said I was a drunk and I was stupid. I didn't know any better.*

> *I was eighteen years old when my son was born. I've been looking for him since* (crying).

She further recounted:

> *One of my granddaughters has a birthmark on her arm, about that big. When she was a baby, they* [social service agency workers] *told me it was a bruise. I said "She was born like that!" Their mom has a similar mark, here about that size, and one here. They thought I was pinching her. This is when they* [the children] *first got apprehended. She still has her birth mark. I said "I haven't laid a hand on them".*

Elder One described how she lost her children to the state because she used unhealthy ways to cope with her pain:

> *Sleeping pills, nerve pills, and valium. I always had those but they never did anything for me, so I turned to alcohol. For a while I lost my children because all I did was drink, and try to forget ….*

Browne and Varcoe's (2006) critical cultural examination of heath care provision involving Aboriginal people found social service child abuse referrals mainly singled out First Nation parents, whereas similar 'questionable' parenting behaviours did not result in a referral for non-First Nation parents. This literature suggests that the criteria used in Canada to make child placement determinations are not applied equally and warrant further consideration.

Marginalization and misrepresentation of Aboriginal women was demonstrated in the Canadian public health campaigns in the 1980s and 1990s which portrayed fetal alcohol syndrome (FAS) as an 'Indian problem.' FAS became a public health issue and "unduly stigmatized and blamed impoverished Aboriginal women for elevated rates of mental and social distress unfolding in their communities while ignoring historical, social, and environmental factors that could account for the same outcomes" (Tait, 2009, p. 197). Interestingly, labeling of non-Aboriginal people with FAS was and remains less common. Motherhood is viewed as a normal part of a woman's life in most societies, however, constructed discourses of Aboriginal mothers deem them *naturally inadequate* which not only depicts societal racism and classism but has a seriously negative impact on the women's lives and health (Varcoe & Doane, 2007). This is evident in the taking of Nigwa's children, as if she was destined, because of the colour of her skin, repeatedly to have her children taken away.

From the 1840's to 1996 when the last residential school closed, Fiske (2009) claimed the Canadian government effectively hid its political intent of containment, assimilation, and elimination of Indigenous peoples. But one could wonder has anything really changed since the closure of these schools? Even though in 2008 the Canadian government offered an apology for acculturation and unjust treatment and abuse of Aboriginal children in residential schools (CBC, 2008), to this date Aboriginal children continue to be taken into custody. However, instead of being placed in residential schools they are put into foster homes that are mostly non-Aboriginal and where the children's culture and traditions are not taught. Ball's (2008) report on Aboriginal children in Canada states there are approximately 27,000 Aboriginal children under the age of 17 in government care, which is three times the number of children enrolled at the peak time of residential schools. In some Canadian provinces, "Aboriginal children out-number non-Aboriginal children in care by a ratio of 8 to 1" (Ball, 2008, p. 10). The consequences of this destruction of Aboriginal families and communities continue today in ways that are serious but not always measurable. Governmental agencies would do well to evaluate current practices that continue to remove Aboriginal children from their homes and to include Aboriginal parents and families at decision-making tables.

After decades of lawsuits and attempted negotiations between Aboriginal residential school survivors, churches and the government, the largest class action settlement in Canadian history led to the Indian Residential Schools Settlement Agreement (IRSSA). The 2006-2012 agreement included a Truth and Reconciliation Commission which was mandated to learn the truth about residential school experiences and to educate the Canadian public about the history and the impact that relocation has on the lives of the children and their families (Changfoot, 2009). Residential school survivors are being offered emotional support and financial compensation for healing and have been invited to participate in forums or to testify individually in court. The Commission has also heard from residential school officials and organizers (Truth and Reconciliation Commission of Canada, n.d.). There is much debate about this attempt to compensate for a governmental policy that destroyed Aboriginal lives and whether this national wide initiative could correct, resolve or erase hundreds of years of abuse and hardship for Aboriginal people when many continue to suffer from these experiences and feel unable or unwilling to talk about what they endured.

Elder One relayed that she sat at the Canadian Government Truth and Reconciliation Commission. With her lawyer and in front of a government adjudicator and officials, she told the Truth and Reconciliation Commission of the abuses she suffered while in residential school. The intent of publically sharing her story was purposeful, and costly. She travelled to Ottawa, Ontario, the capital of Canada, thousands of miles away from her family and home to be heard, to report to the government what happened to her in her search for justice so that criminal charges could be brought against her abusers. She wanted to teach members of the commission and the Canadian public about the crimes and atrocities committed in residential schools and to be a role model for others to show that it was both right and safe to make public their devastating life experiences so they too could begin to heal. She said:

> *I know that nobody has* ***ever*** [Elder One's emphasis] *talked about the residential school. It's just recently that it's coming out, because people like me are starting to come out with it and talk about it.* [Last year] *everything was investigated, in Ottawa. I went way down to details on everything when I had that court hearing. My lawyer told me I could opt out. I said, "No darn way! I'm not opting out. I'm going right through with it. Ottawa is going to know about this, hear about everything! ... Because not enough has been talked about it. I know I didn't. I was scared God was going to punish me and take me to hell. I'm doing this for the ones that are gone* [died]. *That didn't have a chance to talk. I don't give a damn about the money! A lot of my people are still suffering from that* [residential schools]. *Yes some of them go on destroy their lives because they were never heard, at all. My ancestors went through the same thing. They never had that chance. They didn't have that voice ... I don't care if no one believes me, it is true and I speak from the heart.*

Aboriginal people do not fare well in the absence of community, ceremony and language. As Brant Casellano (2009) described so eloquently, dislocations from one's heritage are akin to a hurricane, followed by a flu epidemic, followed by the disappearance of half of the children in the community. Colonial experience isolates individuals and renders them vulnerable and threatened in a frequently unfamiliar world. As Struthers and Lowe (2003) described in their mental health research, historical trauma is a sickness that has an "energy spirit, and the healing process needs to discharge, modify, and heal this troublesome energy" (p. 263). The revelations of the women who participated in this research make it clear that a paradigm shift, which includes Aboriginal healing ways, is required in Western society, to meet the needs of Aboriginal people. Being able to trust, feel safe, and feel connected and engaged in respectful relationships with others can return Aboriginal people to wellness and to the paths to healing.

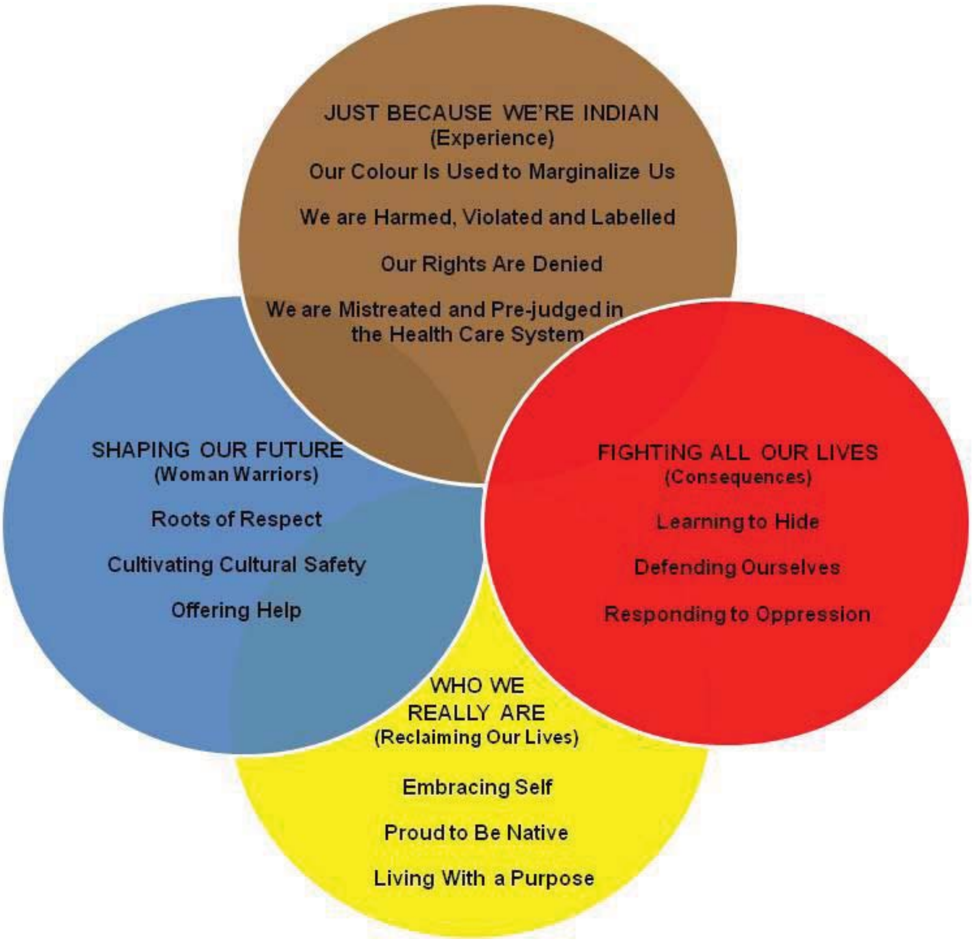
Brave Heart and DeBruyn (1998) identify the importance of using Indigenous healing ways and methods to facilitate recovery. Similarly, Stewart (2008) recognized that inclusion of Indigenous cultural understandings and ways were vital to aid healing and recovery for Aboriginal people, noting that Indigenous ways, healing practices and traditional ceremonies need to be integrated into mainstream health care services. Traditional healing may have helped some of the women in this study early on in their lives and spared them the suffering and losses they endured by being mistreated in a culturally unsafe and unjust system.

This brief foray into the acts of colonization, exemplified by the removal of children into residential school and placement in foster care, nests the stories of the women who participated in this research in a historical context and provides some insights into the storylines identified through detailed analysis. There are four key storylines:

- Just Because We're Indian (Experience)
- Fighting All Our Lives (Consequences)
- Who We Really Are (Reclaiming our Lives) and
- Shaping our Future (Women Warriors).

Each story has a number of threads which were derived from key concepts identified through detailed examination of the Talking Circle transcripts. To enable the reader to appreciate the complexity of the interwoven aspects of the women's stories I present several Mind Maps. Mind Map 1: *Teachings in Our Circle*, gives the broad overview of the four storylines derived through the analytic process. The subsequent Mind Maps (2 – 5) visually portray each storyline in turn, with the associated threads and concepts clustered in such a way as to make it clear to the reader how the analytic process unfolded.

Mind Map 1: TEACHINGS IN OUR CIRCLE



6.2 Just Because We're Indian (Experiences)

The first main storyline, *Just Because We're Indian*, joins the threads of multiple experiences that the women talked about in the Talking Circles. Whereas Life in the Aftermath – Residential Schools and Foster Care unveiled historical contexts of the women's lives. The storyline Just Because We're Indian, exposes the harsh and profound yet intimate and sensitive realities of their current everyday lives. The threads of this storyline were teased out and the women's voices are now shared, through direct quotes from the Talking Circles. Common rich and meaningful threads are emphasized in this poem, created using the women's words:

Just Because We're Indian

We are the ***colonized*** ones,

***Labeled ,mistreated, dehumanized*;**

Our voices ***ignored, silenced***,

Our safety ***threatened*,** shattered with ***violence* and *abuse***.

Just Because We're Indian

People ***prejudge*, *accuse*** and ***lie*** to us,

We reach out to help ourselves but

Our cries, our choices, treated with ***indifference*, *discrimination*, *racism***.

Our ***rights denied*** enforcement of ***residential school*, *foster care***.

Just Because We're Indian

We are ***hated, segregated, accused***.

As ***SQUAWS*** our bodies ***desecrated*** and ***disrespected***.

You know nothing of our ***history***, our ***pain***,

Nor the beauty in our hearts, and the peace for all in ***our vision***.

D. Kurtz, 2010

The storyline, Just Because We're Indian, depicted in Mind Map 2, illuminates the lives of the Talking Circle participants as Aboriginal women and depicts the concepts used in analysis to derive the following threads: 'Our Colour of Skin is Used to Marginalize Us'; 'We are Harmed, Violated, and Labelled'; 'Our Rights are Denied'; and 'We are Mistreated and Pre-Judged in the Health Care System.'

Mind Map 2: JUST BECAUSE WE'RE INDIAN

(Experience)

6.2.1 Our Colour of Skin is Used to Marginalize Us

The women exposed their private life stories where time after time they experienced being ignored, silenced, dehumanized, and treated differently because of the colour of their skin. They described situations that clearly illustrated how those with darker brown skin were treated more poorly than those who had lighter skin.

Ram, a Métis woman shared stories of having lighter coloured skin than her husband, and her daughter having lighter coloured skin than her son. She described where fair skin colour prompted reaction and changes in the way she was treated (as different), when health care professionals read her chart, which exposed her Aboriginality. She recalled:

> *… my son, he is a little darker than his sister. He gets treated differently too. There is racism and assumptions. When they look at me they don't think Aboriginal … when they look at my file and it states it on there … they change and become someone else. They talk to me differently.*

She further reflected on the noticeable difference in treatment between her son and her daughter: *My son, is darker than his sister, he gets treated differently when I go places or do things. He's only four.*

Dialogue about children and their skin colour was also echoed by Elder Two who spoke about her children and grandchildren. She said: *it is extremely difficult to go to school if you have brown skin … not treated the same … not expected to excel … expected to drop out ...*

Spirit revealed particular instances when her skin colour created ambiguity, being too light to look Indian, yet too dark to be seen as a white person. People assumed she was from another race because she did not look native enough and she was stripped of her Aboriginality: *I went through school where I was labeled. I wasn't white, and I wasn't native, so I was Chinese or Japanese.* Each of these are examples of how Aboriginal people are treated with profound disrespect.

The consequences of having brown skin or of being Aboriginal not only weighed heavily on how each woman viewed her place in the world but also impacted her identity. A sense of identity is important for self-esteem, healing, and the ability to cope in life. In particular, having a clear native identity has been proven necessary for attaining and maintaining mental well-being and helping to find, define and strengthen one's personal meaning of identity (Stewart, 2008). However, urban Aboriginal women's perceptions of their identity, as Van Herk, Smith, and Andrew (2011) purport, are shaped by the oppression and discrimination that they experience within their relationships with health care providers. For example, by looking Aboriginal, health care providers may generalize or make assumptions about individual needs or desires, whereas being Métis with light skin and not 'looking Aboriginal', individual needs related to one's Aboriginality may be ignored (Castleden, Crooks, Hanlon, Schuurman, 2010). For example, Woods (2010) claims one of the most important roles of health care providers is to maintain and support an individual's cultural identity and autonomy yet the success of this role is jeopardized by the provider's deliberate or unknowing beliefs and ways of being or the institutional culture of mainstream health care. Adding to the risk to one's sense of identity, and experiences of discrimination because of the colour of their skin, the women's lives were further complicated by threats and acts of violence that continually eroded their sense of self, healing, and ability to cope.

6.2.2 We are Harmed, Violated, and Labelled

In addition to the horrors the women revealed about life in residential schools and foster care described previously, the majority faced several other negative experiences in their everyday lives. The pain and difficulty in remembering and sharing these stories was evident in the women's faces, expressions, and through shedding of tears. They recalled living in fear because they were continually threatened with physical, sexual, emotional, and spiritual harm or violence. Some threats and acts of violence came from unknown abusers (outsiders), anyone other than family members. An example given by Nigwa showed how law enforcement officers (outsiders), who were supposed to protect the public were guilty of mistreatment of Indian women. Nigwa told how when she was a teenager she was raped by white boys and found in a ditch at the side of the road. She remembered hearing the officers say: "*She ain't nothing but a drunken squaw …. She ain't going to remember* [being raped]".

Other threats of violence came from people in their lives to whom they were closest and had no choice but to obey (insiders). Violence within the family by insiders, the manifestations of unresolved intergenerational trauma in which harmful acts and behaviors were unintentionally modeled by parents and witnessed by children, was familiar to many of the women in the study. With great emotion, Nigwa talked about life in her home as a young girl and threats and acts of violence that occurred in her family:

> *Even when you get apprehended, the social workers, they don't believe you. I told them what I went through at home. I told them and they called me a liar. My mom is standing there with black eyes and I was standing with black eyes. Gashes all over me ...* (crying).

Although Quail did not reveal personal accounts of harm or violence, she talked about the lingering effects of forgotten and hidden memories of abuse. She worked in a university with Aboriginal students and relayed:

I taught [a] *human growth and development* [course] *there was sections in that course that covered sexual abuse. Every year I was never prepared for it but, after it finished that part of the course, there would be a lot of absences in my class. It never really dawned on me until I talked to them personally what was holding them away. They said they haven't even really resolved that part of their lives until it came up into the course work. They didn't even know that, or they forgotten and it just came up for them.*

The constant labelling that occurred just because they were Indian was another source of pain for the women, who indicated that they were labelled with words and phrases which marked them as "different". Elder Two stated being called a *dirty fat Indian* was common and further revealed: *What I experienced even as a child, as a new nurse, as a middle aged nurse and old nurse ... hasn't changed much ... instances of racism and prejudice may be a little more subtle now.* For some, explicit labels actually shaped who they became and how they acted and dressed. Nigwa clearly expressed how being labelled affected her life: *I was called a drunken squaw, so I became one*. Spirit recalled she was: *labeled so many different things ... being labeled as a boy, and built like a guy, then I had to do guys work ...*

Labels not only caused emotional hardship but also financial challenges and loss. For example, Sprit disclosed that she was labeled as being handicapped although she was not. This formal label attached to her by social workers meant that she was not allowed to sign her own cheques thus denying her right for independence and management of her own finances. These labels, attached to their being Indian women, created explicit incidences of objectification that tore at the women's hearts and led to them being mistreated, disrespected and dehumanized just for being an Aboriginal female. For example, Nigwa stated: *I did not like being a woman. No matter where I went "native woman" would be bad. "Native women" all they were good for was one thing – to be raped, tortured, beaten.*

For individuals of minority groups, negative stereotypes and labels can become internalized and attack self worth, undermining their very existence (Ahmed, Mohammed, & Williams, 2007), as in the case of Nigwa being called a drunk so she *became one*. For many, "death, disease, destruction and pain became a "dark nucleus" of Aboriginal people's memories that riveted them in spiritual and emotional positions of loss and grief for centuries" (Wesley-Esquimaux & Smolewski, 2004, p. 23). Much of what was uncovered in the Talking Circles revealed long and difficult journeys for the women who were Aboriginal and living in a dominant white world. Being harmed, violated and labeled, mistreated for being different – Indian – caused ripples in all aspects of their lives.

6.2.3 Our Rights are Denied

Earlier in this chapter, the frustration that the women expressed about having their rights to motherhood denied by having their children forcibly removed, was described and explained as resulting from the aftermath of residential school and foster care. The women further explained how their rights, to the same educational opportunities as non-Indian Canadians received were often denied, because they were Indian. They talked about experiences as girls growing up and being labeled, put in a corner, and ignored in the education system. With pain, they recalled harmful words they were called that were common assumptions of Aboriginal women and people, as *stupid* (Nigwa) and *for some reason we all have lice and are* *dirty* (Elder Two), and *treated differently than our non-Aboriginal school mates, colleagues* ... (Nigwa's Daughter).

