

ABORIGINAL WOMEN: PROMOTING SELF, FAMILY  
AND COMMUNITY HEALTH

BY  
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A Thesis  
Submitted to the Faculty of Graduate Studies  
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**Aboriginal Women: Promoting Self, Family and Community Health**

**BY**

**Debbie Viel**

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of  
Manitoba in partial fulfillment of the requirement of the degree  
Of  
Master of Nursing**

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## Abstract

This study tells the stories of 16 Aboriginal women of how they promote their health, as well as the health of their families and communities. There is a focus on the definition of health using a medicine wheel depiction and the determinants of health that are currently recognized by Health Canada. Four additional determinants were identified by the women in this study and a discussion regarding each is included.

This study was viewed through a feminist lens. The qualitative method used was women-centred interviewing of a convenience sample of 16 Aboriginal women residing in rural Manitoba. Content analysis of the verbatim transcripts revealed the following themes and sub-themes: *health defined* – lifestyle choices; physical, emotional, intellectual and spiritual health; healthy self; *I need to be me – the importance of self care* – promoting my health; having faith; hopes and dreams; *barriers to being healthy* – shame; racism; addiction; domestic violence; abuse; teenage pregnancy; poverty; *promoting health in my family* – healthy family; taking care of my children; perceived social supports; and *promoting health in my community, it takes a community to raise a child* – healthy community; strong leadership; employment, housing, education and safety; and lack of available services. The categories are identified in Health Canada's determinants of health with the exception of: faith, social equality, healthy partner relationships and strong community leadership.

Implications for nursing education and practice, policy and research are discussed. There are 10 recommendations for future consideration.

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And finally to the 16 women who participated in this study, thank you for sharing your hardships and your happiness and I wish you all health.

*Dedicated to all the grannies, Past, Present and Future who believed they could  
make a difference!*

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## Chapter One: Introduction

### *Statement of the Problem*

First Nations people are one of the unhealthiest populations in Canada. From illness to political unrest, First Nations people are portrayed negatively in the media. Diabetes, addiction, suicide, heart disease and poverty are words that appear in the literature when discussing this aggregate (Dion-Stout, 1996; Kue Young, 2003; Martens, 2002; Strickland, 1999; Tookenay, 1996).

Being of Aboriginal descent, it is difficult to sit by and be portrayed in this light. Growing up, the thought of being Aboriginal was shameful and damaging to my self-esteem. As an adult, and as a Registered Nurse, I work with First Nations people and I have become proud of my heritage. I have never experienced the strong sense of “community” I observe in my work. Everyone knows their neighbour and helping hands are there when needed. Elders are respected for their wisdom and sought out for advice. An Aboriginal woman living in her community may be considered an auntie, a sister, or a granny, without ever bearing a child or having an immediate family connection (Anderson, 2001). Families are extended to include the community at large. This is different from many non-Aboriginal communities as often people do not know their neighbour and, if they do, they are often not considered immediate family. In a recent conversation with an Elder from Sagkeeng First Nation, she spoke about First Nations communities and the closeness of all people within the community. She told me of a family from a northern fly-in community and their experience when a family member became ill. Parents, children, siblings, nieces, nephews, cousins and neighbours were

present at the hospital with their loved one “around the clock” (G. Starr, personal communication, November, 2003).

Many stories depict First Nations people in a negative light. For young people, being portrayed negatively in the media as an “at risk” population for a vast array of illnesses has severe ramifications to the health of individuals and communities. When you are stereotyped as being ill and being at risk repetitively in the media, the stereotypes are harmful to an individual’s mental health (Kirmayer, Simpson, & Cargo, 2003). Many communities are feeling the crunch of cutbacks and are forced to compete for scarce resources and are required to justify needs. Scarce resources result in what has been described as “competitive victimhood” (Allen, 1997, p. 237). Every community needs to present their reason for requiring program dollars from government organizations and this often results in the exploitation of community members by focusing on opportunities for improvement rather than community strengths. The need to compete for scarce resources, combined with the negative stereotypes portrayed by the media of First Nations people, can be damaging to the self esteem of many First Nations people.

In this thesis, I synthesize the literature to define the determinants of health as outlined by Health Canada (2003) and I discuss the impact history has played in relation to these determinants. The impact of colonization, the implementation of the Indian Act in 1876, the creation of residential schools, the amendments to the Indian Act with Bill C-31 in 1985 (Congress of Aboriginal People, 1998) have effected the health of First Nations people. When completing the literature review it became clear that there are limited research studies that focus on the strengths of Aboriginal people. This study, for

that reason, is very timely and is important given its focus on the strengths of Aboriginal women.

The stories of 16 Aboriginal women are presented and outline how they promote health for themselves and within their families and their communities. Essential to the question of how Aboriginal women promote health is the need to understand how health is defined by this aggregate. I explore the barriers to promoting health and what is required to overcome these barriers. This study provides a snapshot of some of the positive health promoting behaviours in which Aboriginal women engage within their communities.

The experiences of these women add to the nursing body of knowledge as we gain a deeper understanding of strengths that communities possess. At present, these are absent from the literature. This study provides insight into health promotion strategies that may or may not work within the community. The findings also allow for greater understanding of First Nations women and their roles and challenges within their families and within their communities.

### *Purpose of the Study*

In this research project, I heard the stories of Aboriginal women; about the ways that they promote health for themselves, their families and communities.