The women highlighted instances in their lives in which they or family members were considered incapable of learning, were *told not to learn* (Rain) or were removed and segregated from the main classroom where they did not get the same education as non-Native children: *my younger siblings ended up in the stupid class ... sent to the other room* (Nigwa). They provided examples in which teachers assumed they were unable to learn or finish school and thus adopted the attitude that it was not worthwhile teaching them. These examples were not isolated incidents, they occurred across the generations that the women represented. Nigwa's Daughter, who was in her early twenties and the youngest member of the Circle, talked about the teachers who lied to her mother. She said: *when I was in Grade 6 they tried to tell my mom that I couldn't read and that I was dumb .... I was reading a novel that even Grade 12 students couldn't read.* She stated no matter what she did she was treated differently, and was not credited for her academic achievements in the way that her non-Native peers were:

> *When I went to high school ... me and my friend, we both took law.... I would do half the work and he would do none ... midterm grades come out and we'd both get B's or A's ... he never did anything. He should have at least failed it you know. So they* [non-Native students] *got special treatment still.*

> Ram, also in her twenties expressed frustration with the education and the impact this had on her eldest son:

> *My son is in school, he is still in school, but he definitely has a writing disability and the school kept pushing him through. He didn't get the proper*

> *Aboriginal advocacy help that he needed. And now he's in Grade 10 and he reads at a Grade 2 level.*

She went on to describe what she was doing differently to ensure her other children received the help they needed to achieve in school but expressed her frustration with a recent change:

> *I have two younger ones that are just starting in the school system. And my daughter is at a good* [public] *school because they do have Aboriginal help there. But now I've heard that they have taken them out of there. Well, now what's going to happen? Like my, it was really why I put her there.*

Ram described her experience with post secondary school:

> *I went to college and I wanted to be, a nurse or a social worker. And there was no one there to help me and so I ended up dropping out. I did four years and then I dropped out a year ago, and I dropped out because I was struggling with handling all the courses being a single parent and not knowing where to go or where to get any help.*

Exclusion and segregation because of darker skin colour, and special treatment because of whiteness in schools, is presented in Maria Campbell's life story as a Canadian Métis woman (Campbell, 1973). Born in 1940, she described numerous injustices because she was not white nor fully Indian. In a small country public school, she and other Métis children were isolated and separated from white children (whites sat on one side of the classroom and Halfbreeds sat on the other; in school games such as baseball, whites would play against the Halfbreeds). She described constant torment and bullying by her white classmates and teachers. Despite her traumatic experiences, she was thankful that the country school in which whites and Halfbreeds were enrolled was 'Heaven' compared to what was happening in residential schools. Campbell's story reveals disheartening personal accounts as a school child and although she like other Indian children may have not attended residential school, she was also subjected to racism, mistreatment and difficulties in school just for being Indian.

The women's stories uncovered the injustices and mistreatment they and their family members suffered in the Canadian public school system. In the Talking Circles, the women told about several other challenges they faced just because they were Indian women and which extended into their everyday lives, some of which non-Native people do not face or take for granted.

6.2.4 We are Mistreated and Pre-Judged in the Health Care System

The women described how their experiences with *racism* and *discrimination*, affected their overall health and that of their family members. The choices they made, whether or not to seek health care and who they would go to for their health care needs, were influenced by their experiences and were threaded throughout their stories. These accounts, exposed what Kurtz et al. (2008) describe as structural violence – when Aboriginal women are mistreated and prejudged in a mainstream health care system that marginalizes people of difference. For example, Quail stated:

> *A lot of Aboriginal people speak about going to the social workers where they are predominantly white and getting discriminated against there. So no matter where they went, whatever resource* [health or social service] *center they went to, they were being discriminated against*.

She, like several of the other women, expressed frustration because they were often talked to like children by health care providers because it was assumed that they were incapable or *did not understand.* Health care professionals often use their everyday language of medical terms when providing health information making it difficult for the client to understand. For Aboriginal people, being treated as unable to understand, silences or makes invisible health needs. Poudrier and Thomas-MacLean's (2010) research with Aboriginal women living with breast cancer revealed the women did not always understand the health information explained to them and did not seek clarification for fear of being seen as unintelligent. This makes it difficult to receive necessary support relevant to their lives or health care provision needs.

Annabelle talked about her experiences over several years as a caregiver for her frail ill mother-in-law:

> *I have years and years of experience and they* [health care providers] *treat you like you don't know anything or don't have the ability or knowledge of working with your own family or don't have the understanding of what the healthcare professionals are saying. They treat you as if you are dumb. They tell you nothing. They don't even believe you when you're telling them about the family member and how they're behaving and that they're sick ... she didn't understand because there are days when she wasn't capable of, understanding what anyone was saying. So they would need to talk to me, but they wouldn't directly speak with me. It's frustrating ... they just don't care who you are.*

The women also talked about their poor health and revealed that because of past discriminatory treatment and care, they hesitated or refused to return for health care services, and as a result, some became sicker. The women described feeling that they were not trusted or believed by health care professionals. Nigwa's face showed disgust when she expressed: s*o many times* [doctors, nurses, health care professionals] *asked me if I was drunk … if I do drugs.* Elder Two echoed this when she described an incident that occurred a few weeks before attending one of the Talking Circles. She had sought emergency treatment for a potentially serious eye injury but ultimately left the hospital before receiving treatment because she did not like being accused by the physician: *finally, the doctor came in; he took one look at me and said, "Hmm, how much did you have to drink last night? ... I haven't drank anything* [alcohol] *for over twenty years!"* She felt she had no other choice than to leave the hospital without further assessment or treatment, no matter what the potential health risk to avoid further discriminatory treatment.

Annabelle described her experience with a medical specialist, who prescribed medication for a sinus infection that resulted in unusual bleeding. She found the language used by the specialist as discriminatory and racist – it implied she had a drug problem:

> *I didn't take it* [the medication] *because on the label it says if your nose is bleeding you are not to take that medication. When I went back, he says, "Why aren't you taking it?" I said, "My nose is bleeding and the medication says you're not supposed to take it." He says, "Well, are you* ***sniffing*** [Annabelle's emphasis] *too hard?"*

Inhalant use or 'sniffing' has had much media attention and is a problem among young people globally, and prevalent in some Aboriginal communities (Kirmayer, Tait, & Simpson, 2009). While the specialist may not have been inferring that Annabelle was engaging in drug misuse, she felt that he was accusing her not only of drug use but of self-harm because she was inhaling too hard causing the nasal bleeding. Annabelle described being deeply offended, blamed for her illness and feeling unsafe. She refused to return for further care because she did not want to face what she felt as discriminatory treatment and thus became sicker:

> *I was supposed to make an appointment with him two weeks ago and I'm afraid to and I don't know what they are going to do. I don't know what he's going to say. I still haven't gone back, only because the blame was on me. So it's my fault because what he had recommended wasn't working right? … Now* [I have] *a secondary bronchitis because the first doctor didn't treat me properly … There have been other appointments I haven't made because I am scared and so I suffer …*

Ahmed, Mohammed, and Williams (2007) report that institutional and individual discrimination prevalent in the health care system not only affects access to care but also the quality and intensity of health care treatment. Whereas Nigwa, Elder Two and Annabelle were seemingly accused of misuse of drugs and alcohol, discriminatory practices created barriers for them to access care and receive the medical treatment they required without being victimized.

Dodgson and Struthers (2005) highlight that assumptions by health care providers are made if Aboriginal clients are 'noncompliant', fail to show interest, or lack understanding of health care. However, apparent lack of interest often reflects differences in cultural beliefs and understandings rather than actual noncompliance of the Aboriginal person. Meleis and Im (1999), Farmer (2004) and Tester (2007) found political, economic, and social structures disregard or are ignorant of individual values and beliefs and clients are therefore blamed for their illness and portrayed as the victim of disease. Henry and Tator (2002) and Byrne (2000) argue 'blame the victim' discourse assumes individuals or certain groups, Aboriginal women for instance, are: responsible for their social and personal problems; prone to deviant behavior, such as drug use; unmotivated in life; and not educated well enough to fully participate as Canadian citizens. These sorts of assumptions are evident in the words of Annabelle, who felt she was being talked down to, labeled as dumb, and viewed as not capable of understanding or being involved in decisions about her mother-in-law's health care. For Elder Two, the physician's initial comment about alcohol use insinuated deviant Indian behaviour, drunkenness, as the cause of her eye injury. Blame the victim discourse is further pathologized in health statistic reports that categorize substance abuse as a common Indian 'problem,' as evident in the stories of Nigwa, Elder Two, and Annabelle, in which the health care provider assumed because they were Aboriginal they had drug or alcohol problems.

Further difficulties within the health care system such as neglect, mistreatment, and disrespect were evident in many of the women's stories. Nigwa provided details about being in the hospital to have her children. She said: *Yeah, I was put in a corner for two days when I was in the maternity ward. They forgot about me, they came in and looked at me. That was all they did. They did that for both my daughters*.

Ironically Nigwa's Daughter described a similar experience that occurred over twenty years later:

> *When I was in* [a larger centre] *with my son when I had him, they kept me in the room I delivered in. I found out after that I was actually supposed to be moved to a different room. I didn't eat until the very next day when my mom came ... But you know they completely forgot about me. I was way in the back of the hospital… It's the exact same room I delivered in before. I was there for a week, in the same room. They didn't move me and the only reason they brought food was because my mom and ex went and reminded*

> *all them, "Well, she's hungry, you got to feed her." Mom and my ex were bringing me snacks and food.*

A few years later, she again faced similar discriminatory maternal health care in a smaller hospital. When she went to the hospital to have her third baby, health care professionals did not believe her when she told them she was in labour:

> *They didn't listen. They probably didn't want to hear me. My last two pregnancies, the nurses looked at me when I went in with my water broke, "Oh, your water didn't break. You're going to have to find somewhere to go." I was living in a small city several kilometers away at the time …. When my water broke this time, I made sure I didn't change my clothes until I got there. I didn't care whose car I was in, I was wearing my ucky old yellow* [amniotic fluid soaked] *clothes. I got there and I changed my clothes and I gave my clothes to the nurse because they did that paper test thing* [to test staining of amniotic fluid].

This account prompted a traumatic memory for Wolf who told of how she was pregnant and in need of assistance. She was miscarrying and her water had broken. She asked a police officer for help and she said: *the only thing he could say to me was,* "*Shame of you for pissing your pants*." Yet another example of unjustly being judged and treated disrespectfully.

Eagle gave an example of profanity against an Aboriginal woman that occurred when she was working as a health care provider for several First Nations communities. It was a strange and unacceptable act of body desecration:

> *A young* [Aboriginal] *woman, who lived in the remote north, was brought* [flown] *out for a scheduled cesarean section for her second baby. This was terrible I had never ever in my life heard anything like this … Beautiful baby*

> *son, she has. You know what that doctor did to make her scar pretty? He sewed beads on this Anishnaabe*[5] *Indian! It was worse than obscene to see these beads sewed on her beautiful body. How could you desecrate a body like that? You know, to anybody, you don't do that!*

Birch, Ruttan, Muth and Baydala (2009) identified that there is minimal literature regarding Aboriginal women's birthing experiences in hospital settings. In Canada, Browne and Fiske (2001), Moffitt and Vollman (2006) and Smith, Edwards, Varcoe, and Martens (2006), report the impact of negative maternal health care experiences on the mother, infant, and family. These studies identified the urgency for more research to be undertaken to inform health care policy and practices. While this recommendation may have merit, it is timely to consider that gathering more research findings ought not stand in the way of implementing respectful and humane health care.

The impact of health care practices on the lives of Aboriginal women should not be taken lightly. As women, they tend to be the household decision-makers and make the majority of health care decisions for themselves and their families. At the same time, they must navigate through a health care system that is aimed at, and delivered by, the Western culture, in which they, as 'different', are marginalized. Te Hiwi (2008) considered that marginalizing people because of skin colour, position in society, or income, marks them as "*ab*normal, *un*natural – less than and therefore worthy of repudiation…" (p. 16). Such a stance conveys society's attitude and intent to separate Indians from the 'normal' population thereby pushing them to the margins and excluding them from 'white' society. Unfortunately, using non-

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[5] Anishnaabe is the term used for First Peoples in eastern Canada (Alfred, 2005).

coloured people as the norm against whom all others are measured or compared continues to exist.

Canadian Aboriginal researchers, Hill and Kurtz (2008) assert, “current societal views, and social relations are entrenched in dominant discourses of white middle class norms” (p. 8). Adopting taken-for-granted ways often leads to discriminatory assumptions and practices on the part of health care providers and subsequent increased health disparities for those who are marginalized.

Hall (1999), Browne (2005, 2007), Tang and Browne (2008), Van den Tillaart, Kurtz and Cash (2009) found that marginalization increases one’s health risks, leading to severe illness and trauma, restricted access to health care, and societal barriers that unintentionally feed into further health inequities. Health care professionals' practices that differentiate the self from the ‘other’, figuratively pushing the ‘other’ (in this case urban Aboriginal women), into the margins of invisibility, not only increases their health risks but also fails to acknowledge the contextual realities of their lives. Ladson-Billings (2000) report the impact of racism, ethnicity and marginalization on one’s wellbeing:

> Those occupying the liminal position do not seek to move from the margins to the mainstream because they understand the corrupting influences of the mainstream-its pull to maintain status quo relations of power and inequities … the work of liminal perspective is to reveal the ways that dominant perspectives distort the realities of the other in an effort to maintain power relations that continue to disadvantage those who are locked out of the mainstream. (p. 263)

It is claimed that marginalization of Aboriginal women persists because health care providers are unaware of or fail to understand the impact of historical trauma on the women's lives (Dodgson & Struthers, 2005). Being marginalized and 'othered' not only caused the women in this study to be silenced and have their concerns ignored and disregarded, but also isolated them from receiving adequate health care, a point that is raised in the literature (Vass, 2005; Leipert & Reutter, 2005). The women who spoke in the Talking Circles were treated by health care providers as having no power and they were discriminated against in multiple ways – for being Aboriginal; for being female; for having a disability (hearing loss); for supposed drug or alcohol addiction; for living in foster care; and for having their children taken away by the social services. Their marginalization caused a myriad of risks to their health, physical safety and psychosocial well-being, and caused them to receive inadequate health care. This claim is evident in the story of Annabelle, whose condition progressed to a secondary infection, and subsequently endangered her personal health because she delayed seeking health services to avoid facing what she felt was racist treatment by the specialist.

Eagle remembered a specific incident when she was working in the health care system and heard a colleague's racially prejudiced hatred: *This nurse, she said "I wish all those Indians would just go and die! They don't need anything. They are taking up the air. They're taking space in the hospitals."* Several of the women's stories in this chapter exposed realities of being mistreated and pre-judged by health care providers leaving them "stereotyped, rendered voiceless, silenced, not taken seriously, peripheralized, homogenized, ignored, dehumanized and ordered around" (Meleis & Im, 1999, p. 96). Although there were numerous examples of blatant racism, such as sewing beads into an Aboriginal woman's surgical incision, it is remarkable that the women still wondered if people who they interacted with were genuinely ignorant to the fact that they were acting in racist or discriminatory ways.

Several Canadian researchers assert that it is possible that health care providers may not have the necessary knowledge about colonization, and its impact on health inequities and disparities, to provide non-racist, non-discriminatory, and compassionate care. As Browne and Fiske (2001), Kirkham and Anderson (2002), Kurtz et al. (2008), and Van den Tillaart and colleagues (2009) report, misunderstandings (perhaps unintended) persist between the professional and those marginalized and are likely due to the Eurocentric view in which their daily realities – their education, cultural background, and social standing – are constructed from paternalistic and oppressive perspectives. Customary practices within institutions accept colonizing practices as normal and often ignore or are unaware that their practices overtly display taken-for-granted ideals of privilege and difference – those who fit in (dominant) are privileged and those who do not, are marginalized (Giddings, 2005b).

Further research exploring and challenging current societal and political structures and ideologies in relation to urban Aboriginal health care provision has been suggested by Kurtz et al. (2008), and numerous other researchers and this need is emphasized in this chapter. The women’s stories not only provide new insights into the ways these structures have been disputed in literature, as well they also offer ideas to reduce marginalizing taken-for-granted practices. Following the discussion thus far in this chapter, one might surmise that taken-for-granted practices, such as ‘othering’, labeling, and blaming of Aboriginal people could possibly be reduced if education and health care systems embodied a better understanding of Indigenous ideology that enabled the needs of Aboriginal people to be more adequately met. However, the reality shown in the women’s deep-seated expressions of frustration is that not much has changed over the years and hence they continue to endure discriminatory and racist treatment that takes place within the constructs of stereotypical assumptions based on skin colour and race. For the women, blatant incidents occurred without reason or predictability, leaving them more vulnerable and more determined to defend and protect themselves from racist and discriminatory practices.

6.3 Fighting All Our Lives (Consequences)

Fighting All Our Lives is the second storyline that was revealed in the women's stories as they talked about the penalty they paid for being female and Aboriginal. From their stories, this poem which I constructed offers glimpses of what they did to resist and survive in a world that placed them outside the dominant culture:

Fighting All Our Lives

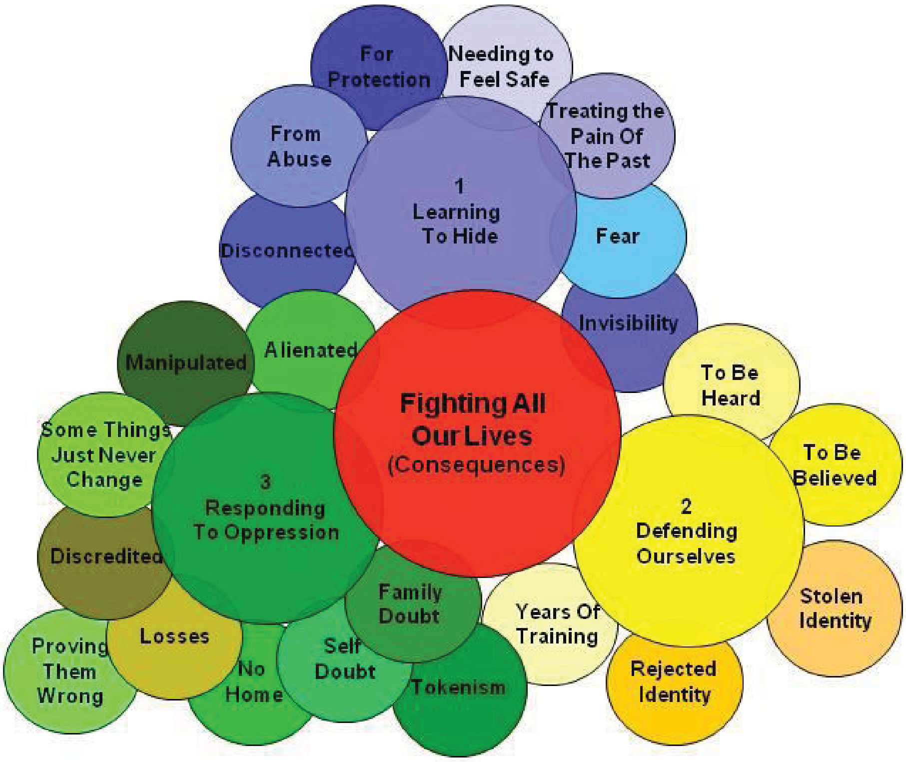
As Aboriginal Women,
For protection from pain and abuse.
We lived in ***fear*** to not be hurt again.
Needing to feel safe*,* be ***invisible***
We ***learned to hide*** and ***defend ourselves***,
From attackers,
Under dark baggy clothes to look like guys;
From everyone in life,
Behind long black hair covering our faces;
Inside the delusionary spiral of drugs and alcohol;
To keep numb.
Yet ***no one heard*** and ***no one believed***,
What was tearing our hearts, ripping our souls,
Playing over and over again in our heads,
Horrid things ***rippled through our lives***, our families, our kin.
Causing ***self-doubt***, ***alienation*** and detachment*,*
Yet through our love, we find our voice,
To ***advocate for our family***,
But realize no matter what we do,
The ones who ***do not hear*** and ***do not believe***,
Stripped away our core,
By ***taking our children***, our **identity**.
Although we ***proved that they were wrong***
We realize ***some things never change***

We learn through ***years of training,***
To reconnect to the harmony of life,
With the earth, creatures, stars, and our ancestors,
To set us free and keep us strong to continue,
Fighting All Our Lives
D. Kurtz, 2010

The dominant culture within Canada repeatedly places Aboriginal women as 'problems', 'different', and 'other', at some cost to the women, when they only want to be treated as 'normal' Canadian women. The costs the women paid ranged from hiding in their home, dressing in disguise, being homeless, living in poverty, acquiring multiple addictions, having poor health, receiving limited education, and living at the door of death.

Within the Talking Circles, all of the women shared at least one insightful story that revealed times of deep and painful vulnerability. They spoke about consequences they faced being native women and strategies they used in their attempts to remain safe and to protect themselves – physically, emotionally, spiritually and mentally. The threads within this storyline Fighting All Our Lives include: Learning to Hide; Defending Ourselves; and Responses to Oppression, and the concepts that gave rise to each of them are portrayed in Mind Map 3.