### *Research Questions*

The following questions were used in this study to gain a deeper understanding of Aboriginal women's health promoting behaviors:

1. What is health?
2. What does it mean to them?

3. What do Aboriginal women do to promote health for themselves?
4. Do they consider themselves and their family to be healthy?
5. Is there anything that they do to help their family to be or to stay healthy?
6. Given their definition of health, what actions do they engage in to promote health within their communities?
7. Are the determinants of health as outlined by Health Canada (2003) determining factors of health for Aboriginal women?
8. What barriers stand in the way of health promoting actions?
9. What services/programs would help to alleviate these barriers?

These questions provided Aboriginal women with a voice to discuss what health means to them and how they promote their health and the health of their families and communities. The data provided by the participants identified the barriers that prevent Aboriginal women from engaging in further health promotion activities and also offered suggestions for possible solutions or programs/services that could further enhance their health promotion efforts. When analyzing the responses, I considered how the determinants of health affected the health of Aboriginal women, their families and their communities. Although this was not a comparative study, it provides some insight into the similarities and differences in health promotion work done by Aboriginal women and non-Aboriginal women. Examples of similarities and differences between populations include the definition of health, the barriers to health promotion, comparisons of demographic data, and health promotion actions.

### *Definition of Terms*

From reviewing the literature, and from my experience as a public health nurse working with Aboriginal families, there are many terms that are used interchangeably but often denote different meanings. Aboriginal can be defined in many ways as can family, community, health and health promotion. I define key terms as they apply to this study. It is imperative that the terms used in one's study are synonymous with the terms that Aboriginal women would understand to ensure a richness of data. Opportunity for their understanding of terminology was encouraged in the interviews.

*Aboriginal women.* The term Aboriginal is used by the Federal Government to include all persons who are Status Indians, non-Status Indians, Métis and Inuit. Status Indians are those individuals registered on the Indian Registry. They are given a treaty number and have inherent rights such as access to post secondary education provided the curriculum and student meet individual band requirements (Department of Indian and Northern Affairs Canada, 2003), and access to approved dental services and free prescriptions for medications and eye glasses from an approved list (First Nations and Inuit Health Branch, 2002) to name a few. Non-Status Indians are those individuals who consider themselves to be of First Nations ancestry but are not registered on the Indian registry. The Métis people are individuals of mixed heritage, believed by some to be a combination of First Nations ancestry and French (Krosenbrink-Gelissen, 1998). In contrast, some people suggest that the only "true" Métis people are those who were part of the Red River settlement (Normand, 1996). Many people of a First Nations background but not of French descendants still consider themselves Métis people (Leclair, Nicholson & Hartley, 2003). Métis people are given a special status with

inherent privileges and rights such as fishing and hunting exceptions (Normand, 1996) and some entitlement to post secondary education (S. Spindler, personal communication with mother of a child with Métis status attending a post secondary institute, August, 2000) but these privileges and rights are not comparable with their First Nations counterparts.

For the purpose of this study, the women participants identified themselves as Aboriginal. Therefore, whether one is a Status Indian or not cannot be used as a measuring stick to determine a person's worldview and it certainly cannot define who they are. The Native Women's Association of Canada (NWAC) also uses self-identifying criteria with their membership (Krosenbrink-Gelissen, 1998). The Native Women's Association of Canada states that to use self-identifying criteria is critical because the alternative of going on the basis of status alone is discriminatory to women. This will be discussed in more detail later.

*Health.* Health has been defined by the World Health Organization (WHO), Health and Welfare Canada, and Canadian Public Health Association as a "resource for everyday life, not the object of living" (1986, p. 1). Health in the Aboriginal community is synonymous with living and cannot be separated out as a resource. It is experienced by the mind, body, soul and spirit of a person (Braswell & Wong, 1994; Ellerby, McKenzie, McKay, Garipey, & Kaufert, 2000; Malloch, 1989), or, as depicted in the conceptual framework (discussed in Chapter 2), emotional, spiritual, physical and mental/intellectual well-being.

In this study, health is defined as living in balance with nature. Health is holistic and encompasses the mental/emotional, physical, intellectual, and spiritual well-being of an individual. Health was also examined as it related to a family and a community.

*Health promotion.* Health promotion has been defined by WHO et al. (1986) in the Ottawa Charter as the “process of enabling individuals to increase control over, and to improve their health” (p. 1). For the purpose of this study, health promotion is defined as any behaviour that assists one to remain in balance. To live in balance is to fulfill one’s physical, emotional, intellectual and spiritual needs. When one is fulfilled is self-defined. Health promotion is further discussed in the conceptual framework chapter. The Ottawa Charter states that health promotion strategies may be adapted to meet the needs of individual cultures or communities and it is noted that to ensure health the principles and concepts of the Charter need to be addressed. In other words, to assist a community in becoming healthy one would need to build healthy public policies, create supportive environments, strengthen community action, develop personal skills and reorient health services (WHO et al., 1986). This study explored how Aboriginal women contributed to these formal health promotion activities as well as informal health promotion activities. Examples of informal health promoting activities include keeping one’s children safe by not allowing them to be in unsafe environments, spending time with one’s children, and being a positive role model for one’s own family and the community. These health promotion activities have been synthesized within the framework of the medicine wheel and the determinants of health.

*Family.* It is difficult to separate the definitions of family and community as one is often a mirror image of the other. Frequently family and community are comprised of

the same people. Anderson (2001) provides many insights relevant to the definition of family and the roles played by Aboriginal women. Extended families often play a critical role in all aspects of family life and they are not determined simply by biology. In traditional families, a woman, usually the eldest, was the centre of the family. The head of the household therefore would be granny, whether granny was the biological grandmother or not she was to be respected for her wisdom. It is believed that her years and experience have provided the wisdom to hold this position. Men were thought of as the providers and the protectors. If a woman needed help she could call upon brothers and uncles from the family, extended family or the community at large.

Today the connection between family and community is still present, but Elders, are not held in the same regard as they once were. Grannies do not hold the power they once did. They are often sought out for their opinion but the decision-making process remains with the individual. Sometimes grannies are not necessarily the oldest person, as today, many grannies are not able to fulfil their traditional role for several reasons. Many people in the current Elder population have been unable to assume their traditional roles as they may have been lost through addiction, illness or assimilation. In this case, the title of granny or Elder is reserved for those who have demonstrated their ability to inherit such wisdom. Anderson (2001) emphasizes that the wisdom of an Elder or a granny often reflects basing decisions on what is the best for the future, for all the cousins, aunties, uncles, nieces and nephews.

For the purpose of this study, family is defined as the immediate family, consisting of a partner and children as well as the extended family, which could consist of grandparents and parents, cousins, nephews and nieces, and aunts and uncles. As

previously discussed, an Aboriginal woman may feel closer to her auntie than her mother. Her auntie may have been the person she lived with and who nurtured her. Therefore, she may be engaging in health promoting actions with cousins more frequently than with her siblings. Families included all those persons identified by the woman as being family.

*Community.* In the book, *Community Nursing: Promoting Canadians' Health*, Cloutier Laffrey and Craig (1995) outline the various definitions of community that were found in the literature. Cloutier Laffrey and Craig include Anderson and McFarlane's definition "people and their values, beliefs, culture religion, laws and mores" (p. 127), Hanchett's definition, "an energy field that is integral with the environment and manifests patterns, such as motion" (p. 128), and Goepfinger and Shuster's definition "a particular group of people and their characteristics, their geographic location, their environment and their purpose and functions" (p.128). Cloutier Laffrey and Craig demonstrate how community can be defined differently by leaders in the community stream.

The definition of community is important in this study. Historically community may have been defined as the tribe in which one belonged. There was a connectedness between all people of the same ethnic background and those who lived in close proximity to each other. Today, the sense of community is still very strong. For the purpose of this study I define community as a group of people who share similar experiences, characteristics and or proximity and feel a connectedness to one another. Being too restrictive or prescriptive may limit the sharing of stories. For example, in many First Nations communities, there are people who are not originally from the community but have for one reason or another, usually marriage, relocated to this community. To say that they are not a part of the community would not be accurate. These individuals may

not be of Aboriginal descent, but still may be very much a part of that community by virtue of their presence. Another example may be if an individual were to move away from the community – to Winnipeg for example. That individual may also identify her or his home as the community in which they left, thereby defining their community by culture. Other influences that could lead to community identity include income, education, social status, social support networks, gender, social environments and physical environments. Community was any grouping of people that the women identified as their community.

### *Assumptions*

In this study, I assumed that the determinants of health as defined by Health Canada (2003) are the same factors that would affect health in Aboriginal communities. Some of the determinants of health, such as education and employment as we define them today, were not as important in traditional Aboriginal roles. Little has been written about Aboriginal women's perceived importance of the determinants of health. In my experience, Aboriginal women promote health within their communities in a variety of ways that are absent from the literature. It is often the women who are or become the backbone of the family. In many families, it is the grannies who are raising children. It is often the grannies who have influence within the family. It is the women who seek knowledge and pass this knowledge on to their children. This study served as a venue for a few of those voices to be heard. The literature on positive health promoting behaviours in First Nations communities is limited. This study contributes to the nursing, health promotion, women's studies, and Aboriginal health bodies of knowledge.

*Chapter Summary*

As evidenced by the literature, many Aboriginal women suffer from physical, mental, emotional and spiritual illness. Traditional roles have been lost and living in harmony with nature has become a struggle. Yet, I have seen many Aboriginal women engage in positive health promoting behaviours. These stories are underreported in the literature and little weight has been given to their significance in the survival of Aboriginal people.

## Chapter Two: Conceptual Framework

In this chapter I explain the conceptual framework that I have used to organize my literature review and to organize my study findings. The conceptual framework depicts how the medicine wheel (as defined below) and the determinants of health can be combined to organize literature as well as to organize the stories that the women provided. This framework thus provides the tool in which the stories and the literature can be organized and analyzed in a meaningful way.

Although the literature was reviewed to obtain a conceptual framework that could be used to organize my thoughts, guide the interviews and provide insight into a discussion of the data coming from the women's stories, I was not able to find a framework that represented the focus of this study. My education and my experience as a public health nurse has taught me to think from a determinants of health perspective. My experience and knowledge of being an Aboriginal woman has shown me the importance and relevance of the medicine wheel (Figure 1, p. 14). Combining both perspectives is a logical evolution because both perspectives are complementary to each other. With the absence of a good model from the literature, I combined my two personal frames of reference to develop the Wheel of Health Promotion (Figure 2, p. 40). This serves as the conceptual framework for this study.