Mind Map 3: FIGHTING ALL OUR LIVES (Consequences)



6.3.1 Learning to Hide

Several women talked about the pain and trauma they experienced in their broken lives. Their stories were filled with chilling incidents in which they unconsciously or consciously, acted to hide and remove themselves from the realities of their existence. Elder One previously described the use of drugs and alcohol to help her forget the memories and treat the pain of abuse and loss. She relayed other ways she learned to forget and hide from trauma, society and life, such as attempting to take her life and living on the streets. She said:

> *I've been in mental institutions. I tried to take my life … I was taught to be ashamed, taught to lie …. I was on the street … never had a home … I didn't feel like I was accepted anywhere. A lot of my people are still suffering ….*

> *Yes, some of them go on to destroy their lives because they were never heard, at all. One of them is my dad. And another one is my brother.*

Even though Elder One freely spoke up and told us about her life and trauma, she explained that many Aboriginal people remain silent as a way to hide what occurred in their lives and they therefore continue to suffer. This explains her reference to the ways in which her people *are still suffering.*

Nigwa learned to physically, emotionally, and relationally run, hide, and cope, to protect herself from violence (sexual, physical, mental): *I ran away from foster care, the* [foster] *father was the same way* [abusive]. ... *I never knew who to trust. I could trust the little ones, children, Elders,* [but] *petrified by the rest*. In another Talking Circle, she explained another way to cope: [I was] *in an abusive relationship, so I drank.*

Spirit described ways in which she hid to protect herself:

> *I felt that I had to have walls up and I had layers upon layers of clothes that were baggy .... Everything was all black, black pants, black hat, black shades, black shirt, everything .... I felt like I had to watch over my shoulder …that's how my attackers would attack me come up from behind.*

The women talked about loss of connections and support from families as a result of having to hide to manage their lives, a disgrace given that Aboriginal wellbeing is strongly related to identity, status, one's place in the world, family, land, and the community (Mussel, n.d). For the women, their well-being was jeopardized by living in isolation in urban areas and being separated from family and support systems on the reserve.

Nigwa hid in her house, away from family, supports, and society for over thirty years. She revealed she was afraid to go *out there.* She had her children get groceries and other household items and only went out if she had no other choice. When she went out, she tried to be as invisible as possible: *I walked like this* [hair pulled over covering most of her face] … *stayed locked up … didn't feel I belonged anywhere.*

Ram described how her Aboriginal grandfather and father did not carry forward the knowledge of their family heritage, language and customs, lessening their Aboriginal identity:

> *My children do know that they are Aboriginal. We don't speak it in our home because my dad was never taught because his father was in the* [residential] *schooling and they were* [assimilated] *to be white and not to be Native. He just decided that he was going to follow what they were doing. So my dad was never taught anything about our Aboriginal heritage. So we weren't taught ourselves*.

Aboriginal people of Canada remain invisible within Western political-economic frameworks and continue to be silenced and 'othered' maintaining their non-status in white society. Kurtz et al. (2008) reported several incidents in which urban Aboriginal people were 'othered,' for instance when accessing mainstream health care, which further complicated their lives and resulted in them being less visible, having less voice and less power to be viewed as competent to make their own decisions. The invisibility that the women in the Talking Circles spoke of has been addressed by others who report that historic trauma, such as intergenerational trauma[6] causes deep breakdown in personal and social functioning, loss of control, powerlessness, hopelessness, lack of self-esteem, and unresolved grief (Brave Heart

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[6] Intergenerational or multigenerational trauma occurs when the effects of trauma are not resolved in one generation (Aboriginal Healing Foundation, 1999)

& DeBruyn, 1998). The women also talked about leaving their families, educational institutions, places of employment, and spiritual beliefs to be accepted, yet their attempts were often futile in the invisibility of marginalization.

6.3.2 Defending Ourselves

For the women, the complexities of historic trauma and being 'othered' resulted in their constant fight to defend themselves in a world that was harmonious prior to colonization. They fought to be recognized for who they were as Aboriginal people in the dominant white world, while at the same time dealing with family dysfunction. The words of Annabelle: *We weren't considered persons until 1960,* could be dismissed as fanciful language were it not for the fact that the Canadian government did not legislate Aboriginal people human, allowing them to vote until 1960. Up until that time Aboriginals had to surrender their special status as Indians and other rights, such as land entitlements, to become legal, full-fledged Canadian citizens and to obtain voting rights (Canadian Human Rights Commission, n.d.). Adding to the discriminatory practices of colonization, oppression of Aboriginal women was demonstrated by the Canadian government when they ruled that Indian women could not keep their status if they married a non-native man. Fairly recently this decision was finally rescinded, through the efforts of the Aboriginal women's lobby, when Bill C-31 (Department of Indian Affairs and Northern Development, 1995; Native Women's Association of Canada, 2007b) was passed. However, although Bill C-31 reinstated some Aboriginal women as registered Indians, it limits entitlements for inter-marriage and inter-parenting with more second generation children losing their right to be registered Indians (Big Eagle & Guimond, 2009).

Given this stark reality, is it any wonder that the women voiced being constantly on the defense, to protect themselves, from racist attitudes, labels, discriminatory treatment, and the injustices of the Canadian government. For some, their vigilance and defense resulted in perpetual attitudes of anger, and mistrust of other people. Elder One told members of the Circle how she guarded herself:

> *I got angry and defensive .... I was angry at my mother. I was angry at the Creator. I was angry at everybody. My husband and my kids ....* T*he only feeling I had was anger ... learning how to defend myself. Anger, that's the only defence I had in my lifetime. How could you get over the trauma?*

For Nigwa, the long term influence of trauma passed down from her family was evident in one of her stories about abuse, addiction, destroyed family relationships, and self loathing:

> *We grew up in a very abusive home, alcohol, drugs, physical, sexual, mental abuse. We hated one another. I didn't like my brother because he was a guy. I didn't like my sister because she always ratted on me. I couldn't breathe. I didn't like me ...*

Symptoms associated with historic trauma disorders such as domestic abuse, alcoholism, and drug addiction can be transmitted to and witnessed by children, leading to socially learned behaviour that is passed to future generations. Although this cyclic behaviour is not intentional, children of traumatized parents often take on the learned behaviours of their role models and manifest for years, decades or generations, which adversely impact social relations (Wesley-Esquimaux & Smolewski, 2004). Whereas Anzuldúa (2007) described defence strategies that individuals use to escape the agony of shame or fear through compulsive and repetitious activity (drinking, popping pills) to distract oneself and keep unaware of the realities of life, Napoleon (2005) stated social problems (addictions, unemployment) of Aboriginal people were created by "soul-crushing powerlessness of colonialism and conflict" (p. 15).

This soul-crushing powerlessness extended to the women feeling the need to defend themselves and it deeply spiraled, affecting their identity, beliefs, and their spirituality. Elder One explained being confused about her spirituality because in residential school she was told she needed to ask for forgiveness, even though she had done nothing wrong. She talked about asking God why He would let her be abused and defended herself to Him that it was not her that did anything wrong. In the Talking Circle, her voice was defensive when she spoke about the memories of her spirituality at that time, although it had occurred over sixty years ago. She said:

> *I was so mixed up with the Creator, God and Jesus, all because of residential school. All I was taught in the residential school is to be 'perfect', to be 'clean', 'pure', to forgive, to forgive myself. I used to always wonder what should I forgive myself for, why do I have to forgive myself? For what?! ...*

In defending themselves and their family members, the women continually had to respond to the consequences of being Aboriginal in a dominant white society. Years of turmoil were evident as they spoke about learning strategies to survive in a white world in which they were continually being marginalized. Several of these strategies – hiding and defending themselves – also uncovered ways in which they responded to being oppressed within the dominant system.

6.3.3 Responding to Oppression

Wolf described the long term affect on one of her adult children who was alienated and mistreated in the public school system: [Years ago] *one of my sons had to struggle through school and he never completed because he was pushed* *aside all of the time … He had that attitude nobody could tell him anything. He was angry all the time … but he is starting to do a little better now …*

Rose relayed that Aboriginal youth and family members were told by teachers in residential and public school that they could not learn and would not be successful in attaining higher education. This caused self-doubt: *the younger people underestimate themselves,* and thwarted the children's hope of success. In addition, family members believed what teachers said and regrettably echoed this sentiment to their children:

> *Some youth do not think about going to post-secondary school …. My cousin was thinking about going into nursing … her mother said, "Oh don't you think you should go for something else?" Like it's too hard … I find that sometimes families are their own barriers to younger people going into it.*

Mahoya voiced her conflict of being an Aboriginal university student in a nursing program. She faced times when she simultaneously had to explain, justify, and defend herself at university and her home community. At university, because some of her courses were mandatory, she was expected to attend. In her community, Elders and community members also expected her to attend community activities, funerals, and other ceremonies. She explained: *I haven't been able to make it to the Aboriginal Council meetings because the program is so demanding … I have missed family funerals …. Your family is your extended family in your life … everyone goes.* She talked about these struggles, and expressed feeling trapped between two worlds (school and community). On one hand she had to defend herself at school and explain to her teachers why she needed to miss school to attend a family funeral. On the other hand, she had to defend herself by explaining to her family that rules of mandatory attendance at the university only allowed students to miss school for the death of an ‘immediate’ family member.

Structural, political, and societal misrepresentations of Aboriginal people, frequently assume Aboriginality is used as an excuse or demand for privilege or special consideration (Te Hiwi, 2008). Little appreciation or acknowledgement was extended to Mahoya and it was clear that university policies failed to recognize or embrace her Aboriginal culture and tradition, where one’s ‘family’ is regarded as the whole community. Henderson (2000a) describes every Aboriginal member belongs to an extended family that includes families, clans, communities, and other nations.

It is not surprising that a recent provincial report about the health and healing of Aboriginal people in British Columbia found that Aboriginal children in school achieved less than non-Aboriginal students (British Columbia. Provincial Health Officer, 2009). An attempt to improve academic performance of Aboriginal students and recognize the importance of traditional Aboriginal culture is acknowledged through the signing of Aboriginal Enhancement Agreements. Although this initiative was promising to Aboriginal people, signing of partnership agreements have been slow over the last ten years and there are differing reports of success and commitment to partnership agreements by some school districts. This is concerning given that a strong link exists between an individual’s health status and their level of education, income and employment, with education being possibly the most influential factor on future employment and income. Adding to this concern, the authors of the report note that Aboriginal students face more challenges (historical, geographical, social, cultural, and personal barriers) than non-Aboriginal children and have higher dropout rates. As resonated in Rose’s story, if families believe the assumptions of teachers that their children are incapable of succeeding in school, it is not surprising that the report found a number of Aboriginal students fail to do well in the public school system, because nobody expects them to do well and recognition of achievements is minimal or absent.

Even though slight improvements have been made with regard to academic success of Aboriginal students, the authors of the Provincial Report recommend further advancements. For example, it has been identified that the voice of the Aboriginal student and family is needed to identify and address underlying issues that may impede student success; school policies and activities should include clear commitment and collaboration with Aboriginal representatives; a dedicated and active 'front-line educator' committee must meet regularly, and findings about the initiative must be made transparent, leading to accountability of all partners (British Columbia. Provincial Health Officer, 2009).

Other initiatives have been implemented to reduce educational barriers for Aboriginal children, such as educating more Aboriginal teachers to work in the school system. However, Kitchen, Cherubini, Trudeau, and Hodson (2009) recently studied new teachers, who are Aboriginal, and found that they received no specialized educational preparation to teach Aboriginal children or to manage teaching in Aboriginal settings. The new teachers faced several challenges in the school system. They described instances in which they were subjected to discrimination by fellow teachers when working in mainstream schools. In other instances they were removed from the front line of connecting with Aboriginal students in the classroom and assigned non-teaching duties.

The reports of school system improvements that support the academic success for Aboriginal children are encouraging on the surface; however, the discouraging reality is that racism and discrimination similar to that of residential schools and public schools of the past continue today. The women in the Talking Circles provided examples of how they or their children continued to be subjected to being labelled 'stupid' and 'dumb', and are ignored and tormented and some of these have been described in previous sections of this thesis. The barriers and challenges identified in the government health and healing report and the new Aboriginal teacher research is disheartening. Without a wholisitic approach that considers the underlying roots of challenges, social determinants of health, and cultural needs unique to Aboriginal children, and fostering a system that includes the voice and involvement of Aboriginal people, the challenges and barriers of academic success will remain and take its toll on their health and education and impact on other social determinants of health.

Additionally, the women faced oppressive situations in their places of employment. Rain shared her scepticism when as a health authority employee she was told she had to educate health care professionals about Aboriginal people's health and ways to provide cultural care. She reflected on the health authority's motives in choosing her, an Aboriginal nurse, to provide this education, knowing that because she was Aboriginal, many health care professionals would not attend:

> *Why was this put on me to educate these healthcare providers? Because in doing so it will become an Aboriginal issue and* [management saying], *"You go deal with the Aboriginal issues and health concerns."... It's the ones who really need to learn and don't think they're racist or discriminatory; those are the ones who stay away because they don't think it's important .... I realized that it had to be a collaborative between a health authority. It had to become entrenched in a healthcare system, in a hospital setting, and it had to go way back into the education curriculum where it belonged.*

Even though the invitation to be involved could have been genuine and a real attempt to right a wrong, Rain had past experiences of racism in the workplace to make things right, which turned into lip service and a futile tokenism in which she hesitantly engaged. Hence she was skeptical about the motive of selecting her to be involved.

How the women interpreted themselves and their position in the world outside their home or community was evident in their stories. They were conscious of the positions from which they spoke and acted – as being invisible or visible; rejected by others; and at times, choosing to remain silent to hide and to prevent facing unjust racist treatment. When they used their voice, their words were not valued and often unheard, not only in their family and community, but also in mainstream health, education, and other service systems.

Elder Two conveyed her frustration to everyday oppressive incidents as an Aboriginal registered nurse: ... *I had so much difficulty in trying to get policy changed when I worked as an Indian nurse.* She highlighted inequities that many Aboriginal women faced because the dominant culture viewed them as *lazy, uneducated, drunken squaws.* She also gave examples of institutional oppression within government agencies that funded Aboriginal service programs less and paid Aboriginal employees lower wages than mainstream health care programs and employees: *It's unbelievable the inequities in wages in urban Aboriginal health and social service organizations. I was hired as an RN coordinator, my wages were very low. On the reserve, wages are lower than if you worked in the hospital.*

Elder Two, at a later Talking Circle, disclosed a particularly painful experience she had as a nurse. She was commissioned to develop the first Aboriginal Health and Wellness Plan for the local health region. The committee usually hired: *people who they could manipulate*. Despite laboring under a common assumption that she would be unable to complete the task, she proved them wrong and submitted the plan on time. When she presented the plan to the Board she recalled:

> *When I presented it … the Executive Director started to laugh and said to the Board members, "a few of you lost some wine" … They had bet I would not complete the plan on time ... I needed to feel safe. I quit working for them ...and could not work for people I do not respect.*

What is most astounding about the women in this study is that many have remained silent for decades and many of their stories have not been told before sharing in the Talking Circles. These stories, "counter-stories" as Thomas (2005) suggests, are acts of resistance because they not only validate the women's lives and times of Aboriginal people, but also provide insights into life that is in conflict with another perspective, that of whiteness. Goudreau, Weber-Pillwax, Cote-Meek, Madill and Wilson (2008) indicate most Indigenous women's stories have not been told or have been misrepresented. For example, Baker (2007) states modern white society discourse consists of speaking about white women's business to white men in ways that destroy acknowledgement or connectedness with Indigenous women and in doing so they fail to understand that Indigenous women are telling their stories about living and surviving as a critique to lead them out of patriarchy and colonialism.

In the telling, the women in this study found further meaning and hope in their lives enabling them to envision a better future, even though the odds were against them as they survived genocide, violence, abuse, silencing, "othering", racism and discrimination in a system that continues to abuse them. In telling their stories they expressed hopefulness that changes would occur and result in improved health for them, their families and their communities.

6.4 Who We Really Are (Reclaiming Our Lives)

The third storyline, *Who We Really Are*, surfaced as a common thread among the women's stories as they exposed intimate details of life learnings that helped them reclaim their lives. This poem contains a selection of their spoken words to highlight who they were as women.

Who We Really Are

Even though we have been colonized, marginalized, othered,

We are not broken,

We are ***Proud to Be Native***,

We have survived.

We are ***Coping, Letting Go and Forgiving***,

What has been done to our people.

Who We Really Are,

A strong people with,

Belief in Ourselves,

Living Life with a Purpose,

Advocating for Our Rights,

Being Role Models to rebuild,

Strength in Our Families.

Throughout the generations,

Living for the Future,

By ***Reclaiming Ourselves***,

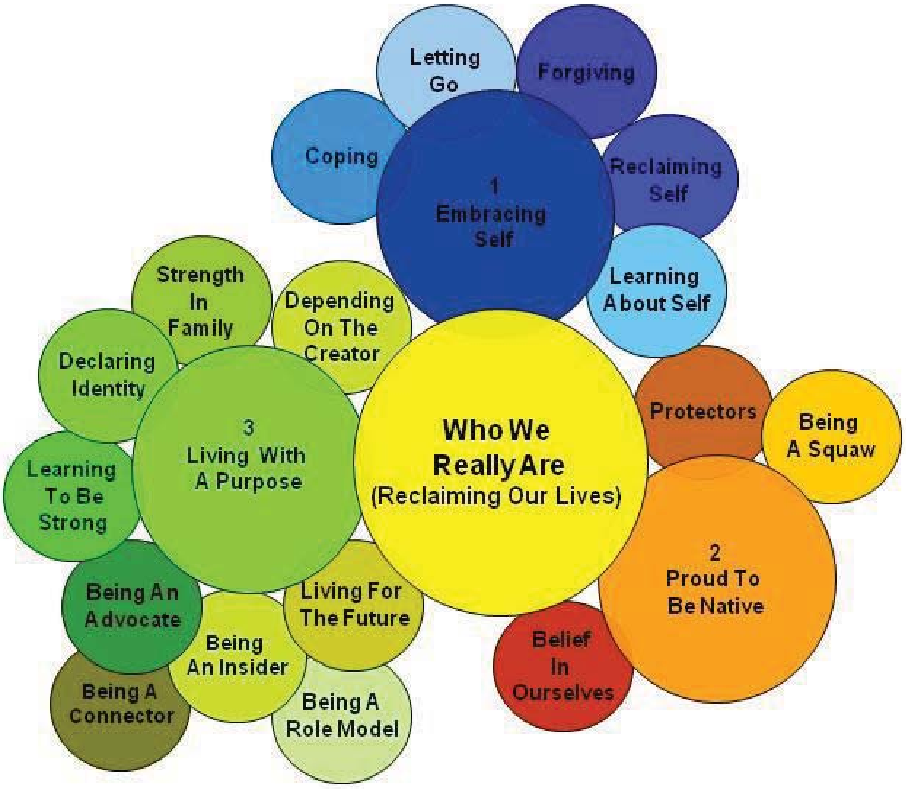
Learning to Be Strong and,

Depending on the Creator *to be*

Who We Really Are D. Kurtz, 2010

The third storyline, Who We Really Are, visually presented in Mind Map 4, reveals essences that shone through the women's lives apart from trauma and losses. These are: Embracing Self; Proud to be Native; and Living With a Purpose. This storyline moves the journey from the telling to the taking action strategy for positive change in the lives of women, the Aboriginal community, and the dominant society.

Mind Map 4: WHO WE REALLY ARE (Reclaiming Our Lives)



As previously revealed the women's stories clearly identified traumatic experiences and memories that left deep and residual wounds emotionally, physically, mentally, and spiritually which many people will never be able to empathize with or truly understand. However, their stories also describe how their lives were transformed by finding who they were in their Aboriginal family, forgiving themselves and others who hurt them, and finding meaning and purpose in life.

6.4.1 Embracing Self

Eagle explained the importance of knowing one's own history and place in the world and passing on this knowledge to future generations: *Aboriginal people that sit here and sit everywhere ... they know where they came from, they know what they're doing, they know where they're going*.