### *Medicine Wheel*

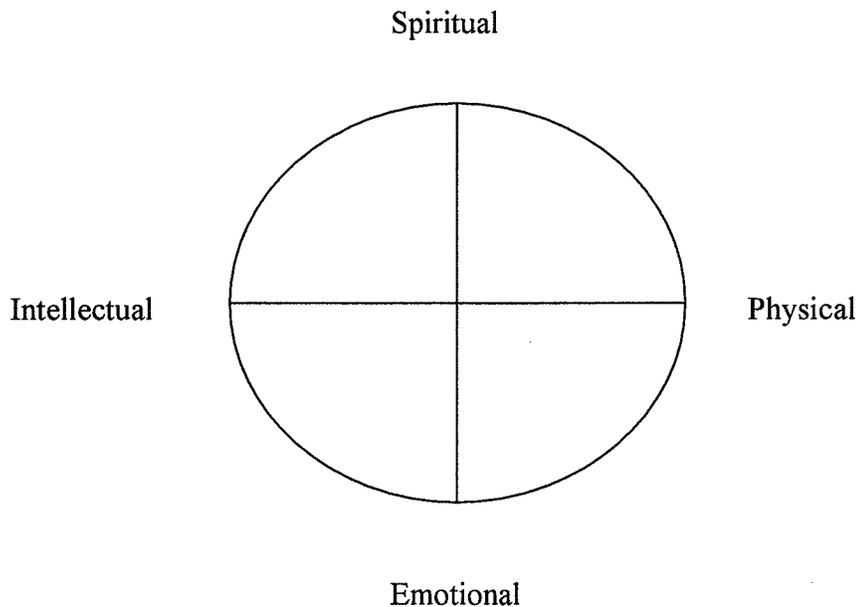
The medicine wheel or the Wheel of Life, as it is often referred to (Bartlett, 2001, 2005), is a framework used by many First Nations people and represents the individual, the family or the community. The Wheel is divided into four quadrants that represent the

physical, intellectual or mental, emotional, and spiritual well being of the individual, family or community. All persons, families and communities have these four quadrants. It is believed that to be healthy, a balance of the quadrants must be achieved. Malloch (1989) states that achieving a balance between these four elements is crucial to the well being of all individuals. Illness is thought by some to be a symptom of weakness (Lee, 1996). Weaknesses are the result of living out of balance which may be caused by “working too much, being too greedy, wanting too much, not paying attention to other parts of one’s self or one’s family” (1996, ¶2). This perspective is found in the literature and may be the beliefs of some First Nations people. Using a medicine wheel framework to depict illness as a weakness can result in feelings of guilt if one were to become ill. There would be the perception that the individual must have done something to cause his/her illness. This is one limitation associated with the medicine wheel.

I use the medicine wheel framework to represent the individual, the family and the community. The demonstrated wheel in Figure 1 represents health as the wheel is balanced. It also demonstrates that health is greater than the absence of illness and encompasses the physical as well as the other quadrants of the wheel. By stating that the quadrants must consume an equal part of the person is stating that all four quadrants are equally important. When any one area is out of balance then illness could occur. In other words, illness can come in all forms. There are physical illnesses, as well as mental, spiritual and emotional illnesses. Often, if a person is lacking in the spiritual or the mental realm of the wheel, it affects the emotional and/or physical part of the wheel. The same may be said for any quadrant. Knowing that wellness or illness in any quadrant of the wheel affects other quadrants of the wheel demonstrates how all four quadrants are

connected. The quadrants are self defined and unique to the individual, the family or the community (G. Starr, personal communications, July 14, 2005). In other words, it is the individual, family or the community that determines when they are out of balance.

The medicine wheel is depicted in a variety of ways in the literature (Bartlett, 2001; Brandt-Castellano, 2002). The placement of the quadrants varies depending on the author. The placement that I will be using is that of Brandt-Castellano. The physical quadrant would be first as this is the quadrant that is most easily recognized to be out of balance. The emotional, intellectual, and spiritual quadrants will follow.



*Figure 1.* The medicine wheel used as a conceptual model to define health as being holistic and having four equal quadrants.

In traditional Aboriginal cultural practices, medicine and religion are often seen as being one in the same and to maintain health requires one to live in accordance to the laws of the Creator (Avery, 1991; Braswell & Wong, 1994). The circle has no ending and no beginning, this representing the continuity of life as well as the four elements of life.

I heard an Elder speaking at a healing circle. He stated that it is not the White Man that he hates, it is his system. Life, to the White Man, is like a ladder. Life, to those living in accordance with Aboriginal tradition, is like a circle. To remain healthy, one must live in the circle, not on the ladder (E. Courchene, personal communication, November, 2001). Although not all Aboriginal people understand or live in balance according to the Medicine Wheel (Fast Consulting, 2004), many non-Aboriginal people do not live on a ladder, as has been depicted by this Elder. During a recent symposium, Dr. Bartlett (2001), a professor with the Faculty of Community Health Sciences at the University of Manitoba, spoke of the medicine wheel and how it can relate to the determinants of health. She stated that the term health promotion should be changed to life promotion, because when you live in the circle it is life that is being affected not just health or disease. In other words, the medicine wheel framework is a way of life not a means to balancing health. Strickland (1999) in her research regarding cultural relevance found that circular models rather than linear models best represented Aboriginal world views and values.

The maintenance of quality of life is more important than the quantity of life with regards to pursuing cure at any cost (Ellerby et al., 2000). In other words, intervention and life, as defined by a beating heart, are not always desirable. In my experience as a public health nurse, I have seen examples of this belief and in particular a man who had died from diabetes complications. He had an ulcer on his foot that became gangrenous. He was told that his foot needed to be amputated. The man stated that he would rather die than leave this world with one less part. It was his belief that the Creator had put him in

this world with two legs and he would leave this world with two legs. Death, in this circumstance, was a more desirable outcome than a cure.

As a student nurse, I recall a patient from a northern reserve who was a single father. His lungs were so diseased that to receive life sustaining care he needed the assistance of a machine that would enable him to breathe. As a consequence of needing to breathe with the assistance of a machine he would have to relocate to Winnipeg. After careful consideration and discussions with his family he decided to be released from hospital and return to his home. I was horrified, how could he make this choice? Did he not realize without treatment he would die? I spoke with the man and asked him why he did not want to live in Winnipeg. He stated that to move his young children to a place like Winnipeg would be too difficult. What kind of a life would they have? They would have no aunts, no family, no friends and the potential to get into trouble would be great. They were accustomed to their life in the north and had never visited Winnipeg. They had never traveled away from their small reserve community. He stated that he needed to be there for his children and, when he needed them, his family and community would be there for him.