Wolf explained her need to understand her history and herself before she could forgive and move on: *We have to learn about our own history .... I learned from other people. That helped me understand and helped me to forgive and let it go*. Nigwa, who grew up in an environment in which violence and substance abuse were rampant, learned to forgive. She revealed:

> *In the last four years I started talking to my mom. She asked for forgiveness for what she did. I hated her, but I don't anymore because I kept thinking what she must have gone through to put us through that.*

At another Talking Circle she tearfully revealed her difficulty in being able to embrace herself:

> *It's taken me a long time to learn how to really love me, how to really care for me. All I know is that today I don't know what hate is anymore. It was so bad in me I could feel I was packing it around. I had this big heavy thing on my back. It took me a long time to finally say 'I do love me, this is who I am'.*

Elder One also talked about forgiveness as part of her healing: *I had to forgive myself ... forgive even my mother, how come she left me ...*

Despite historical and contemporary perspectives that continue to "other" Aboriginal populations, the women in this study illuminated situations in which they paid the price, resisted, and responded to the marginalizing identities imposed on them by society. The pain and suffering that emanated from the women's stories in this and previous chapters unfolded their histories and exposed who they really are. They uncovered some of what they are doing to shift away from the realities of multiple trauma, lack of self-identity and self esteem to responsive resistance from which they embrace hope to carry on and initiate change.

Turner's (2007) research with homeless youth found hope as a driving force for human connectedness and "hopelessness enabled them to make meaning of their circumstances and to vision a future that was full of hope and purpose" (p. e57). In a similar fashion, the women clearly shared stories of their suffering and grief and described periods rendering them hopeless – loss of children, abuse, loss of home, addictions, suicide attempts – but also illuminated hopefulness and continuing on in life no matter what the circumstance.

6.4.2 Proud to be Native

The women spoke outwardly about accepting themselves as native women, despite societal labels, stigma, assumptions, and the negative aspects in their lives. After years of enduring being silenced, mistreated, abused, and dismissed, they came to be proud of their heritage. They identified that being native was a positive aspect in their lives and they were proud to be native. Demonstrating resilience, Spirit stated: *Gotta prove to ourselves that yes we are Native, and we're proud of it. I'm trying to learn everything about it.* Nigwa said: *I'm a squaw and I'm damn proud of it*.

Several studies have explored ‘resilience’ and ‘resistance’ of Aboriginal people in Canada to analyze their lives, success and failures and their ability to turn their lives around for a better future (Alfred, 2005; Dion Stout & Kipling, 2003; Kirmayer, Brass, & Valaskakis, 2009; Smith, et al., 2006; Tousignant, & Sioui, 2009). Resilience is the ability to recover from challenges faced in everyday life (Wesley-Esquimaux, 2009); or the historical anthropological description of individual and community social and psychological adaptation to life challenges (McGill University, 2010).

Research by Kirmayer and colleagues (2009) reconceptualizes resilience as a measurement of hardiness and considers enculturation (the acceptance of oneself) in the role of an individual’s identity in their ability to do well in life. There are a plethora of cultures and identities from which people classify or identify themselves within multiple contexts. In the case of the women in this study, whether acculturation (being forced to be “white”), or enculturation occurred, they had pride in their cultural heritage, a strong native identity, and participated in cultural activities (Iarocci, Root, & Burback, 2009) which had an impact on the acceptance and pride of their ‘Indianness’ or ‘Aboriginality’ (Waldram, 2009, p. 64).

Elder One shared a poignant story about the special meaning of being a Squaw. Rather than the term being an objectifying, violent racist term as discussed earlier in this chapter, she taught members of the Talking Circle that the word Squaw was an endearing and honourable name to be proud of:

> *Squaw is a wonderful word in Cree, not a dirty word like the way they say. The farmers and white man come along, and my grandfather introduced my grandmother as Miskwim, “That’s my wife.” It’s a wonderful word. It could be your mother, your sister. It could be anybody, “That’s my woman.”*

> *"That's my lady." ... So when you hear that word Squaw, think of a beautiful lady, of the beautiful mother you are. That's what it is, and correct* [people] *if you have to.*

In choosing to embrace themselves and being proud to be native, the women provided details about beliefs and aspects in their lives that were important to them and helped ground them as Aboriginal women. Eagle stated**:** *This is our lives and we're in control of our lives.* She talked about being protectors of Aboriginal people, culture, identity, and land: *We are the keepers of this land ...*

Resistance on the other hand, can in itself be a way to take control over life choices and activate change. It can reclaim, create and sustain connectedness to self and community through a conscious or reactive positioning in which people resist or take power in relationships in society. For example, Elder Two left her job rather than staying and fighting with management about her unjust treatment. To her, the act of resigning was visible and impacted the organization more than if she had chosen to stay and work it out with her employer.

6.4.3 Living With a Purpose

Familial respect and responsibility for supporting family members was an important value for the women and how they identified themselves as Aboriginal women. The connectedness within families (immediate family members, relatives, and community members, friends, and nations) helped them embrace themselves, feel safe, and give them purpose in life.

Bear, who has a hearing deficit, described the significance family had in her life when seeking health care services: *I need my sister to come with me ... because I don't hear most of the words ... and I wouldn't understand anything* [crying].

Contrary to dialogue of Rose that was noted earlier in this chapter about lack of support of family members, she explained that her life decisions were often shaped by her own family's belief in her and their encouragement helped her believe in herself. She felt this support was critical to her success in becoming a nurse:

> *There was a reason why. My grandma always told me, "I want you to be my nurse. I want you to take care of me" … I told her, "Okay grandma, I will be your nurse" … I was fortunate enough to have a supportive family like my parents and my sister and our Band …*

Another poignant example of the importance of support was described by Elder Two, who provided assistance and mentorship to others by being a role model: *I have three ladies now who write to me all the time. They are from three different reserves and they've said to me, "If we didn't know you and didn't talk to you, we would have never become* [nurses]."

Although Nigwa talked about multiple traumas she suffered within her birth family, she provided recent details about the impact that her immediate and extended family had on her life and how this enabled her to build caring relationships:

> *I know the closest thing to my heart, is how my family is. My family has grown a lot since I started coming out of my house and it's not just my blood family. I've gotten to know a lot of other people. When they hurt, I feel it. When they're happy, I feel it. It took me a long time to feel anything, I was a block of ice.*

Connectedness to family as well as believing and depending on the Creator was common in several of the women's stories. This connectedness helped give them strength to heal and to find purpose in life. For example, Wolf stated, *I guess a lot of stuff from my past I've learned to let go. Now I depend on my Creator.*

Nigwa exclaimed that belief in a Higher Power saved her: *There must be a higher power out-there somewhere ... cause everything I've gone through ... anyone else would have died.* Elder One offered her wisdom about her spirituality, purpose in life and comfort in being cared for by a loving God:

> *The Creator put me on earth for a purpose. This is why we are still here. We have to pass that on ... I smudge*[7] *... I sing. I drum songs that come to me in visions. Everything I do has meaning. There is a loving God that takes care of us, no matter how we suffer.*

In the oral tradition of storytelling, each time a story is told, the storyteller is responsible for whom the story is shared with, and when and in what circumstances it is told (Wilson, S, 2008). The stories told by the participants were intimate offerings for others in the Talking Circle to hear, open their hearts and minds and learn about life as Aboriginal women. In telling their stories in a safe place, they were able to teach others in the Circles. Wolf reflected that the Circles were the first time she had ever disclosed some of her stories. She realized she wanted others to learn about the life of Aboriginal people through her experiences: *I have this urge to tell my story.*

Being proud to be native and reclaiming one's nativeness enabled the women to let go, forgive, and accept themselves for who they are**.** In an earlier chapter in this thesis, I situated myself and offered an explanation why as Aboriginal people, it is important to let it be known where we come from, where we are located. Moving

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[7] Smudging is a sacred ritual performed by an Elder or individual to physically and spiritually cleanse and heal oneself, people, places, food or objects. The smoke from burning medicines such as sage, sweetgrass, cedar or tobacco rids negative energy and allows an opening for positive energy (Chansonneuve, 2005).

beyond merely stating one's name, nation, and geographical roots, one's locatedness reflects the identification of oneself as an Aboriginal who is transforming their life (Absolon & Willet, 2005). Locatedness represents certain aspects of the realities of our lives, which shift and change depending on what we emphasise in our lives.

By accepting one's self and having a purpose in life the women gained strength to advocate for their needs and those of family and this was evident in many of their stories. Several women had already talked about the barriers in the public school system. As stated earlier in this chapter, Aboriginal children were not expected to learn or succeed in school, were separated from the non-Aboriginal children, and thus did not experience the same level of education. Nigwa reflected on memories of when she was a volunteer teaching assistant at a local public school. She used her insider position to advocate for the rights of Aboriginal children in the classroom in which she worked. She worked against the status quo of separating children and worked purposively to help the children so they could come up to the same level as the non-aboriginal children:

> *I volunteered for two years. I met a lot of young Native children in that class. They wanted the next level, but they were told "No you can't do that, that's too hard." Within two weeks I had these little kids, they call[ed] "stupid" getting on to the next level.*

Nigwa's Daughter claimed she did not want to have a special helper in school, so she would not be segregated and labelled as unlikely to achieve. She made sure this did not happen to her: *I don't know how I got out of that one* [having a helper in school]. *I was very verbal I guess. I was very verbal.*

The women also recounted incidents of advocating and learning to be strong for themselves and family members when dealing with the health care system. As a registered nurse, Mahoya was expected by her people to advocate for Aboriginal patients and families by doing what she could as an insider (employee of the local health authority). She talked with pride: *I know how to advocate for other parents and other Aboriginals and as an Aboriginal when I'm out there working*. Rose spoke about how being insider and registered nurse enabled her to be more familiar with the needs, humanistic values and ways of being with Aboriginal people. In her words she was *able to connect with First Nation patients on a different level than other* [non-Aboriginal] *people can*.

Elder Two recalled that when she worked as a registered nurse in a specialized unit within a large hospital, as an insider she was able to advocate for Aboriginal people to have more visitors than the hospital policy allowed. She related her action to knowledge of the cultural importance of family and family being more than immediate members: *When I had my people* [Aboriginal] *there … we tried to accommodate our families … not just two visitors at a time.*

Ram advocated for her father to not only receive appropriate health care coverage but also to be reinstated as Aboriginal and receive what he was entitled to:

> *Dad could not find resources for himself, so I started looking for him. He didn't even know that he could get Status* [category of Indians who are entitled to receive funding for health service] *so it would help him pay for his insulin.*

After numerous unsuccessful attempts to get help for her hearing problems, once Nigwa became stronger and came out of her house, she had the courage to advocate for herself: *I finally went to a place where they didn't act different … first time I didn't feel belittled or discriminated in fifty four years.*

All of the women's stories exposed an array of purposeful locatedness depending on what was most relevant at that time in their lives. Being an advocate, role model, protector and insider were identified as factors that made a difference in the lives of fellow Aboriginal people. For example, as a nurse working in the local health authority or as a teaching assistant in the local schools, being an insider gave the woman opportunity and voice about Aboriginal issues and possibility for change.

In the Talking Circles the women freely shared how they felt, what they did to cope and how they reacted and resisted in a world that continues to examine concepts of 'their' acculturation and enculturation. Their truths are their knowledge, but unfortunately, subaltern knowledge of people who have been oppressed is often not accepted or taken as legitimate. Yet as Moosa-Mitha (2005) so eloquently expressed, knowledge is shaped by traversing multiple perspectives as individuals navigate between white societal worlds and their Aboriginal traditions and values.

Similarly, the urban Aboriginal women who participated in the Talking Circles had already commenced the journey of transformation of their lives and their stories provide evidence that reflect positive attitudes, self-confidence, and knowing their legitimate place in society. They spoke about the importance of personal spiritual beliefs, and family connectedness that healed and gave meaning and balance in life. By accepting who they were as Aboriginal women, they were more able to seek opportunities for cultural and social connections, build courage, become motivated, and volunteer to educate those who remained ignorant, for example, colonialists and health care providers, about Aboriginal health and healing. Their individually and collectively developed strategies for change were based on their unique needs, those of their families, and situated in communities that are rural, remote, and urban, areas in which Aboriginal women have resided.

Telling and taking action was evident in the women's stories. As Monture (2008) illuminated, stories teach about identity and responsibility, how to live life, and how to be a good 'Indian.' Monture claimed that words give strength to individuals and enhance women's power. Using voice is complicated, complex, and courageous and emanates from a strong sense of self. For all individuals, self-determination is articulated in agency, autonomy and relationships and as was found in this study, is more useful if it incorporates individual and collective self, and includes the voice of Aboriginal people inclusive of women (Napoleon, 2005). Based on the women's stories as proud native women and living life with a purpose, their life activities were interwoven with a life journey of living in the future, a life that was improved for themselves, their children, grandchildren and all creatures in the universe. Life choices about living for the future, was evident in their stories and described ways they ultimately supported each other through the generations. They illuminated the importance of acknowledging Aboriginal identity, strength of family, and depending on the Creator to help them through life.

Brant Castellano (2004) suggests self-determination for native people is the construction of knowledge based on one's own values and realities and the freedom to determine one's own path through decisions based on political, economic, social and cultural development. As the excerpts from Elder One demonstrated, the gaining of wisdom is important in telling one's stories for healing and teaching. In the telling it is important to note that the "sharing of common experiences of colonialism cause connections among First Peoples, but it is the shared experiences that make us appear monolithic" (Monture, 2008, p. 156). The importance in telling one's story for healing and teaching was a common thread in the Talking Circles.

Such telling resulted in freedom to choose self-determination and the capacity to shape one's health (Reading & Wien, 2009).

Numerous authors have written about resilience, trauma, co-dependency, and post traumatic healing. However, taking a step back and looking full circle at the atrocities endured by the women, they reveal who they are today. One wonders if their connectedness is nested in the simplicity of hopefulness for a better life for them and for their people in years to come. They exclaimed their hope for change at the initial outset of the research, stating that they wanted this study to make a difference for Aboriginal peoples, not be left on a shelf at the university. Using their voice in this research study was purposeful – because it was part of their telling/action strategy for change to occur.

Whether or not the ability and strength for the women to lead successful lives is rooted in resilience or hope, requires further exploration. However, what is crucial about the findings of this study is for the reader to become aware of the complexities that were faced by the women as they learned about life and lived through unpredictable mayhem, multiple identities, and the consequences of their conscious and unconscious actions that occurred in their life journey. Apart from gaining theoretical understandings and generating research findings, the raw truths detailed in the women's stories reveal who they really are and the women represent themselves as resilient and dynamic. They illuminated past, present and future worries of Aboriginal people by deconstructing their own history and exposing the impact (personal and political) of patriarchy, paternalism, and racism on their lives and how, because of who they are, they were able to transform their lives. Even though the women revealed who they really are as Aboriginal women, they also put forward a vision for the future that included ways to achieve balance and harmony, respect, trust and shared power as a pathway to the future.

6.5 Shaping Our Future (Woman Warriors)

The fourth storyline *Shaping Our Future* became illuminated within the Talking Circles as the women shared ways to enhance health care relationships, education, and practices to ultimately improve the health of Aboriginal people. The urban Aboriginal women understood that by teaching those who lack knowledge and understanding of Aboriginal people in Canada, health care professionals, educators, governments and society may come to acknowledge, respect, and accept them. From the words of the women, I was able to reflect on what they said and write this poem that captures what I feel holds their core beliefs, values and vision for action towards a world of understanding and honour.

Shaping Our Future

We Stand Strong
We are Women Warriors
We've been told
When all our hearts are on the Ground
Our tribes are conquered.
Hey Hey
You cannot defeat us
Our hearts are soaring
We've ***Become Self-Sufficient***
We continue fighting for our rights
With ***Family Support***
Challenging the status quo
Demanding Respect that we deserve and earned
Long before the white skins walked on our land.

Hey Hey

We are stronger now

Using Our Voice

Proving Them Wrong

We love our land, our language, our customs, our people.

We ***Offer Help*** for you to understand us

Proud Wise Women, Aboriginal Peoples

To live in harmony and balance together.

Hey Hey

D. Kurtz, 2010

The women's specific words, stories and insights are grounded in a wholistic Indigenous perspective that outlines a vision of world harmony between people of all races, colour, gender, level of education and other social political and economic forces that separate people. Their embodied vision of life and teachings are nested in a world in which everything is connected and in which we help each other learn and together shape our lives and our future. This vision includes the education of health care professionals, teachers and all others young and old to embrace difference. The threads of this storyline are Roots of Respect; Cultivating Cultural Safety; and Offering Help and these, along with the concepts that informed them, are clustered and portrayed in Mind Map 5.

Mind Map 5: SHAPING OUR FUTURE (Women Warriors)

6.5.1 Roots of Respect

Throughout the women's stories, respect – self respect, respect among Aboriginal peoples, and respect between all people – surfaced repeatedly. They stated that respect begins with increasing awareness, knowledge, and acceptance of Aboriginal people as equal to other Canadians. They also felt that respectful ways of being, attitudes, and actions comprise the foundation for relationships between all people, not only Aboriginal people. Eagle articulated the paramount value and belief she and her people embrace being Aboriginal:

> *I must have respect and honor for what we were taught … from generation to generation. We still hold that and we're not going to let go …. No matter what you* [non-Aboriginals] *do to us, there are going to be more of us.*

Elder Two eloquently described her vision of respect that is inclusive of all people across the universe:

> *We are the First People of this country, of this land. If you learn that, you learn to respect people that are different from yourself, that are of a different color. If you can learn to respect and deal with me, then you will be able to learn to respect and deal with those that are black, yellow, brown, white.*

Even though most of the women's stories described negative and unjust encounters with health care and other urban services, there were a few heartwarming stories in their teachings about respect. Examples of situations in which they felt respected by health care providers and patients were evident. Elder Two remembered when she was the only Aboriginal nurse working in a large urban hospital: *Staff that I worked with did come to respect me…* [Patients] *have been happy with me and said, "Oh, are you really an Indian? You've got blue eyes". But then … put their arm up next to me* [to compare skin colour].

Wolf shared a story that demonstrated health care providers at times had a genuine sense of compassion when she talked about visiting the local physician's office:

> *I was lucky to have a good doctor. He was very helpful when my kids got sick. He made sure they went to the hospital and he made sure they got the right treatment. He used to speak for his patients if they didn't get the treatment they needed … In smaller communities the doctors and the people who work with them get the same attitude about Aboriginal people. They take care of them. We can go in anytime, no appointments if we need it we just go.*

Canadian Aboriginal researchers Battiste and Henderson (2000), Kovach (2005) and Steinhauer (2001) suggest we are accountable to each other and the universe for our relationships and ensuring these are respectful and reciprocal. The women provided examples of what helped them feel reciprocal respect. Quail told members of the Circle what helped her: *I would feel good if I felt you listened to me. That you listened to me and respected me.*

It became evident in the women's stories that being respected and acting respectfully were tied together in a vision of harmony and moving forward to improve human relationships. For example, they unanimously agreed it was helpful and at times crucial, for Aboriginal people to have another Aboriginal person, rather than a non-Aboriginal person, caring for them. Annabelle expressed that Aboriginal people have an inner sense of knowing and connectedness through unspoken words and actions amongst themselves that show respect and trust:

> *That connection, that trust that's already there without even knowing one another, but just knowing that there's another brown face. Being able to see that brown face. Trusting with not even asking and not saying anything. Just nodding your head or not even doing that. Acknowledging through eye contact however brief or long .... It's the history of Aboriginal people that's imperative even with Aboriginal people that don't know their own history and begin to know it. There is a way of working with us, and connecting with us, building relationships with us, and giving us an opportunity to be a part of* [society] *and not always forgetting us.*
>
> [Realizing] *we are here and you need to consult with us and ask us, what we need and how that is going to work. It's respect, support and having the actual person there, even if that person is just standing in the room. Just being there, if there's any questions. It needs to be an Aboriginal person that has been in both worlds and understands both of the worlds, rather than having the power over us, having the power within.*

Browne (1993) identifies non-verbal messages, verbal messages, and having an understanding of a patient's culture are basic components that impact on providing respectful culturally sensitive nursing care. Ring and Brown (2003) report that both educating non-Indigenous providers in Indigenous history and increasing the numbers of Indigenous health care providers can address disparities and inequities experienced by Canadian Aboriginal people. Evans et al. (2006) found that when asked if they experienced differences in health care delivery between mainstream health care services and Aboriginal health services such as Friendship Centres, many Aboriginal people stated they felt more comfortable with "a safe place", "run by Aboriginals", where they could trust the service providers. Numerous other studies from Canada, and Australia, demonstrate that Aboriginal health status is improved when there were Aboriginal health care workers educated and providing care (Arnault-Pelletier, Brown, Desjarlais, & McBeth, 2006; Kulig & Stewart, 2006; Usher, Lindsay, Miller, & Miller, 2005).

Although such studies provide evidence that Aboriginal clients feel safer and their health is improved when they have an Aboriginal health care provider, researchers and educators must be cautious, because being Aboriginal or having physical Aboriginal traits does not necessarily guarantee best practice. For example, according to findings in the Urban Aboriginal People's Study (Environics Institute, 2010), almost half of urban Aboriginal people interviewed had never read or heard anything about residential schools until the federal government apology in 2008. Thus, even though many Aboriginal health care providers have lived under the patriarchal hand of the colonizer, and suffered generational effects, others may be ignorant of their people's history and situate themselves within the dominant culture (Shaw, 2010).

In addition, the education of Aboriginal health care providers apart from non-Aboriginal students may perpetuate segregation within health care and result in minority (Aboriginal) health care providers being the only health care providers for minority (Aboriginal) patients. A broader more concerted approach that goes beyond initial education could improve health outcomes of Aboriginal populations and narrow the health status gap between Aboriginal and non-Aboriginal people in Canada.

According to recommendations in the literature and the stories of the women, there is no doubt that it is imperative for health care providers to be aware of the history of Aboriginal people, yet many remain ignorant. For example, Elder Two shared her experiences with physicians, both as a registered nurse, and as a patient:

> *I've talked to physicians and they've said, "Well yeah I heard about that residential school, what is it?" And that's all they know… or "Yeah I've had Indians in my practice for a long time," but you know it was just sort of, well, "I heard that word" that's it. There was one physician that I know in town here and he said, "You know, I've been practicing for over 30 years, I've heard this talk about residential schools. What is it? I don't know anything about it". Even my own physician doesn't really know anything about the history about our people.*

Ignorance about residential school experiences results in failure for health care professionals to be aware of potential racist and discriminatory practice. For example, because of the long-term effect of abuses and shame that resulted from the very strict teaching of sexual modesty and morality in residential schools (Browne & Fiske, 2001; Brave Heart & DeBruyn, 1998), many women experience extreme discomfort and hesitate or refuse to expose their body for medical assessment or treatment. Elder Two described an incident that occurred in the local emergency department incident when her elderly mother, an Elder and residential school survivor refused to remove all of her clothing and put on a hospital gown to have her arm examined. Elder Two stated, when an Aboriginal woman hesitates or refuses to remove clothing because she feels uncomfortable and health care professionals are unaware of the underlying realties, she is labeled as *non-compliant* or as a *difficult patient* and *threatened* by health care providers that if she continues to refuse to do as she is told, she will not receive treatment (Elder Two, personal communication, 2006).

Ram talked about her insights about being treated as ‘different’ once it was known she was Aboriginal; that may not have otherwise occurred had health care professionals been more aware, understanding, and accepting of Aboriginal people:

> *There is a stigma mark attached to being Aboriginal. People don’t see they’re doing it or being that way. I don’t know if they do it on purpose or not on purpose, or both. But definitely people* [health care professionals] *need to be educated and not make assumptions.*

Towle, Godolphin, and Alexander (2006) propose that the quality of the relationship and communication with one’s health care provider affects Aboriginal people’s health. They suggest physicians can greatly improve their relationships with Aboriginal people by learning their history and building trust through getting to know the patients as individuals. Macaulay (2009) suggests that all health care professionals can promote improved Aboriginal health by understanding the history and legacy of colonization and residential schools, and the impact on social determinants of health. In order to understand and respect difference, Canadian nurse researchers Browne and Varcoe (2006) and Métis physician Smylie (2001), suggest examination of one's own beliefs, assumptions, attitudes and stereotypes is necessary to build respectful and equitable relationships across cultures and lessen marginalization, enabling health providers to provide culturally safe and socially responsible care. This suggestion resonates with recommendations put forward by women who participated in this study most noticeably Annabelle, Nigwa, and Elder Two, who voiced that health care providers should be educated about the history of Aboriginal people so they can better understand and respect them.

The women's stories provided realities of living in a society in which they were discriminated against and, in the hands of health care providers, received unjust treatment that "diminishes, demeans and disempowers their identity, and wellbeing" (Nursing Council of New Zealand, 2005, p. 4). Although having knowledge may make a difference and promote respectful care, the gap between having knowledge and putting it into practice must be considered. There are complexities in the way health care is delivered and the way relationships are honoured that also need to be unraveled. The women adamantly recommended education, however they were not only talking about academic or 'book knowledge', but also about how to be in relation with Aboriginal people in respectful ways that help improve health care practices and ultimately improve the health of Aboriginal people.

6.5.2 Cultivating Cultural Safety

As the women spoke in the Talking Circles, I was captivated by their insights about what felt safe for them as recipients of health care. I realized they were talking about cultural safety. Not all of the women were aware of the language or concepts of cultural safety that require a shift in the role of culture away from a person's ethnic background toward a critical exploration of power imbalances between non-Indigenous health care providers and Indigenous patients (Peiris, Brown, & Cass, 2008). In order to achieve this shift, health care providers need to evaluate their "own invisible baggage - attitudes, metaphors, beliefs and values" and be more aware of their assumptions and behaviours in practice (Ramsden, 1992, p. 23). Further, nurses who evaluate and reflect on their own cultural identity are more able to recognise the impact that personal culture has on their professional practice. (Nursing Council of New Zealand, 2005). For Aboriginal people, culturally safe practice includes the examination of health and health care within the context of their history, political and social environment and other issues that shape their lives (Moffitt & Vollman, 2006).

The women were able to give clear examples of culturally safe practice and ways of being. For example, as an Aboriginal nurse, Rain offered solutions to address power imbalances and safe practice in the health care system. She said:

> *... cultural safety is about power relations with healthcare professionals and clients, and that's really grounded in what the healthcare professional knows of Indigenous perspectives and experiences around colonization, their experiences with healthcare systems, with education systems, with judicial, you know, all of it. The* [health care provider] *curriculum is supposed to be based on ... cultural safety concepts, so health care providers are aware of their privileges, that they are in a powerful role as a healthcare provider ... What they need to do to ensure safe care is to transfer that power to the client ... Cultural safety ... should be taught to* ***everyone, everyone*** [Rain's emphasis].

Rain previously captured difficulties she had in being told to educate health care professionals about Aboriginal people when mainstream health care failed to use a systematic approach. A disconnect between power holding and power sharing within structural, organizational and societal coordination interferes with provision of culturally safe non-judgmental heath care delivery. As noted by the National Aboriginal Health Organization (2006), cultural safety "analyzes power imbalances, institutional discrimination, colonization and relationships with colonizers, as they apply to health care" (p. 1). Collaboration between all levels of government could initiate the necessary shift to culturally safe environments within the health care and education systems by transferring decision-making power from the health and education authority to Aboriginal governments (Browne, Fiske, & Thomas, 2000). This would help ensure Aboriginal people are actively involved in education, health policy decision-making (Adelson, 2005) and the integration of appropriate culturally safe care in both urban and rural settings.

However, dominant structures remain within institutions and systems and fail to value inclusion and diversity by maintaining the *status quo* and remain persuasively situated within the hegemonic discourses of 'othering' and marginalizing people in our society (Hill & Kurtz, 2008). The women shared how this positioning increased their experience of discrimination and racism not only in education and health, but throughout society as a whole. They felt such attitudes and behaviors are learned, at home and in school. Elder Two, an Aboriginal health infant and child health nurse expert recommended that learning about difference and cultural safety: *should start in Kindergarten or even before, in the home.*

Annabelle, a social worker who has worked in Canadian health care and social service systems explained ways to reduce racism:

> *It's quite visible, it's everywhere you go and people saying things and people doing things because of your skin color and because of who you are.* [I saw

> and encountered] *racism in school from professors right down to the student. It was continuous. So the learning has to start even before the students go into the universities. It has to begin at home. It has to begin with our professors.*

MacNaughton and Davis (2001) explored the development of prejudice and racism in young children in Australia. They found differences in non-Indigenous children's knowledge about Indigenous Australia arose from different experiences of learning. The children learned about Aboriginal people from the media (newspapers, television, stories), and through friends, family, school, teachers, and parents. Rather than learning about embracing diversity, much of their early age constructed knowledge of Indigenous people, recreated an 'othering' perspective that portrayed a "colonial self-identity based on a binary opposition between 'black' and 'white' as signifiers of who they are" (p. 92). Such antagonism between coloured and non-coloured, and normal, abnormal, was echoed in the recommendations from Elder Two, Annabelle, and several of the other women – that successful and respectful ways to prevent and challenge racism and discrimination must start at home and be taught to all children, Aboriginal and non-Aboriginal, from an early age.

The women expanded the concept of cultural safety that traditionally applies to health care and social services practice, to include reciprocal respect, trust, and power relations as being an everyday part of everyone's life. Elder Two defined:

> *... cultural safety has to be a part of all of our lives so that whether I'm a provider, or a receiver, that I feel comfortable, I feel respected. And there's a shared trust. And that this happens in healthcare. It should* [also] *happen if I go into a restaurant. It should happen in life.*

Even though some of the women did not know the term cultural safety, their knowledge was evident in their descriptive words, expressions, behaviour, language, and recommendations for change. This knowledge shared in their teachings developed through experiences of feeling culturally unsafe most of their lives. What intrigued me was that they had clear recommendations about ways to cultivate a culturally safe world that included everyone, all races, all cultures, not only Aboriginal people.

6.5.3 Offering Help

The women developed a collective vision in which the world could become a culturally safe place. Their vision included ways to share knowledge and foster teaching and learning. For example, Rain explained:

> *I think the regional health authority really needs to have an environment that supports cultural safety and cultural sensitivity because its fine for people and workers to come to it* [cultural safety education classes]*, but if the whole structure doesn't support that, in the workplace and in the schools, it's not going to work.*

Eagle provided insight on actions she thought were needed to support understanding and education:

> *... because there was discrimination and racist treatment ... It's time that these people acknowledge and asked for help from Elders. I want to share as much as I can of what I was taught .... We don't want to talk* [just] *because we want to hear ourselves… it's for everyone to hear and listen …*

Some of the women's recommendations foreshadowed the work of Birch et al. (2009), who recommend that cultural competency sessions or culturally safe education in health care needs to be understood and be acknowledged as important by society. In order to gain this knowledge and apply it to practice to rid racist and discriminatory practice and health care delivery, systemic wide interventions such as curriculum development, experiential sessions, and teaching done by Elders and Aboriginal people, and other activities about cultural safety change must occur.

The women talked expansively about strategies for change and gave clear examples of what they thought would work to shift current realities toward a culturally safe world. Elder Two described discrimination and racism in the workplace as an Aboriginal nurse and how she used her position to help other health care providers learn and begin to understand: *I would confront them … Do you realize this? Do you know this* [the history our First Nations people]*? …. I did share experiences with them and explain why* [I felt their actions or attitude were racist] …. *They didn't have the knowledge …* [I] *saw attitudes change.*

One of the necessary changes in health care practice the women recommended was for providers to understand the importance of inclusion of the family for the well-being and healing of Aboriginal people. Wolf described this as being connected with and belonging to family:

> *There's two of us in our family that are always there for our family, me and one of my sisters up the valley. We try to tell them if they need help to call us. But we can't always be there. So we need somebody in hospitals for these young mothers to help them through their care or whatever for their children. Cause our mothers, our young Aboriginal kids, they're having kids, fifteen, sixteen* [years old]. *They need the help to raise these children. Not be taken away from them just because they're young. Cause they have more knowledge than we think. Cause they have people that let them know*

> *about all this knowledge. So we need more people to help them out in the hospitals, to understand and respect them.*

The women repeatedly exclaimed the crucial importance of Aboriginal and mainstream people working together and learning from each other, to help facilitate a universal understanding of Aboriginal history, current ways of life, and vision for the future. This included contextualizing education, curricula and inquiry to consider the impact of acculturation and the social determinants of health and health disparities. The link between disparities and social determinants is not new, however Zambrana and Carter-Pokras' (2010) found persistent use of individual or culture driven health models ignores the effects of income, living conditions and the "social construction of marked cultural identities, and institutional practices of unequal treatment" (p. 21) that contribute to health disparities. This could be resolved as Rain suggested, by ensuring teaching includes and is done by Aboriginal Elders and youth to provide, *a whole different perspective*, in which through storytelling, realities of social, economic, physical, emotional, and spiritual determinants of health are shared. As Annabelle stated:

> *It happens too many times … having grassroots people always being ignored and not being acknowledged. I would love to work with you, because I only see that if their* [Aboriginal people] *voices are not on the paper, if they're not listened to, we're just experiencing the cultural genocide, over again right? I mean, silencing our voices and not giving us the opportunity … It's time the Anishnaabe talk with the Talking Sticks, with the rock … We'll go into their place … Is there any way we can get a team going to act on the regional Aboriginal health and wellness plan?… I will go and teach …*

The women, including the Elders in the Circle, nodded their heads in agreement to Annabelle's statement. They recommended the transfer of knowledge be in all areas and levels of society. They stated that Aboriginal people know who has the knowledge and skills to teach in schools and educate not only the mind, but also the heart, body and spirit. For example, using Indigenous stories in face to face teachings is ideal to enhance listening with "three ears: two on the sides of our head and the one that is in our heart" (Archibald, 2008, p. 8).

Those who participated in this study were self-sufficient and represented multiple voices, different histories and various tribes. They may not have faced the exact struggles in life or shared commonalities in the way they demonstrated their resilience and strategies of resistance, but they respectfully and graciously engaged in dialogue and reflection to create the kind of collective vision which is written about by Brant Castellano (2004). The power of woman's collective vision is echoed in Brant Castellano's (2009) work with Aboriginal women, who although deprived of resources, disempowered, and brutalized in their settler (colonial) communities and in their own families and households, held a strong sense of identity as Aboriginal women and envisioned "restoring safe, respectful, collaborative, and gendered relationships in their communities and the Aboriginal world" (p. 206).

Indeed the urgency to change the culture of education is echoed in the women's teachings. Local, provincial, and federal power holders would do well to join with Aboriginal people to identify, develop, implement, evaluate and appropriately fund programs for Aboriginal people and communities. Numerous authors including Ring and Brown (2003) identify the need for health care institutions, colleges and universities, and government agencies and funding bodies to acknowledge their responsibility and commitment. This includes competent and responsive education of health care professionals and policy makers, the contribution that Indigenous practitioners make to the workforce, especially as recent evidence about causes of disparities and recommendations for effective improvement in the health of Indigenous peoples abounds. In addition, Macaulay (2009) encourages all health care professionals to advocate for more Aboriginal health care professionals, Aboriginal self-government with control of health and education programs, and adequate funding of relevant programs that are developed with Aboriginal input and evaluated appropriately. As well, she states health education programs such as nursing and medicine could lessen assumptions and gaps in knowledge about Aboriginal people by including Aboriginal history and health disparities in their curricula.

This is not to say there have been no attempts to address these issues, because there have been initiatives and programs directed at improvements. However, for improved Aboriginal health, the leaders of all levels of government in this country would be wise to instigate a higher level of effort to include Aboriginal people in health and education systems with support from society as a whole to advance the cause of Aboriginal people.

6.6 Stories Tell Harsh Truths

Stories that tell harsh truths without flinching,

that honour the resilience of individuals and communities

who are restoring balance in their lives,

and that give evidence of a commitment on all sides

to transforming relationships,

have a chance of becoming a part of the grand narrative of Canada,

shaping our understanding of who we are as a people

and enabling us to live our live differently.

(Brant Castellano et al., 2008, p. 409)

The aims of this study were to learn about the women's experiences with Canadian health care services, and to identify strategies that could promote respectful, non-racist, non-discriminatory care. Along the journey, a web of complexities were uncovered as the women told how institutional violence, oppression, stigmatization, dehumanization, being ignored, silenced and voiceless forced them into a stereotype that resulted in their being marginalized. Their current positioning in life was illuminated through their teachings, healings and cultural ways of supporting each other; understanding each other's struggles; and cherishing all living things. The women's stories provide crucial insights into necessary changes that will begin to decolonize health care provision; prevent further acts of structural violence, stigmatization, and misrepresentation of Aboriginal peoples; and support ways to improve their health and well-being.

It is hard to understand that as Canadians, Aboriginal people continue to be placed by – government, institutions, individuals – as 'different to' and 'less than' white people. Colonization continues to cause much hardship and it is imperative for the Canadian government to embrace decolonization to stop such atrocities. As previously stated, in order for change to occur, a comprehensive national approach is necessary for Canadian citizens to begin to more fully understand and include Canadian Aboriginal peoples. However, this is difficult since the government fails to fully acknowledge the plight of the Aboriginal populations and ignores antidiscrimination legislation within the Canadian Charter of Human Rights and Freedoms (Constitution Act, 1982) that "prohibits discrimination on the grounds of race; national or ethnic origin; colour; religion; gender; age; and mental or physical disability" (para. 3).

In addition, federal and provincial governments have legislated the Canadian Human Rights Act (1985) for the protection of Canadian citizens to be treated with equality and respect. Until recently the Canadian refusal to recognize the United Nations' *Declaration on the Rights of Indigenous Peoples* (United Nations, 2008) demonstrated to the Canadian people and the rest of world that Canada did not support the international recognition of the historical atrocities suffered by Indigenous Peoples, and did not intend to join the universal movement towards protecting their rights of equality. Although legislation exists, it is evident in the women's stories that discrimination and inequality are rampant thus rendering them impotent.

Physicians, nurses and other health care professionals are bringing cultural safety curriculum to their education programs and some health care professionals, although in the minority are advocating for necessary changes in professional practice to uncover misunderstandings, reduce racism and intolerance and the pathologization of Aboriginal people. However, positive changes are not evident in the women's stories and are scarce in the literature. It is in continuing the journey and in including Aboriginal people in all levels of decision-making, education and practice, that questioning of the status quo and ongoing learning and knowledge transfer will occur. Importantly, legitimate inclusiveness of Aboriginal peoples as part of, not lip service to, government, health and education systems will finally drive change over time. Through ongoing Aboriginal led research and program delivery, changes may be expedited sooner as Aboriginal people themselves lead the way for the necessary changes

What the women recommended in the Talking Circles does not consist of a trivial list of things to do – and be easily ticked off as they are completed. Rather their vision is a life long journey of balance and harmony that includes respect, trust, listening, education, reciprocal and accountable relationships; it is a way of being as one in humanity. The women agreed they each had responsibility to share their knowledge and teachings about their lives and history. They made it clear that Aboriginal people are here in Canada and are not going away and they are stronger and actively speaking out about their issues and visions for change at local, provincial, national, and international levels. Yet Aboriginal women have in the main, been vastly undervalued and silent. Powerful Aboriginal women exist, but in any discourse that analyzes or describes them without understanding their stories, feelings and motivations – their histories – they will never really be seen or acknowledged for how they have survived and even flourished despite the ravages of colonization (Mihesuah, 1998). With minimal literature available that describes their role in upholding economic, socio-political and spiritual survival of their tribes, their teachings in the Talking Circles unveils their hopes of being heard and suggests improvements in health care practices. According to Anderson (2008) a Canadian Cree/Métis scholar:

> As Aboriginal women, we have been organizing, helping, healing and researching throughout history. This has been possible because of the types of relationships, connections, and knowledge exchange systems that we have established among ourselves and with the human, natural, and supernatural worlds around us. (p. 12)

In summary, as Carol Lévesque (2001) eloquently described, Indigenous knowledge is much more than information, it develops and is renewed through relationships between individuals, societies, and spiritual worlds. Being oral in nature, as demonstrated in the Talking Circles, the women's knowledge was transferred to others in a very personal intimate way. As a consequence of their participation in this research, and the new Stage 2 that we constructed together, the women have shared their wisdom and taught others at numerous conferences, Talking Circle workshops and formal presentations locally, nationally and internationally. Additionally, they have participated in or instigated workshops conducted at the local university for faculty; they have presented in university classrooms for health care professions; and have contributed to shaping the university health care professional curriculum. Thus far the response to their sharing of knowledge has been positive, with participants voicing that they truly appreciated what was shared. Many participants also shared that they did not realize or know that colonization continues today in Canada; or they frankly admitted they unintentionally practiced in culturally unsafe ways. It is clear that the women's "stories have the power to make our hearts, minds, bodies, and spirit work together" (Archibald, 2008, p. 12).