Spiritualism is prominent within traditional native beliefs. As we move away from the medical model, health is taking on a more holistic view. Canadian society is adopting traditional Aboriginal beliefs in relation to holism and environmental concerns. To have a sense of spiritualism is to truly believe and know oneself. To truly know oneself is to know one's strengths and weaknesses, to know one's purpose in life and the reason for being. Reynolds Turton (1997), in her article on Aboriginal ways of knowing about health, argues that to know oneself aids in promoting one's health. It is believed that

many health concerns originate because one does not know his/her purpose in life. Many First Nations people use traditional ceremonies such as “Sweats and Pow Wows” to discover themselves and their purpose. Ross and Ross (1992) recommended in their study that the term *Medical Services Branch* should be changed as it implies illness and disease care. The new terminology is *First Nations and Inuit Health Branch* which references health rather than medical services.

Within traditional and contemporary Aboriginal culture there are individuals who may practice medicine or healing rituals. These medicine men or shamans as referred to by the Ojibway are chosen by the Creator to follow this path in life (Waldham, Herring, & Young, 1995). Men are more likely to hold this position, as women are seen as already having a lot of responsibility as the life givers and nurturers (Malloch, 1989). In other words, a medicine man can help you when you are sick, but women are the health promoters within the family. It is the woman’s responsibility to teach children how to keep in balance, thus, how to remain holistically healthy.

Medicine men receive their teachings orally through a previous descendent (Avery, 1991; Gregory & Stewart, 1987; Malloch, 1989; Reynolds Turton, 1997). It is said that their future is chosen by the Creator (Malloch, 1989; Reynolds Turton, 1997) and may come to them in a vision or a dream (Avery, 1991; Beck, Walters, & Francisco, 1993; Ross & Ross, 1992). Medicine is often made of a mixture of herbs that are blessed by the Creator (Avery, 1991; Gregory & Stewart, 1987; Malloch, 1989). In combination with herbs, ceremonies/rituals may also be used for healing (Avery, 1991; Malloch, 1989). In a traditional life, there may be different realities that exist. Anything that affects any aspect of these dimensions affects one’s health. Therefore, illness may be the result

of bad medicine that interferes with a person's balance because somebody has wished them harm (Reynolds Turton, 1997). Throughout my nursing practice, I have heard stories of families who have been cursed and as a result experience much tragedy in their lives. Love spells may be cast as well. Once under this spell, I have known women who chose their partners over their children in cases where Child and Family Services were involved. The result was the apprehension of children who were placed in foster care. The women claimed they have been given love medicine and they were "unable to escape these men".

Not unlike the medicine man, women receive their teachings from their grandmothers and mothers. They learn how to live in balance and thus are the storytellers and carriers of information for their children.

Health is also closely linked to the environment. It is believed that if Mother Earth is not healthy, then it is difficult for the people who live upon her to be healthy, as she will not be able to provide them with what they need (Reynolds Turton, 1997). Just as life is sacred, so is the environment.

### *The Determinants of Health*

What makes people healthy? The Department of Aboriginal and Northern Affairs (2000) states that to improve quality of life, communities need to be safe and healthy. This may be achieved by ensuring that drinking water meets standards and that environmental regulations are followed. Also, that recreation programs are planned and implemented. Public safety needs to be addressed in the areas of crime prevention, fire safety, and disaster/emergency planning.

Health Canada (2003) proposed 12 determinants of health. These include: income and social status, social support networks, education, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, culture, health services, gender, biology and genetic endowment. The determinants of health are the influential factors that affect a person's well-being. Some factors we cannot change such as our own early childhood development and biological endowment. Other things we can change such as social environments, social support networks, personal health practices, gender, culture and education. Other determinants are extremely difficult (without policy changes) for First Nations people to change such as income, physical environment, and education (as it relates to schooling).

Therefore, to achieve a balance on the medicine wheel, or to remain healthy holistically, one needs to refer to the determinants of health. Aboriginal people are greatly affected by the determinants of health. For example, at a workshop I heard a NADAP (Native alcohol drug awareness program) worker state that it is his job to "fix" addiction. He found this to be an overwhelming task because in order for him to "fix" addiction he needed to look at the underlying causes of addiction such as unemployment, inadequate housing, etc. (F. Courchene, personal communication, November, 2001).

To gain a better understanding of how the 12 determinants of health affect Aboriginal women, I have defined the determinants below.

*Income and Social Status.* Health Canada (2003) states that income is the single most important determinant of health. Gorin (2000) states it is not the income level that greatly affects health, rather it is the distribution of income. He terms the unequal

distribution of income as relative poverty. "Relative poverty refers to inequality or poverty in relation to the mainstream communities" (p.271). Many First Nations communities have been compared to third world countries. In a recent report on poverty and health, it was found that Aboriginal people are especially vulnerable to poverty as 43.4% of the population was poor in 1995 as compared to 19.3% of the population of non-Aboriginal people (Phipps, 2003). A study for the Women's Health Clinic in Winnipeg on poverty found that Aboriginal women are more likely to live in poverty than non-Aboriginal women or Aboriginal men. This study cites that in 1995, 42.7% of Aboriginal women lived in poverty compared to 35.1 % of Aboriginal men, 20.3% of non-Aboriginal women and 16.4% of non-Aboriginal men (Donner, 2002).