The women who joined in the study represented several tribes and Bands and multiple Canadian provinces including, British Columbia, Alberta, Saskatchewan, Manitoba, and Ontario. Their roots differed genealogically and geographically however, such diversity failed to lessen their attachment (Cunningham & Stanley, 2003) to family, land and Indigenous worldviews. No one Indian voice exists. The strength of the threads that connected their stories demonstrated that "centuries of colonial oppression and exploitation have created enough commonality of experience to justify a united approach to social change" (Ontario Native Women's Association, n.d., p. 1) and for the women this was through the creation of a grassroots collective vision for change. This included explicit ways of gaining knowledge and ways of being that were grounded in cultural practices, with storytelling being a key role in this learning. The women's vision was based on all aspects of their knowing in combination with wisdom shared through generations, informal and formal education, their simple yet complex everyday life problem-solving, and the progression through the journey of life. The knowledge they shared came straight from their hearts and was shaped also by their families, and communities. We can draw from their stories, learn from them and join together as health care providers, individuals, friends, and citizens to continue to share our knowledge, thoughts, and journey in which we can all enhance the life, health and future of all peoples around the world. In the telling of their stories and vision, they hope change will occur.

This study exposes the realities of being Indian and the callous indifference shown by some health care professionals and educators to women and the concerns they brought to the interface. This apathy appears to be perpetuated within Canadian government and society. There is no excuse for obstinate acts of violence, racism, and discrimination. Being called a liar; treated differently based on skin colour; being expected to drop out of school; growing up with an expectation that rape and torture are normal; and being labeled as dirty and having lice, and being mistreated and pre-judged in the health care system all highlight the reality that Just Because We're Indian, differentiated us from the rest of society. Living with coloured skin shaped their lives in which they continually rethought their existence beyond injustices, surfacing dialogue about Fighting All Our Lives and striving to be treated as 'normal.' Learning how to hide from abuse; losing one's Aboriginal identity, family and community connections; paying the price; and suffering for being violated, dehumanized, 'othered', labelled, silenced, and marginalized; defending rights as persons, in school and health care; and being mistreated in the workplace; were common everyday experiences, yet the women carried on. Their resilience and strength for survival shone through as they talked about reclaiming their lives by explaining Who We Really Are. Atrocities and the worst imaginable life experiences set aside, the women were proud to be native, forgave themselves and others, embraced hope, lived life with a purpose that included family, community and the future, and depended on the Creator. As woman warriors and leaders of the future, their wisdom of world harmony was grounded in respectful relationships and was inclusive of all people of all colours. Their offerings to help and be part of the movement toward non-racist and non-discriminatory health care practices to improve life for themselves and their families and communities demonstrate their truths, reciprocal relations, and commitment. I have no doubt that more lives than theirs will be improved as their vision is carried out. Health care providers, students, and the lives of those who join them will be forever altered and blessed.

Browne and Fiske (2001) claim that by sharing marginalized experiences of Aboriginal people, although oppression and discriminatory practices are unlikely to stop, colonial behaviours and practices may shift and improved health care experiences for Aboriginal women may occur. For the women in this study, I as an Aboriginal woman and the main researcher hope that in the telling of their stories, those who read this work will become compelled to reflect on their own biases and beliefs and begin to consider the perspective of those that have been marked, 'othered', marginalized and mistreated so health care encounters can become culturally safer.

By working together in defining what we, as Aboriginal women need, want and how we see best to move forward and prepare the future; our strength continues to be in our connectedness to our families, communities, ancestors, the universe and beyond:

> *Lest we become paralyzed by the severity of our situation as Aboriginal women, struggling in a society that excludes us, ignores our voices and discriminates against our sisters we must remember that we are the heart of our nations. The heart of a woman is the first sound that fills the ears of every Aboriginal person as it gave life and sustenance. Our bodies nourished our young ones. Our Aboriginal mothers have worked and sacrificed to ensure the survival of our nations.*
>
> (Ontario Native Women's Association, n.d, p 21)

CHAPTER 7: THE CIRCLE CONTINUES

7.1 Talking For Action

In this chapter I present concluding remarks about my doctoral research journey. Undertaking this journey resulted in a shift in my self-identity as a researcher and Indigenous woman. Through my engagement in this research I developed respectful reciprocal relationships with the women who graciously participated, from which Western and Indigenous worldviews were integrated in the construction of a unique and local Indigenous methodology; and collective vision and strategy for health care change. In this concluding chapter I offer insights into successes, limitations, and revelations that arose from undertaking this research journey. At the same time I provide thoughts for how I can continue to work with Indigenous women who participated in this research to enable them to see the strategies they recommended for changing health care practice become a reality.

As I reflect on the significance of the study in relation to the study aims and the importance of situating myself in the research journey, I also reflect on the research process, which enabled me to embrace Indigenous Methodologies and methods. I highlight limitations of the study; the relevance of the research findings; knowledge sharing of the research discoveries; future work and research that is necessary to continue the ongoing work of decolonizing the health care system and practices.

In this thesis I described part of my journey of working shoulder to shoulder with urban Aboriginal women to increase their presence, visibility, and voice in the provision of improved health care delivery for them, their families, and for future generations. The women who agreed to participate in the research study did so on the proviso that the research outcome would partly focus on their visions for health care reform, as they felt it was time to contribute to changing current health care policy and practice, rather than simply telling their stories. Hence, the reconceptualization of Stage 2 of this project was vital to the realization of their dream, which was to engage in Talking for Action Strategies. As a consequence of their engagement in this study the women commenced their Talking for Action Strategies and found the strength to participate in academic forums that contributed to curriculum change; they reveled as they used their voice and were heard at national and international conferences; they used speaking in classroom settings as a means to inform future health care providers about what Aboriginal people need when they present for health care; and they modeled at national and international workshops how to use Talking Circles to initiate much needed change. Each of these actions demonstrates that the women formed a collective vision aimed at forging new understandings and maintaining a sustained commitment to change the health care system. In so doing they contributed to social justice reform. This is a unique aspect of this study and one which ought to be replicated in future research with Indigenous people.

7.2 Aboriginality in Research

Early in the thesis I described the background that led to me undertaking this study. I wondered why Aboriginal people in Canada experienced health inequities and disparities and hence constructed this study to provide a safe environment for urban Aboriginal women to share their experiences with Canadian health care services, and to form their collective vision for health care reform. I acknowledge that through my engagement in this research I wanted to step up to my responsibility to join my Aboriginal relations as a force for change.

In Chapter 2 I revealed deeply personal and professional insights that shaped who I am as a researcher and the importance of situating myself as an Aboriginal woman and researcher at the beginning of the doctoral research. As I prepared for the research journey, I considered research methodologies and learned about Indigenous worldviews and their differences from Eurocentric knowledge and worldviews. By selecting an Indigenous approach, I traversed multiple perspectives and protocols as together the women and I constructed a unique and dynamic research approach that blended Eurocentric and Indigenous worldviews and methods to provide a culturally safe environment and relationship for intimate, rich and empowering findings to emerge. In traversing multiple realities, I continuously learned about ways to embrace Indigenous methodologies as a living process. The worldview that I embraced ultimately was imbedded in the research proposal and framed the research process. My immersion spoke to me of the importance of being in relation with the women to learn about their worldviews, which were quite different initially from the Eurocentric worldview which I initially held and with which I was more familiar.

Claiming my personal Aboriginal locatedness enabled me to demonstrate my commitment to engage in respectful and truthful Indigenous research. As well, it reminded me that my role was to bridge expectations held by the University for producing scholarly work, whilst simultaneously upholding a commitment to remain true to Indigenous Methodology. This journey was not easy. While I was learning culturally appropriate ways of being, I had to remain continually conscious of how to stay true to the methodology that guided my study and which was presented in my ethics application. Over time I began to deeply appreciate that a fine balance existed between maintaining respectful relationships and ensuring inclusivity of the women whilst simultaneously fulfilling the mandates of my ethics proposal.

Throughout all aspects of this research I worked hard to ensure the women's stories and vision were at the forefront, to prevent misrepresentation or inappropriate positioning of the research from a solely researcher perspective. It was important throughout this research to ensure I did not burden or offend the women or community through my ignorance about their culture, aspirations and vision. By truly centering myself and focusing on and learning with and from the urban Aboriginal women and community, I was able to understand how to work together, based on multiple ways of knowing that included Indigenous and Western paradigmatic views from which we shaped the direction of the research methodology, to ensure the study outcomes met the women's purposes for joining the project.

As I learned to become more aware of and sensitive to what was culturally appropriate and how to work together with Aboriginal people, the white-raised blue eyed blonde girl of my early childhood, who innocently feared and judged Aboriginal people without any grounds for such judgment, changed. That girl, now an academic researcher, has became a proud Aboriginal woman. The daily learning and struggles that arose while navigating white, Aboriginal, and in between places shifted, to include understanding of historical, socio-economical, political, and generational impacts of colonization on both Aboriginal people and non-Aboriginal people.

One factor that I believe was crucial to being accepted by the women who participated in this research was being introduced as a trustworthy Aboriginal person by a respected Elder who was my mentor. This positioned me as an 'insider', a point which will be elaborated upon shortly. Because of my insider status the women were able to trust and embrace me and the depth, richness and intimacy of their stories was a result of our mutual respect and my promise to them that their stories would not ‘sit on a shelf’ at the university and remain untold. As we understood, their stories were to be used to pave the way for change.

As my relationships with the women and the women with me became more endearing, I also became more aware of the core values and tribal knowing and beliefs that guide each of their lives. By learning from them, I was able to come to a deeper understanding of the diversity from which Indigenous knowledge is developed and how it shapes one’s worldview. My heart, mind and spirit are now grounded in a mixture of Eurocentric and Aboriginal worldviews and I find that I now embrace the intersecting in-between places of both.

I learned the real meaning of respect and its importance in the presence of Elders and the respect Aboriginal people have for them within the family and community. They are the ones to share their teachings and traditional knowledge with the next generations. Consequently I now find I have more respect for non-Aboriginal seniors, because they carry the histories of their people. I also found unique Indigenous meanings and answers to long held questions within my own relational sensitivities and deeply emotional, physical and spiritual connectedness with nature, wilderness, cosmos, and the sound of the playing of a native drum. I had always wondered why other people did not have the same sensitive inquisitiveness and awe of nature and all living things. The women in whom I found genuine friendships taught me it was in my blood, my special gift. I now live in a world in which I face day-to-day challenges as one who is Aboriginal. I wonder: *How do we live and understand what has been; what is and what will be; the challenges, the successes, and the ways of being, in life, research, and health professional practice?*

7.3 Embracing Indigenous Methodologies to Fulfill a Successful Research Journey

My learning about Indigenous knowledge and ways of knowing and the research methods that I crafted with the women were the result of bringing together the literature, teachings from relationships, and cherished conversations with all of the people that entered my life over the course of this doctoral journey. However, it was by being with the women numerous times in a variety of contexts and spaces – at the Aboriginal Centre, in their homes, at community meetings, when we travelled together to present at conferences – where we shared each other's knowledge and held each other as friends, confidants, extended family members, and experts in urban Aboriginal health from their Indigenous perspective that most informed my understanding of how to engage in Aboriginal research. As we walked the journey together, we discussed Indigenous and academic worldviews. I learned to see the world in other ways in which my one-eyed gaze shifted from a colonial Western view to a 'two-eyed seeing.' This enhanced and increased my sensitivity to who I was, how I talked to others, and how I represented Indigenous people while continually questioning the status quo of colonizing practices. My participation in this research enabled me to shift toward using my Indigenous voice in my personal and academic life. Two-eyed seeing signifies learning:

> to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western (or Eurocentric or mainstream) knowledges and ways of knowing … and to use both these eyes together, for the benefit of all. (Marshall & Bartlett, 2009, p. 9)

Within two-eyed seeing there is deepened understanding and wisdom of an integrated view by weaving back and forth between the two perspectives (Wiber & Kearney, 2006). Using this two-eyed view, I was easily able to remember each separate Talking Circle, the women who were there, and the expressions on their faces as they spoke. From the perspective of a wholistic Indigenous worldview that all things in life and on earth have significance, I used my own knowledge and intuition that developed as a result of my close relationship with the women to help me see their teachings and meanings within their stories. Using multiple ways of knowing in the consideration of the stories helped increase my sensitivity and awareness in unfolding the most significant insights. The Talking Circle certainly provided the space for each woman to share only what she wanted to share, without query, respecting the authenticity of her story.

In previous research I have used focus group discussions, open ended and semi-structured interviews and other qualitative data collection methods. However, in my previous research experiences none of these data gathering techniques have come close to unveiling the rawness of the life stories that were shared within our safe and sacred traditional Talking Circles. An important distinction I make here is that from the outset I knew once I settled on Talking Circles that I did not conceive of them as a data collection activity; but rather as means for the women to share their stories and to create a vision for health care reform. What caught me by surprise was the realization that engagement in Talking Circles was beneficial for healing, which I now regard as an important benefit of this methodological choice. I therefore recommend that researchers who use this method have an awareness of this important benefit, as it may cause them to position themselves differently as they commence their research journey. Using Talking Circles with Aboriginal people is the most respectful, culturally appropriate, supportive, and honorable way in which stories of the heart can be told and heard and for collective action for change to be shaped.

7.4 Boundaries and Limitations Uncovered During the Journey

As I thought about the imperative to identify limitations to one's study I regarded that being an insider was both an advantage as well as a limitation in this research. It was an advantage for reasons previously articulated. However, it can also be considered as a study limitation, because not all research can be conducted within the privilege of having insider status. Becoming or being an insider is difficult to replicate.

Further, a confounding factor of this study, which could be regarded as a study limitation, is that literature and academic protocols are often written in an unyieldingly colonial and patriarchal way that silences the voice of those who have been 'othered' by the dominant society. Research within academia is complicated by institutional limits, expectations, intent, and pushes for new knowledge, which are often for the benefit of the researcher or academy rather than the community or population that owns the knowledge, issue or vision. Undertaking research with an Aboriginal community requires the researcher to embrace fluidity throughout the research process. While within an ethics application one may specify that a 'data gathering session' will end within a specified period of time, in reality time constraints are not always crucial to those engaged in the research. In fact misunderstanding between academics and an Aboriginal person or community can occur if the researcher engages disrespectfully and rushes through meetings for the sake of keeping to allotted time frames; or if the researcher fails to provide space for all voices to be heard.

There are numerous Aboriginal protocols that although largely unfamiliar to the academic world, must be included in the research design, such as starting meetings and gatherings with a traditional prayer; and going clockwise around the room for each person to introduce themselves, sharing information about their Aboriginal heritage or geographical location, and anything else those present want to share about the day, their life, family, work, and political stance. These customary imperatives often take up to thirty minutes of meeting time and members of academe who are unfamiliar with Aboriginal ways of life may struggle with understanding and accepting these normative behaviours. In addition, the beginning and end of meetings often involve catching up with what is going on in our day to day lives, how family members are, and what community cultural ceremonies and events are upcoming, such as PowWow gatherings. Time must be allocated for these activities and yet within academe there is often little appreciation for their importance.

Interestingly the women who participated in the study expressed they were less than satisfied that constraints were imposed to sharing with others the knowledge that was generated through their participation in the research. They wanted to share their stories and collective vision at the end of the first Talking Circle and in as many places as possible, even ‘analysis’ was completed. Additionally, some women wanted their real names to be used in the study findings, to demonstrate that they stood by what they said. Although I explained the ethical process that was developed to protect them and the importance of undertaking meticulous doctoral work, this did not prevent them from asking every time they saw me when they could share their collective vision at conferences and at the university and be involved in other work that would benefit their community, through educating others about Aboriginal people and ongoing racist and discriminatory treatment. I found my explanations less than satisfactory and concurred that the research project was lengthy and was taking years to complete. However, once the Talking for Actions Strategies commenced the women began to see the wisdom of moving forward strategically. They continue to remain deeply committed to this initiative and their work is still unfolding. They believe that much more needs to be done and are standing strong on their commitment to be agents for change.

The language of academe is not always easily understood outside of academic circles. For the participants of this study the University required 'plain language statement' was less than plain and clearly was confronting to many of the women, despite having been written as simply and directly as possible, within the constraints imposed by the form. Additionally, having to sign a consent form was, for most women, imposing. These factors although not necessarily limitations to the study, are important points to consider, particularly if one is undertaking research with Indigenous people. Ethics committees must be sensitive to the many and varied nuances that are inherent in undertaking research with marginalized and disenfranchised groups, lest these groups of people be further, but unintentionally, victimized. It was my experience that in attempting to align a path that included multiple perspectives, I often felt I was an interpreter and a negotiator striving to provide a space for all voices to be heard. As I became more and more comfortable with my Aboriginality, I found myself resisting the academic push-pull and at times became so frustrated with linear research protocols that I thought it might be easier to give in. However, I held my ground and remained authentic to an Indigenous perspective to the best of my ability, while also maintaining academic integrity.

The ‘limitations’ from an academic perspective also include the reality that the findings from this study cannot be generalized to other urban Indigenous people. While the experiences the women described do resonate, they are only beginning to be told, heard, and cared about within dominant society. Because the women shared their subjective experiences, they are unique in this sense and only legitimately describe how these experiences affected their lives, health related decisions and recommendations they thought best for health care reform. What they shared however provided a relational background to their life experiences and provided teachings to help others understand how their history impacts the lives of Aboriginal people and how these experiences inform a collective vision.

Finally, a potential limitation of this study is that the reader may focus on the profound and negative stories the women shared without appreciating the intersectoral impacts of historical, societal and political forces that the women faced in their daily lives. As well, the reader may miss the positive and resilient aspects of the women’s lives, which for me took repeated listening to the audio-tapes and numerous readings of the transcribed stories to see past pain and abuse to the strength of the women. As discussed earlier in this thesis, institutions and systems change the relational links that situate cultural, social and historical discourses within life experiences in ways that subvert, resist, alter, ignore, or fail to acknowledge, in this case the links in life stories of urban Aboriginal people, when they seek health care services (Hardin, 2001; Hill & Kurtz, 2009; Kurtz, et al., 2008).

7.5 Vision for Change

This doctoral study is almost completed, yet I remain deeply involved with the women and other Aboriginal researchers, curriculum developers, educationalists and those responsible to recruit and retain Aboriginal nursing students. Together we continue the work of reshaping mainstream health care policy and practices through sharing our experiences and visions for individual and system wide change locally, nationally and internationally. It is our goal and intention that respectful and non-discriminatory health care will be provided for all Aboriginal women and their families.

The research clearly identifies the need for the provision of health care services that address not only diagnosable health concerns of Aboriginal people, but also the social, emotional, spiritual roots of poor health within the context of historical and contemporary socio-economic and political factors. This research clearly elucidates determinants of health for Aboriginal people, which include social exclusion because of physical appearance, gender and being ‘marked’ and how this contributes to less opportunities in all aspects of their lives – education, health, and human and Aboriginal rights.

As the women recommended, the adoption of cultural safety within health care systems is crucial. Education of health care providers, students, educators and policy makers is urgently needed to enable these providers to understand and consider Aboriginal life circumstances, and the distal roots of the determinants of health and wellness. Acknowledging the strengths and contribution of Aboriginal health care providers in the workforce is also critical as they, as insiders, can advocate for Aboriginal people while at the same time teach non-Aboriginal providers about Indigenous ways and history.