Poverty has been found to be directly related to children's physical and mental health, cognitive and social development, and academic achievement (Bhatti, 2000), as well as chronic respiratory diseases, otitis media with hearing loss and tuberculosis to mention a few (Kirmayer, Brass, & Tait, 2000). Williamson (2001) states that poverty negatively impacts individuals, communities and societies at large. Crichton, Robertson, Gordon, and Farrant (1997) in their book entitled *Health Care: A Community Concern?* list several studies that have illustrated the relationship between ill health and income level (p. 319). The Manitoba Center for Health Policy (MCHP) has also linked poverty to poor health. Research has found a correlation between those living at a low socio-economic status and wellness. The MCHP also links many chronic conditions with poverty, such as diabetes, mental illness, and disorders of the digestive system (Roos et al., 1996). Polakoff and Gregory (2002) found that women who lived in poverty had

fewer options for “support, advice, information and assistance in their pursuit of wholeness” (p. 844) as well as insufficient funds for essentials of life.

Another interesting correlation discovered was that women living in poverty were more likely to bear children between the ages of 15-29 and women of a high socioeconomic status were most fertile between 30-49 years of age (Roos et al., 1996). If Aboriginal communities are deemed to be the poorest communities in the province, and fertility rates at a younger age are often seen in families that live in poverty, one could expect that Aboriginal teenagers would have higher rates of pregnancy and, according to Hallett, Nemeth, Stevens, and Stewart (2002), they do. Hallett et al. state that the percentage of Aboriginal adolescent girls having babies is over 23%, which is higher than the 7.5% rate of their non-Aboriginal counterparts. They further state that “almost 20% of First Nations children are currently born into the homes of single parents less than 20 years of age” (p. 31). The study conducted by MCHP reinforces the fact that a growing number of adolescent Aboriginal girls become pregnant each year (Roos et al., 1996).

Individuals from a lower socioeconomic status are more likely to die or become chronically ill as compared to those individuals from a middle or high socioeconomic status. Inequities in health may account for 5-15 years difference in life expectancy rates between the rich and the poor (Wilkinson, 2001). This mirrors the life expectancy rates of First Nations people as being lower than the Canadian average (Hallett et al., 2002). Chronic conditions occur earlier in life and Aboriginal women report a greater burden of illness than Aboriginal men or their non-Aboriginal female counterparts (Donner, 2002). A wide ranging study conducted by the Manitoba Centre for Health Policy (Martens, 2002) using 1986 administrative data found that the health of Manitobans varies

markedly in relation to socio-economic status particularly in mid-life. Wilkinson (1997) further states that income inequality affects deaths caused by homicide, accidents and alcohol. Violence in First Nations communities is much higher than other communities, to quote Hallett et al. (2002) "drowning and homicide are particularly common in Manitoba," (p. 7). In a survey of 98 Aboriginal women, Deiter and Otway (2002) found violence was the number one health concern in over 70% of the responses. The Canadian Panel on Women Against Violence found 80% of Aboriginal women were experiencing violence in the form of abuse at the time of being questioned and this was twice as high as non-Aboriginal women (Green, 1993). Aboriginal women are 2.4 times more likely to die as a result of violence when compared to their non-Aboriginal female counterparts (Donner, 2002).

For the purpose of this study, social status is defined as one's social position within the community. The literature is sparse regarding social status and health. Social status is often referenced in relation to income and is seen to be the same determinant in many instances. This may be because social status is influenced by several factors. Manitoba Health (n.d.a) defines social status as a hierarchy that may be improved through education and job training, increasing control in work, home and community environments. Homans (as cited in Willer et al., 2002) stated that power is the greatest source of status in a community. Hay (1994) defines social status as being a measure of education, occupation and income difference. He further states that poor health leads to lower social status because those who are ill are not able to engage in educational, occupational and monetary opportunities.

Bartley (2004), when looking at inequalities in health, found that social status is dependant on many other factors and raises many questions. Do women and men in the same occupation have the same social status? Is occupation a social status indicator for married women? Is social status a predictor of health globally? When considering First Nations communities and social status we would expect that the community leaders would be those in decision-making roles and those who have wisdom. Therefore, the Chief and Council would be considered to be of high social status as would Elders as they are wise. In other words, social status in First Nations communities would be those in power. Power may be defined as having wisdom, charisma, and knowledge.

*Social support networks.* Social support is defined by Stewart (1995) as “interactions with family members, friends, peers, and health care providers that communicate information, esteem, aid, and emotional help” (p. 93). Stewart goes further to state that social supports act as buffers against stress. Anderson (2001) states that extended families, biological and otherwise, often are a social support network in Aboriginal communities. Social support networks are a very strong determinant of health and may be defined in differing ways. Gorin (2000) found that social relationships may work to offset the detrimental effects of poor lifestyle choices. Adults require social supports to develop fully and friendship is related to positive health outcomes (Bhatti, 2000; Wilkinson, 2001). With reference to health promotion and social support, Hurdle (2001) found that women in particular benefit by reduced mortality rates, quicker recoveries from illness, and increased likelihood of engaging in health promoting behaviors if they had a strong support system. For the purpose of this study, I define social support networks as an individual’s perceived social relationships that may be

family, friends or agencies who provide the individual with support and have a positive influence on the individual's health.

A study that looked at parenting competence and social support in teen mothers found that family support was indicative of successful parenting (Herrmann, Van Cleve, & Levison, 1998). Other studies have compared teens who had strong support systems to those who did not and found that those with strong social support networks had lower stress levels, higher self esteem and stronger parenting skills (Wasserman, Brunelli, & Rauh, as cited in Hermann et al., 1998; Thompson & Peebles-Wilkins, 1992).

Spanier and Allison (2001) in their study looked at social support and physical activity. The researchers found that involvement in a large social support network influenced the individual's sense of identity and self-esteem through positive interaction. It also increased motivation and aided in individuals taking better care of themselves.

Hallett et al. (2002) have stated in their government report on the *Health of Aboriginal People in Manitoba* that the largest difference in health outcomes is in the rates of suicide. Aboriginal males aged 15-24 are five times more likely to complete suicide than any other group of individuals. Their female counterparts are three times more likely to complete suicide than other female Canadians. Other studies echo similar results (Kirmayer et al. 2000) and some report even higher percentages (Dion-Stout, 1996). Perceived social support networks – positive ones, such as affiliations with the church and connectedness to community, are excellent buffers for suicide prevention (Kirmayer et al., 2000). That the rates of suicide are higher than any other Canadian population group speaks to the lack of perceived social support networks, particularly in the young Aboriginal population. Durkheim (as cited in Thompson, 2004) in his work on

suicide stated that suicide could be altruistic or anomic. Anomic suicide is caused by “disturbances of the collective order” (p. 99). He goes further to state that “no living person can be happy or even continue to exist if his needs are not sufficiently in proportion to his means” (p. 99). Durkheim believed that those who completed suicide had greater needs than could be granted or that the needs were in constant conflict which only resulted in pain. As a result of this pain, the individual is no longer able to exist. When I think about disturbances of the collective order, the history of Aboriginal people comes to mind and will be discussed below.

There clearly are a number of studies that have been conducted that reflect the importance of social support networks within a person’s life (Clinton, Lunney, Edwards, Weir & Barr, 1998; Eyler, Brownson, Donatelle, King, Brown & Sallis, 1999; Norbeck & Tilden Petersen, 1983). The benefits of a strong social support network range from quicker recovery times, buffers against illness and increased mental and spiritual wellness (Norbeck & Tilden Petersen, 1983).

*Education.* Manitoba Center for Health Policy (MCHP) has reported that education level is linked to frequency of physician visits. It is also assumed that the greater the number of physician visits the more ill the client. The lower the education level, the more frequent the physician visits and thus the lower the health status of the individual. When comparing socio-economic status (SES) and health outcomes, MCHP linked education level with SES to determine that health may be positively or negatively influenced depending on where one sits with respect to SES and educational levels (Mustard et al., 1995). For example, if an individual is highly educated they are more likely to have a higher paying job and also more likely to have good health. The reverse

is often true as well. If an individual has little or no education, they are less likely to be employed in an adequately paying job and more likely to become ill.

Many First Nations communities have less than desirable formal education systems. Only 33.7% of Aboriginal youth age 15-29 have completed high school. Although it is improving, it is still less than the provincial counterpart (Hallett et al., 2002). Some Aboriginal people, however, complete their schooling later in life and obtain a university degree. About 2.9% of all Aboriginal people over the age of 15 complete university. Those who do complete university however are much more likely to be women (Hallett et al., 2002) and women later in life. In several instances schools only go as high as Grade 9 and students would be required to leave their community to complete Grade 12. Even in schools where Grade 12 is offered, many students do not graduate. There are few employment opportunities for those who are educated unless one wants to leave their home community. Combine this with the role of Aboriginal women as the child nurturers, education would definitely take a "back seat" to family life.

*Employment and working conditions.* Unemployment contributes to ill-health. One might argue that it is indeed the low socioeconomic status that actually affects health and not the unemployment, but research has shown that ill health even starts before job loss and begins when individuals begin worrying about becoming unemployed (Wilkinson, 2001).

The entire issue of employment may need to be revisited. As previously stated, Aboriginal women are often young and often single when they give birth to their first child. These women are often working, in other words, they are raising their children, but this work is neither paid nor valued (Thurston & O'Conner, 1996). It is the woman's role

to be the carrier of tradition and nurturer of children so therefore their employment role is determined (Malloch, 1989).

What is the impact of employment on health? Is any job a "good" job? Does any job mean that one is employed and therefore gaining some meaning and greater health benefits? Arenas (2003) states that to positively influence health and to be of benefit, employment must provide enough money for basic needs, there must be personal compensation (money, power, prestige), technical and/or creative excellence, and finally there must be respect for the community and environment. Greater than 60% of Aboriginal women in the work force are in low-paying jobs. Unemployment rates for Aboriginal women are over 21%. This is more than double the unemployment rate of all Canadian women (Dion-Stout, 1996).

Control or ability to have a voice at work is a strong predictor of health (Wilkinson, 2001). We know that autonomy in the work force is usually associated with management and jobs that require a higher education. If over 60% of Aboriginal women are working in minimum wage paying jobs (Dion-Stout, 1996), then they will not have a lot of autonomy.

Working conditions for Aboriginal women within their communities are often terrible (Dion-Stout, 1996). The women are threatened with being laid-off or being fired if they speak out about sexual harassment or other injustices within the work place. Since the women need their jobs, they keep quiet and survive the conditions. Another influencing factor may be that there are very few jobs available within First Nations communities.

*Social environments.* People need to feel in control of their environments. To feel out of control and powerless has been well documented as having ill-effects on health (Gorin, 2000). Aboriginal people's resolve for self government is an example of trying to take control over one's environment.