In providing the women’s perspectives and insights for improved health care delivery, the women were at the centre of the research and empowered to lead actions for change, rather than being left on the margins of the dominant Western society, voiceless and invisible. I trust that by sharing my research journey I have provided the reader with details about using a relational, reciprocal and reflexive approach to research. I trust that the reader was able to read the women's stories, without becoming defensive, ashamed, or guilt ridden. The stories are offered for learning and for us to move forward together. It is in the telling of my own story that I hope to initiate change in the academe and help those who continue to hold onto power bestowed from colonial positions to see differently. Thus, by sharing my unique journey, although it is neither replicable nor generalizable, I hope others can learn about the empowering gift of discovery in undertaking respectful, culturally safe Indigenous research. The insights gleaned from this study cannot easily be listed or shaped into a framework as Indigenous Methodologies are fluid and shaped by those involved in the process. I can however offer guidelines from the women and my own journey that are crucial in the success of the research with urban Aboriginal women and can help others who are considering decolonizing research methodologies:

- Work with an Aboriginal community member or Elder, who is known and respected within the community, who can introduce the researcher to the community, and more importantly, be a mentor and guide the research journey to ensure protocols are respected and followed;
- Start conversations and relationships (preferably face to face) with Aboriginal people long before the research begins to ensure the community identifies the research that would best benefit them, formulates the research questions, are inclusive to all aspects of the

research process including analysis and dissemination of the information gathered;

- Ensure that inclusiveness of Aboriginal people includes active involvement on the research team. ‘Book learning’ about research with Aboriginal people is not enough;
- Inclusion of Aboriginal people in all levels of the research process and policy development requires the researcher to be aware of and utilize research methodologies and methods that are acceptable and appropriate to Aboriginal peoples and communities with whom they are working;
- Gain knowledge and understanding of historical colonization and a critical awareness and ability to identify ongoing contemporary colonial practices within the health care system and society as a whole that impact on Aboriginal people and marginalized populations;
- Realize that our own actions may purposefully or unintentionally perpetuate racist and discriminatory practices that marginalize and place people as ‘other’;
- Advocate for Aboriginal people to be part of the whole within health, education, policy, decision making and delivery;
- As researchers, be humble, be willing to learn, be patient doing research ‘with’ rather than ‘on’ Aboriginal people, they are the experts;
- Follow national and Indigenous research ethics protocols. In Canada this includes the Canadian Institutes of Health Research Guidelines

  for Health Research Involving Aboriginal people and the First Nations Ownership, Control, Access and Possession;

- Follow the guidelines of Aboriginal research scholars, in particular, the 4Rs of *respect, relevance, reciprocity,* and *responsibility* in all your relations to frame the research and education;
- Realize embracing cultural safety is a learned way of being and acting with all people and in all areas of life, not just professional health care practice.

In summary, the findings of this study have implications for front line health care workers, health care professionals, educators, clinical practice, research, and public policy. This study created a link that connected Western and Indigenous philosophy, knowledge, ways of knowing and doing research. It also illuminates links between urban Aboriginal women's experiences and health care practices. My journey continues and I am committed to the reality that research in Aboriginal Circles does have a goal, but not a finish. There is a process between the beginning and the end of any research project in which "the final product is always secondary to the community benefiting from the process, and in order for the process to happen, the researchers must locate themselves (Absolson and Willett, 2005, p. 107).

Cajete (2000), a Pueblo Indian from New Mexico, eloquently captured the meaning of my journey. He explains there is a shared understanding among many Indigenous people that education is about helping an individual find his or her *face*; which means finding out who you are, where you come from, and your unique character. He suggests that education should help the individual find their *heart* – the passionate sense of self that motivates the individual and moves him/her along in life. Education should also help the individual find a foundation on which he/she may most completely develop and express both their heart and face. This foundation is their vocation, the work that they do, whether as an artist, lawyer, or teacher with the intent of finding that special kind of work that most fully allows one to express their true self, "Your heart and your face" (Cajete, 2000, p. 183).

During my journey, I learned about Indigenous ways of being, epistemology and research, however, by far one of the most significant findings was my Aboriginal face and heart which gave me the strength, courage and resilience to stir my spirit and motivate me personally and professionally. I now know and understand better where I came from, where I am, and where I am going. I feel embraced within a complex web of relationships that connect me to my ancestors, relations, all people, the earth, universe, and beyond. Shawn Wilson (2008) stated, "if research doesn't change you as a person, then you haven't done it right" p. 135). I found:

Engaging in Indigenous research,
not only changes who you are, it enriches one's life,
builds life-long respectful relationships with Indigenous peoples,
shifts the gaze, from a colonial view to a place of opportunities,
in which to work harmoniously within
the borderlands of Western and Indigenous worldviews,
and inspires one to commit to ensuring Aboriginal Circles continue.

(Kurtz, 2011)

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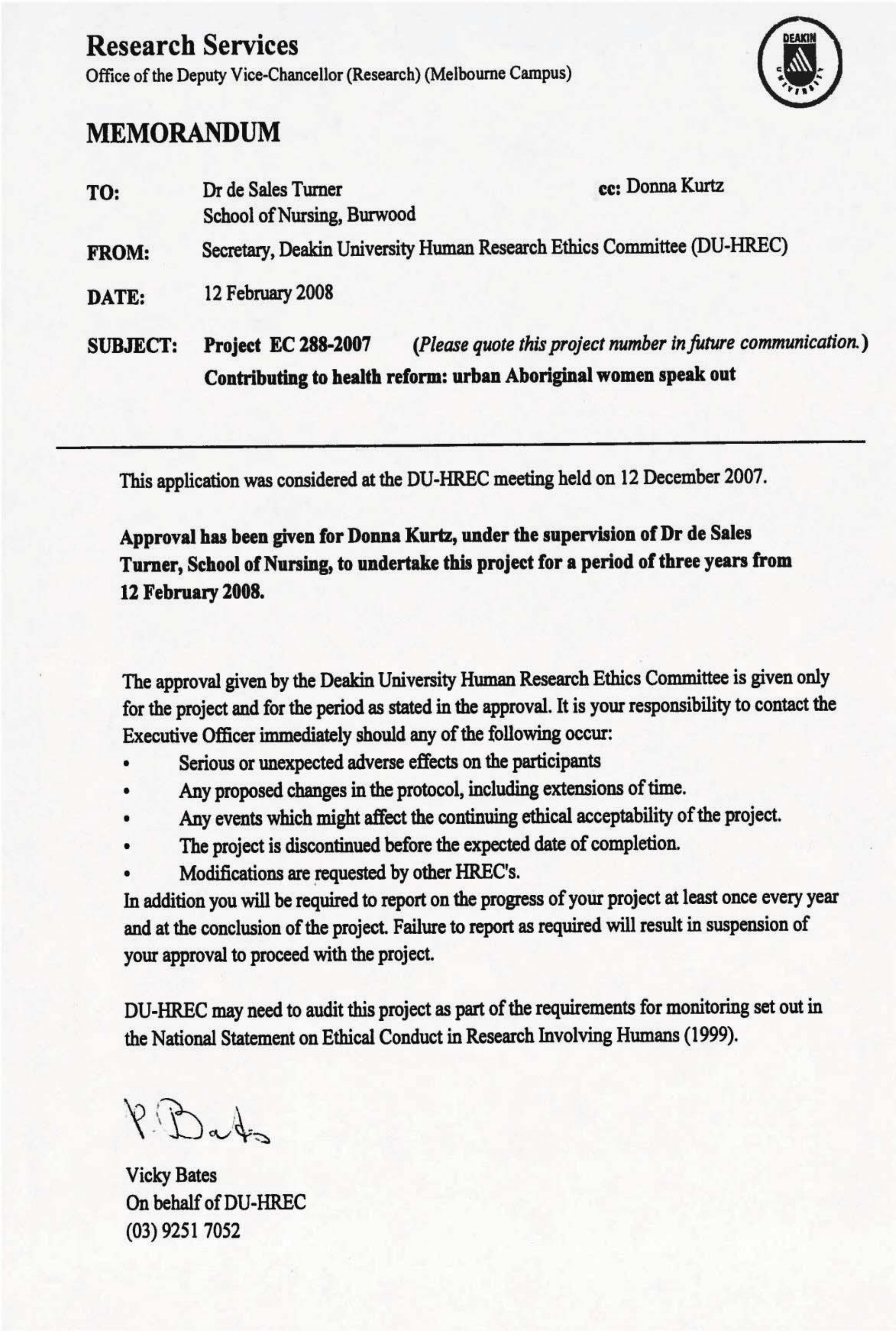
APPENDIX A: Ethics Approval



Research Services
Office of the Deputy Vice-Chancellor (Research) (Melbourne Campus)

MEMORANDUM

TO: Dr de Sales Turner
School of Nursing, Burwood
cc: Donna Kurtz

FROM: Secretary, Deakin University Human Research Ethics Committee (DU-HREC)

DATE: 12 February 2008

SUBJECT: **Project EC 288-2007** *(Please quote this project number in future communication.)*
Contributing to health reform: urban Aboriginal women speak out

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This application was considered at the DU-HREC meeting held on 12 December 2007.

Approval has been given for Donna Kurtz, under the supervision of Dr de Sales Turner, School of Nursing, to undertake this project for a period of three years from 12 February 2008.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Executive Officer immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HREC's.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DU-HREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Research Involving Humans (1999).

V. Bates

Vicky Bates
On behalf of DU-HREC
(03) 9251 7052

APPENDIX B: Invitation to Participate

You are invited to join a research project, involving talking circles, to share your unique ideas about your experiences of health care as well as your visions for health care reform and to identify strategies that could be used by health care providers to promote respectful, considered, non-racist, non-discriminatory care to Aboriginal people in the future.

In addition, this project will establish a collaborative interdisciplinary and partnership with the community, health and education agencies to support recruitment and support of nursing students, the retention of Aboriginal nurses and education (professional development) of non-Aboriginal nurses who work with Aboriginal people.

If you are interested in joining this project please read the enclosed information about the study that includes a consent form. If you are interested please do not hesitate to contact Donna Kurtz for further information.

Regards,

Donna Kurtz RN MN
Associate Professor
University of British Columbia Okanagan
School of Nursing
3333 University Way, Kelowna BC V1V 1V7
(Phone) 250-807-9627
email – donna.kurtz@ubc.ca

APPENDIX C: Consent Forms

DEAKIN UNIVERSITY PLAIN LANGUAGE STATEMENT AND CONSENT FORM

Full Project Title: Contributing to health reform: Urban Aboriginal women speak out

Principal Researcher: Dr. de Sales Turner

Student Researcher: Donna L. M. Kurtz

Associate Researcher(s): Professor Emeritus Helen Cox; Associate Professor Kristine Martin-McDonald

This Plain Language Statement and Consent Form is 8 pages long. Please make sure you have all the pages.

Your Consent

You are invited to take part in this research project - Contributing to health reform: Urban Aboriginal women speak out.

This Plain Language Statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Plain Language Statement carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Plain Language Statement and Consent Form to keep as a record.

Purpose and Background

The purpose of this project is to provide a safe forum for you to contribute your unique ideas about your experiences of health care, as well as your visions for health care reform and these are the main aims of this research. If you are interested in being involved in this research I invite you to join talking circles, to identify strategies that could be used by health care providers to promote respectful, considered, non-racist, non-discriminatory care to Aboriginal people in the future.

In Canada, we already know that there are major inequities in health between Aboriginal and non-Aboriginal people. Aboriginal people die sooner and have greater burden of physical and mental disease (Dion Stout, Kipling, & Stout, 2001; Dion Stout & Downey, 2006; Wardman, Clement, Quarts, 2005). Inequities also exist *within* the Canadian Aboriginal population; off –reserve Aboriginal people have lower-economic status and higher rates of smoking, diabetes, arthritis, high blood pressure, and obesity, as compared to those who live on-reserve (Statistics Canada, 2006, Tjipkema, 2003; Young, 2003). Several health programs and initiatives therefore fail to deal with the root causes and structural issues causing socioeconomic and health care gaps among the Aboriginal population (Health Canada, 2007; Kurtz, Nyberg, Van Den Tillaart, Mills and the Okanagan Urban Aboriginal Health Research Collective, in press).

The results of this research may be used to help the researcher, Donna Kurtz, to obtain a Doctor of Philosophy in Nursing.

Funding This research is not being funded.

Procedures

As participants to a former research project that explored *Barriers to Health and Social Services Research,* you are invited to come to the First Nations Friendship Centre for the purpose of being involved in Stage 1 and possibly Stage 2 of a new project. For Stage 1, of the project, you are invited to participate in a talking circle that will be formed to continue the dialogue about your health care experiences and identify strategies that you believe could be used by health care providers to promote respectful, non-racist, non-discriminatory care. Prior to engaging in the talking circle you will be asked to sign a consent form which will be supplied to you on the day.

At the conclusion of this talking circle if you agree to participate I will ask you to assist in the recruitment of other participants to form a second talking circle, using what I call a snow ball technique as the means of recruitment. What I mean by this is that you will be asked to invite, through word of mouth, 3 to 5 people whom you feel could contribute to our dialogue, thereby expanding the circle of participants who develop a collective vision for health care reform. The group of people whom you could consider inviting could include for example, community Aboriginal elders, Aboriginal registered nurses, Registered nurses who work with Aboriginal people, nurse educators, or other registered nurses whom you may know and with whom you want to share your stories and vision for better health care. Once you find individuals who would like to be involved, please ask them to contact me on the telephone number provided at this end of this document, so that I can formalize the invitation to join this research. Please note that when you extend this invitation I ask you not to use coercion, as I am only interested in working with people who genuinely want to be involved in this research.

At the conclusion of the talking circles you may wish to discontinue from further participation in this project, or alternately you may wish to nominate to be involved in Stage 2 of the project, as a steering group member, which will be shortly explained.

All talking circles will be held at the First Nations Friendship Centre in Vernon British Columbia, to provide a space that is culturally comfortable, safe, convenient, private and centralized in the community for easy access for you to attend. As the researcher I will audiotape all discussions and take field notes during all data gathering episodes. Afterwards, dialogue from the transcribed talking circles will be analysed for storylines and perspectives and a summary of the findings that emerge will be mailed to all participants for your consideration. The time involved for each talking circle will be determined by the participants, and hence they will continue until the participants have determined that they are satisfied they have completed telling their story. This approach of honouring traditional storytelling will include consideration of time constraints for child care and transportation arrangements and these will be established from the outset.

For Stage 2 of the project, should you nominate to become one of approximately 12 steering committee members, you will again be asked to use a snowball technique to invite to a talking circle social workers, medical doctors, health professional educators, policy makers and others whom you identify as important for sharing your stories and visions for improvement in health care. Those who accept the invitation to participate will be invited to join with you to form a talking circle for the purpose of engaging in in-depth dialogue and to learn about your collective vision(s) for improving Aboriginal health care. For individuals whom you find who are interested in being involved, please ask them to contact me on the telephone number provided at this end of this document, so that I can formalize the invitation to join this research.

Possible Benefits

It is possible that you may find your involvement is this research is invigorating, in that it enables you to raise issues related to your health care experiences that are important to you. Hence, although I cannot guarantee or promise that you will receive any direct benefits from your participation in this research; your involvement may contribute to you having an active voice in identifying your concerns and possibly contributing to health care reform. Research demonstrates that when Aboriginal women are involved in their health care, they can make significant contributions to opening the dialogue for changes to occur in the health care system. Thus, this research has the potential to reshape health care practices, which is arguably vital for your health.

Possible Risks

During this research you will be asked to reflect on your health care experiences, some of which may not have been very pleasant for you. It is possible that while you are telling your story you may become temporarily distressed. Should you become distressed at any point, I will ask the group to turn off the audio-tape recorder and a trained and experienced stress counsellor, who will be part of the talking circle, will leave the room with you to support you and help you to identify the nature of your distress. If you and the counsellor identity that you will benefit from receiving ongoing support, the counsellor will refer you to the First Nation Friendship Centre for the purpose of obtaining on-going professional counsellor support at no cost to you. At this point you may choose to either continue with the research, or you may wish to withdraw from that day and/or from the research entirely. Should you choose to withdraw from the study I will fully respect this decision and an assurance is given that your future health care services will not be compromised

While I have taken these measures to support you during this research, please be aware that throughout all talking circles all participants will be encouraged to share only those details about their health care experiences and visions for health care reform as they feel comfortable and safe in sharing, and this point will be reinforced at the beginning of each group meeting.

Finally, please note that your involvement in this research will in no way prejudice the health care services that are provided to you.

Privacy, Confidentiality and Disclosure of Information

If you decide to participate in this research, measures will be taken to ensure that your privacy and confidentiality are maintained at all times. Privacy will be maintained by keeping the group composition known only to the group. You will be assigned a pseudonym (fake name) so that when the information from the research is put together, your identity will not be revealed. Audio tapes, transcripts, CDs, and equipment will be stored securely in a locked cabinet in my office, to which only I have access, at University of British Columbia Okanagan while it not is use.

Any information obtained in connection with this project and that can identify you will remain confidential. It will only be disclosed with your permission, subject to legal requirements.

Please note that the information you provide for this study will be transferred to Deakin University upon successful completion of the study, where it will be stored as per University procedure for a period of six years. After this time, the information will be destroyed as per the specified University procedure.

Your name will not be used in any written documentation or published work. While you are free to disclose to anyone whom you choose that you were involved in this study, as a condition of your participation you are asked to respect the confidentiality of members of the group and not to reveal what you or others said during the talking circles. Without breaking confidentiality, all participants will have the right to share unidentifiable information of the study findings in appropriate educational forums. Participants wanting to access to this information are asked to discuss their requirements with me.

Results of Project

To enable what was learned to be shared with others, a summary of the study findings will be mailed to all participants; the community including Aboriginal and non-Aboriginal health care and social service organizations and agencies; and for wider dissemination through community forums, conferences and professional and community journals. If you give me your permission by signing the Consent Form, please note that I will publish the study findings in the form of my doctoral thesis. Additionally, I plan to share and discuss the study findings in publications such as Journal of Aboriginal Health, Canadian Nurse, Canadian Journal of Native Education and in professional conferences such as the regional Conference on Aboriginal Health.

Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. However if you do withdraw, please note that your contribution will still form part of the group’s information. Your voice may be reported, using a pseudonym, just as it may be for other participants.

If you withdraw, your contribution remains with the group, and it will be the group's decision about what might be included in the final report. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with the University of British Columbia, or the First Nations Friendship Centre.

Before you make your decision to be involved I will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.

If you decide to withdraw from this project, please notify me or complete and return the Revocation of Consent Form attached.

Ethical Guidelines

This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans* (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethics aspects of this research project have been approved by the Human Research Ethics Committee of Deakin University.

Complaints

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

Ms Silvia Rametta, Executive Officer, Human Research Ethics, Deakin University, 221 Burwood Highway, Burwood Victoria Australia 3125, Telephone: 92517123, Facsimile: 9244 6581.

Please quote project number EC *288* -2007.

9.1 Reimbursement for your costs

You will not be paid for your participation in this project. However, I am pleased to advise that on the day(s) or your participation refreshments will be provided.

Further Information, Queries or Any Problems

If you require further information, wish to withdraw your participation or if you have any problems concerning this project (for example, any side effects), you can contact me or my supervisors. The researchers responsible for this project are:

Researcher's name

Donna Kurtz
University of British Columbia
School of Nursing
3333 University Way
Kelowna, British Columbia V1V 1V7
250-807-9627
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krismm@deakin.edu.au

DEAKIN UNIVERSITY PLAIN LANGUAGE STATEMENT AND CONSENT FORM

Full Project Title: Contributing to health reform: Urban Aboriginal women speak out

I have read and I understand the Plain Language Statement

I freely agree to participate in this project according to the conditions in the Plain Language Statement.

I have been given a copy of the Plain Language Statement and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details, including where information about this project is published, or presented in any public form.

Participant's Name (printed)

Signature …………………………………… Date …………………………

Please mail this form in the attached pre-stamped addressed envelope to:

Donna Kurtz
University of British Columbia Okanagan
School of Nursing
3333 University Way
Kelowna, British Columbia V1V 1V7
(P) 250-807-9627
donna.kurtz@ubc.ca

Or hand deliver in the attached envelope to:

Donna Kurtz

c/o First Nations Friendship Centre

2904 29th Avenue

Vernon British Columbia V1T 1Y7

DEAKIN UNIVERSITY PLAIN LANGUAGE STATEMENT REVOCATION OF CONSENT FORM

Full Project Title: Contributing to health reform: Urban Aboriginal women speak out

I hereby wish to WITHDRAW my consent to participate in the above research project and understand that such withdrawal WILL NOT jeopardize my relationship with Deakin University, First Nations Friendship Centre, or University of British Columbia Okanagan

Participant's Name (printed)

Signature Date

Please mail this form in the attached pre-stamped addressed envelope to:

Donna Kurtz
University of British Columbia Okanagan
School of Nursing
3333 University Way
Kelowna, British Columbia V1V 1V7
(P) 250-807-9627
donna.kurtz@ubc.ca

Or hand deliver in the attached envelope to:

Donna Kurtz
c/o First Nations Friendship Centre
2904 29th Avenue
Vernon British Columbia V1T 1Y7

DEAKIN UNIVERSITY PLAIN LANGUAGE STATEMENT AND CONSENT FORM FOR ADDITIONAL PARTICIPANTS TO THE RESEARCH

Full Project Title: Contributing to health reform: Urban Aboriginal women speak out
Principal Researcher: Dr. de Sales Turner
Student Researcher: Donna L. M. Kurtz
Associate Researcher(s): Professor Emeritus Helen Cox; Associate Professor Kristine Martin-McDonald

This Plain Language Statement and Consent Form is 7 pages long. Please make sure you have all the pages.

1. Your Consent

You are invited to take part in this research project - Contributing to health reform: Urban Aboriginal women speak out.

This Plain Language Statement contains detailed information about the research project. Its purpose is to explain to you as openly and clearly as possible all the procedures involved in this project before you decide whether or not to take part in it.

Please read this Plain Language Statement carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the project with a relative or friend or your local health worker. Feel free to do this.

Once you understand what the project is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research project.

You will be given a copy of the Plain Language Statement and Consent Form to keep as a record.

2. Purpose and Background

The purpose of this project is to provide a safe forum for you to contribute your unique ideas about your experiences of health care, as well as your visions for health care reform and these are the main aims of this research. If you are interested in being involved in this research I invite you to join in talking circles, to identify strategies that could be used by health care providers to promote respectful, considered, non-racist, non-discriminatory care to Aboriginal people in the future.

In Canada, we already know that there are major inequities in health between Aboriginal and non-Aboriginal people. Aboriginal people die sooner and have greater burden of physical and mental disease (Dion Stout, Kipling, & Stout, 2001; Dion Stout & Downey, 2006; Wardman, Clement, Quarts, 2005). Inequities also exist *within* the Canadian Aboriginal population; off – reserve Aboriginal people have lower-economic status and higher rates of smoking, diabetes, arthritis, high blood pressure, and obesity, as compared to those who live on-reserve (Statistics Canada, 2006, Tjipkema, 2003; Young, 2003). Several health programs and initiatives therefore fail to deal with the root causes and structural issues causing socioeconomic and health care gaps among the Aboriginal population (Health Canada, 2007; Kurtz, Nyberg, Van Den Tillaart, Mills and the Okanagan Urban Aboriginal Health Research Collective, in press).

The results of this research may be used to help the researcher, Donna Kurtz, to obtain a Doctor of Philosophy in Nursing.

3. Funding

This research is not being funded.

4. Procedures

You are invited to come to the First Nations Friendship Centre for the purpose of being involved in Stage 1 and possibly Stage 2 of a new research project. As you have expressed interest in being involved, for **Stage 1** you are invited to participate in a talking circle that will be formed to explore your health care experiences and identify strategies that you believe could be used by health care providers to promote respectful, non-racist, non-discriminatory care. Prior to engaging in the talking circle you will be asked to sign a consent form which will be supplied to you on the day.

The talking circles will be held at the First Nations Friendship Centre in Vernon British Columbia, to provide a space that is culturally comfortable, safe, convenient, private and centralized in the community for easy access for you to attend. As the researcher I will audiotape all discussions and take field notes during all data gathering episodes. Afterwards, dialogue from the transcribed talking circles will be analysed for storylines and perspectives and a summary of the findings that emerge will be mailed to all participants for your consideration. The time involved for each talking circle will be determined by the participants, and hence they will continue until the participants have determined that they are satisfied they have completed telling their story. This approach of honouring traditional storytelling will include consideration of time constraints for child care and transportation arrangements and these will be established from the outset.

At the conclusion of this talking circle you may wish to discontinue from further participation in this project, or alternately you may wish to nominate to be involved in Stage 2 of the project, as a steering group member, which is now explained.

For **Stage 2** of the project, if you accept a nomination to be a steering committee member, you will be asked to use a snowball technique to invite to a talking circle social workers, medical doctors, health professional educators, policy makers and others whom you identify as important for sharing your stories and visions for improvements in health care. Those who accept the invitation to participate will be invited to engage in in-depth dialogue with the steering committee and to learn about their collective vision(s) for improving Aboriginal health care. For individuals whom you find who are interested in being involved, please ask them to contact me on the telephone number provided at this end of this document, so that I can formalize the invitation to join this research.

5. Possible Benefits

It is possible that you may find your involvement is this research is invigorating, in that it enables you to raise issues related to your health care experiences that are important to you. Hence, although I cannot guarantee or promise that you will receive any direct benefits from your participation in this research; your involvement may contribute to you having an active voice in identifying your concerns and possibly contributing to health care reform. Research demonstrates that when Aboriginal women are involved in their health care, they can make significant contributions to opening the dialogue for changes to occur in the health care system. Thus, this research has the potential to reshape health care practices, which is arguably vital for your health.

5.1 Possible Risks

During this research you will be asked to reflect on your health care experiences, some of which may not have been very pleasant for you. It is possible that while you are telling your story you may become temporarily distressed. Should you become distressed at any point, I will ask the group to turn off the audio-tape recorder and a trained and experienced stress counsellor, who will be part of the talking circle, will leave the room with you to support you and help you to identify the nature of your distress. If you and the counsellor identity that you will benefit from receiving ongoing support, the counsellor will refer you to the First Nations Friendship Centre for the purpose of obtaining on-going professional counsellor support at no cost to you. At this point you may choose to either continue with the research, or you may wish to withdraw from that day and/or from the research entirely. Should you choose to withdraw from the study I will fully respect this decision and an assurance is given that your future health care services will not be compromised

While I have taken these measures to support you during this research, please be aware that throughout all talking circles all participants will be encouraged to share only those details about their health care experiences and visions for health care reform as they feel comfortable and safe in sharing, and this point will be reinforced at the beginning of each group meeting.

Finally, please note that your involvement in this research will in no way prejudice the health care services that are provided to you.

6. Privacy, Confidentiality and Disclosure of Information

If you decide to participate in this research, measures will be taken to ensure that your privacy and confidentiality are maintained at all times. Privacy will be maintained by keeping the group composition known only to the group. You will be assigned a pseudonym (fake name) so that when the information from the research is put together, your identity will not be revealed. Audio tapes, transcripts, CDs, and equipment will be stored securely in a locked cabinet in my office, to which only I have access, at University of British Columbia Okanagan while it not is use.

Any information obtained in connection with this project and that can identify you will remain confidential. It will only be disclosed with your permission, subject to legal requirements.
Please note that the information you provide for this study will be transferred to Deakin University upon successful completion of the study, where it will be stored as per University procedure for a period of six years. After this time, the information will be destroyed as per the specified University procedure.

Your name will not be used in any written documentation or published work. While you are free to disclose to anyone whom you choose that you were involved in this study, as a condition of your participation you are asked to respect the confidentiality of members of the group and not to reveal what you or others said during the talking circles. Without breaking confidentiality, all participants will have the right to share unidentifiable information of the study findings in appropriate educational forums. Participants wanting access to this information are asked to discuss their requirements with me.

6.1 Results of Project

To enable what was learned to be shared with others, a summary of the study findings will be mailed to all participants; the community including Aboriginal and non-Aboriginal health care and social service organizations and agencies; and for wider dissemination through community forums, conferences and professional and community journals. If you give me your permission by signing the Consent Form, please note that I will publish the study findings in the form of my doctoral thesis. Additionally, I plan to share and discuss the study findings in publications such as the Journal of Aboriginal Health, Canadian Nurse, the Canadian Journal of Native Education and in professional conferences such as the regional Conference on Aboriginal Health.

7. Participation is Voluntary

Participation in any research project is voluntary. If you do not wish to take part you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. However if you do withdraw, please note that your contribution will still form part of the group’s information. Your voice may be reported, using a pseudonym, just as it may be for other participants. If you withdraw, your contribution remains with the group, and it will be the group’s decision about what might be included in the final report. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with the University of British Columbia, or the First Nations Friendship Centre.

Before you make your decision to be involved I will be available to answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had a chance to ask your questions and have received satisfactory answers.
If you decide to withdraw from this project, please notify me or complete and return the Revocation of Consent Form attached.

8. Ethical Guidelines

This project will be carried out according to the *National Statement on Ethical Conduct in Research Involving Humans* (June 1999) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

The ethics aspects of this research project have been approved by the Human Research Ethics Committee of Deakin University.

9. Complaints

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

Ms Silvia Rametta, Executive Officer, Human Research Ethics, Deakin University, 221 Burwood Highway, Burwood Victoria Australia 3125, Telephone: 92517123, Facsimile: 9244 6581.
Please quote project number EC 288- 2007.

9.1 Reimbursement for your costs

You will not be paid for your participation in this project. However, I am pleased to advise that on the day(s) or your participation refreshments will be provided.

10. Further Information, Queries or Any Problems

If you require further information, wish to withdraw your participation or if you have any problems concerning this project (for example, any side effects), you can contact me or my supervisors. The researchers responsible for this project are:

Researcher's name

Donna Kurtz
University of British Columbia
School of Nursing
3333 University Way
Kelowna, British Columbia V1V 1V7
250-807-9627
donna.kurtz@ubc.ca

Supervisors' names

Dr de Sales Turner
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School of Nursing
Burwood, Victoria, Australia
desales.turner@deakin.edu.au

Professor Helen Cox
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helencox@deakin.edu.au

Associate Professor Kristine Martin-McDonald
Deakin University
School of Nursing
Geelong, Victoria, Australia
krismm@deakin.edu.au

DEAKIN UNIVERSITY PLAIN LANGUGE STATEMENT AND CONSENT FORM

Full Project Title: Contributing to health reform: Urban Aboriginal women speak out

I have read and I understand the Plain Language Statement version

I freely agree to participate in this project according to the conditions in the Plain Language Statement.

I have been given a copy of the Plain Language Statement and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details, including where information about this project is published, or presented in any public form.

Participant's Name (printed)
Signature Date

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Full Project Title: Contributing to health reform: Urban Aboriginal women speak out

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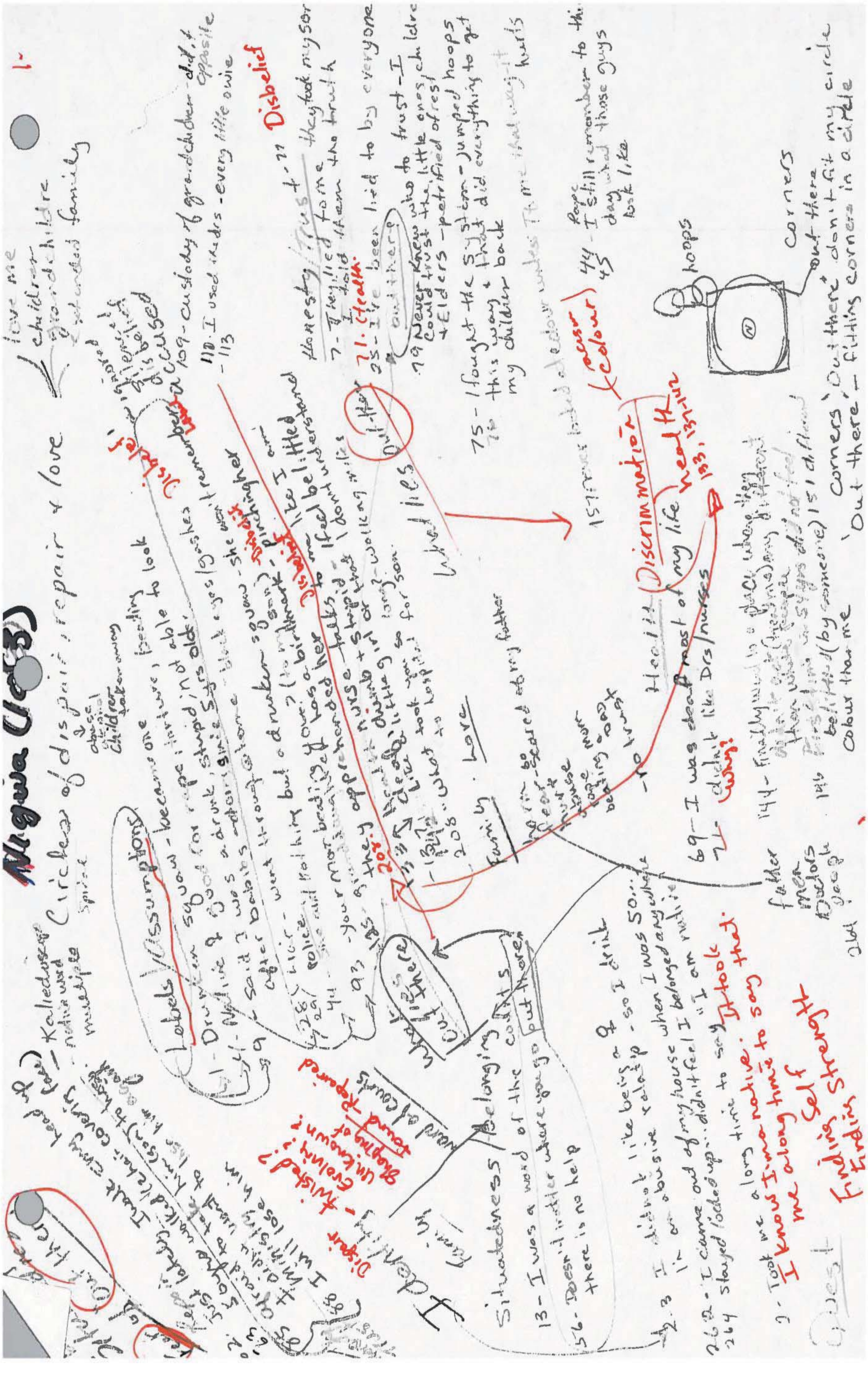
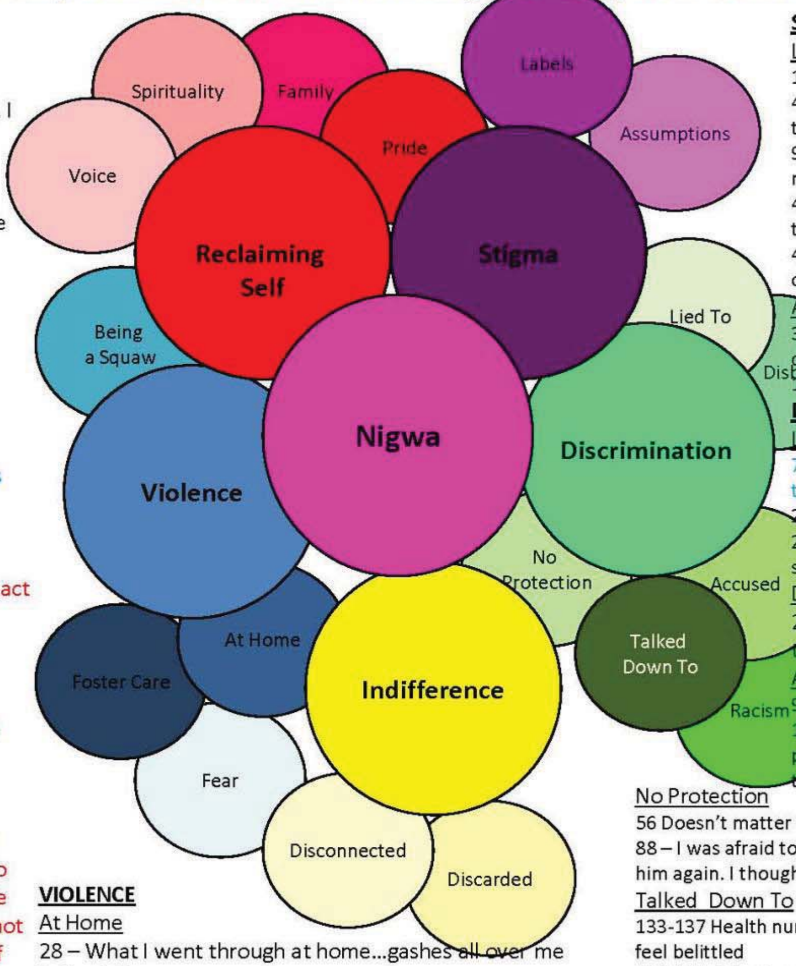
APPENDIX D: Scribble Work



APPENDIX E: Mind Map Story Image

Nigwa

In Society, Violence, Indifference, Reclaiming Self (5/18) Draft 3 June 15, 2009



INDIFFERENCE

Discarded

13 – I was a ward of the courts (in foster care). I did not like being a woman. In an abusive relationship so I dr(a)nk

63 -I walked like this (hair covering face) 50.

452- I was in that other room all my life (where the dumb kids went)

Disconnected

262-264 I came out of my house when I was 50…stayed locked up…didn't feel I belonged anywhere.

RECLAIMING SELF

Pride

2- took me a long time to say "I am native"

62- Just lately I walk with my head up…fifty yrs

262-264 I came out of my house when I was 50…stayed locked up…didn't feel I belonged anywhere.

146 I finally went to a place where they didn't act different…first time I didn't feel belittled or discriminated in 54 yrs. (hearing aide)

401 – I quite drinking. Quit doing drugs

Spirituality

401–There must be a higher power out- there somewhere …cause everything I've gone through…anyone else would have died.

Voice

109 –I was afraid of doctors…did it opposite. I used doctors every time something happens to my granddaughters…to record every little owie they have. I started using them (to show was not abusing the children) instead of being afraid of them.

Family

342-Closest thing to my heart is my family, not just my blood family

355 – they taught me how to love ***me***

VIOLENCE

At Home

28 – What I went through at home…gashes all over me

Being A Squaw

44 – Cops - "she ain't nothing but a drunken squaw …won't remember (being raped)"

Foster Care

33-I ran away from foster care, the father was the same way (sexual abuse)

Fear - 79 Never knew who to trust. I could trust the little ones, children Elders, - petrified by the rest

STIGMA

Labels

1 – called a drunken squaw so I became one

4 – Native women only good to be raped, tortured beat

9 Said I was a drunk, stupid, not able to look after my babies.Been doing that since I was 5

444– I wanted to be a teacher…tired of ..told not to learn

449 - My younger siblings ended up in the stupid class..sent to the other room

Assumptions

332 so many times (drs, nurses) asked me if I was drunk…if I do drugs.

142 like a little girl or that I don't understand

DISCRIMINATION

Lied to

7 They lied to me. They took my son I told them the truth.

25 I have been lied to by everyone out-there

28 told me they weren't going to let my parents see me (in juvie)

Disbelief

28 Called me a liar for saying what I went through at home

Accused

93–They asked my son "Your mom beating you?"

125–granddaughter's birthmark – said I was pinching her; they apprehended her; she still has that birth mark

No Protection

56 Doesn't matter where you go out-there, there is no help

88 – I was afraid to take my son) to the hospital I didn't want to lose him again. I thought I will lose him

Talked Down To

133-137 Health nurse talks to me like I am deaf, dumb, & stupid. I feel belittled

208 "What took you so long?" to visit my son in the hospital walked miles to get there

Racism

319 – if my son was white he would have got help (sooner in the hospital)

331- I hope in the future…doctors, nurses will look at you for the (health) problem, not the colour of your skin.

405-How did they come up that we're not human, we're not smart, we're dumb by the colour of skin?