There is a strong correlation between equality and social environments. These data have come from the research on violent crimes and homicide (Wilkinson, 2001). There seems to be a strong tendency for homicide rates and rates of violent crimes to be higher in countries where greater inequality exists. Dion-Stout (1996) quotes the Ontario Native Women's Association study completed in 1993 which reported 80% of Aboriginal women have been victimized by family violence. As clearly outlined, there exists a large inequality between First Nations communities and communities that are not comprised of Aboriginal people.

*Physical environments.* Living in a safe and supportive environment reduces stress and contributes to positive health outcomes (Bhatti, 2000). This point is common sense. If one lives in an environment that is unsafe, such as an abusive home, stressors are increased and as stressors are increased, the likelihood of having positive health outcomes is decreased. The physical environment is also linked to being a contributing factor in several illnesses, Multiple Sclerosis being one example (Ghardirian, Dadgostar, Azani, & Maisonneuve, 2001).

A recent report by the Canadian Public Health Association (2001) titled *Climate Change Air Pollution and Your Health: Some Basic Answers to Some Basic Questions* reports that due to global warming there will be increased deaths and illness, more weather disasters, more water shortages, spread of tropical disease and social unrest

caused by the catastrophes. Air quality is also at a steady decline as more than 66% of Canadians report their health as being worse due to air pollution. Air and water quality are very important determinants of health.

A situation that has been experienced by First Nations communities concerns sub-standard housing. Often there are several families living in a home; crowding becomes a problem (Dion-Stout, 1996), and increases the likelihood of contracting communicable disease and increases the probability of accidents due to the increased likelihood of poor construction. Some families, especially in more northern remote communities, do not have running water. Many houses throughout Manitoba have problems with mold. This mold poses a threat to several individuals and can be especially harmful to those adults and children that are already combating other chronic illnesses (Dr Eilish Cleary, personal communication, June, 2001).

There are several other problems present within First Nations communities concerning the physical environment. Many of the communities are located a fair distance from any police protection. This is true for the fly-in communities where police protection is often provided from neighbouring communities which is an airplane flight away. In communities which are accessible by road, the police often provide coverage from a neighbouring community that may be an hour away by car. If a person is not feeling safe in a fly-in community and requires police assistance, it may mean that the police will come the following day. In communities that are within driving distance, the police will be there in an hour or two. In urban areas such as Winnipeg, many Aboriginal people, especially those on a limited budget, live in areas that have higher crime rates because the cost of living in these areas is less.

Mercury is found in high levels affecting fish, part of many First Nations people's diets. In many communities, fish is a staple food which is consumed in large amounts. Further to the nutritional needs of First Nations people, there is often a problem with obtaining fresh fruits and vegetables due to their distance from major urban centres. Shipping costs add exorbitant additional costs to food items that are shipped to remote and northern communities resulting in high prices for groceries in general. There is an exception to liquor as the Liquor Commission protects the price of alcohol throughout the Province. Therefore, the price of a bottle of whiskey in a northern reserve is the same price as a bottle of whiskey in Winnipeg. The interesting aspect of this story is that the same does not hold true with other beverages such as milk. The \$3.19/4 litre jug in Winnipeg does not compare with the \$11.00/4 litre jug in the north.

The importance of one's physical environment is embedded in Native history. Mother Earth is referred to as the producer of life (Malloch, 1989). This determinant is crucial to Native survival and all people. Traditional First Nations people would be outraged with the pollution and careless way we treat Mother Earth, as she is to be treated only with respect. Ross and Ross (1992) state that arguments need to be made to government leaders emphasizing the importance of health and land when Aboriginal people are negotiating land settlements.

Health is also closely linked to the environment. It is believed that if Mother Earth is not healthy, then it is difficult for the people who live upon her to be healthy, as she will not be able to provide them with what they need (Reynolds Turton, 1997). Just as life is sacred, so is the environment.

*Personal health practices and coping skills.* Personal health practices became a determinant of health with the document *A New Perspective on the Health of Canadians* (Lalonde, 1974). This determinant has become such a focus that other social determinants are given little recognition (Poland, Coburn, Robertson, & Eakin, 1998). It is this determinant of health that many health promotion workers try to influence through educational efforts.

This category looks at what people do to stay healthy. For example, if one exercises, makes healthy food choices and gets plenty of rest, s/he will be more likely to be healthy than a person who has negative health practices. With the past example of the costs and availability of healthy food choices, it reinforces the need for healthy public policy to remain an action in health promotion.

How we cope is an important or influential determinant of health. Stress, for example, has the ability to raise blood pressure and upset normal patterns of healing (Gorin, 2000). Coping skills may overlap with personal health practices as lack of coping skills are often recognized as poor personal health choices. Low socio-economic status is also linked to poor coping strategies such as smoking. Research has shown that almost 25% of girls in Canada smoke before the age of 20 (Greaves as cited in Cohen & Sinding, 2001). This number is more than double in First Nations communities (Health Canada, 2005). Smoking and any addiction (gambling, drinking, drug misuse) may result in a lack of positive coping skills. Poor coping skills keep the emotional part of the wheel out of balance, thus impacting on health. First Nations communities often have higher than provincial average rates of addiction, violent crimes, suicide, smoking, and other negative

health behaviours (Dion-Stout, 1996; Martens, Sanderson & Jebamani, 2005; Moore, 1993; Silverman, Goodine, Ladoceur, & Quinn, 2001).

*Healthy child development.* Healthy child development has been given a lot of weight lately as many government departments are beginning to invest in children. Programs such as Healthy Baby, Canadian Prenatal Nutrition Program, Head Start, Baby First, Early Start and various breakfast, lunch and literacy programs offered through parent-child centers throughout the province are attempting to impact on this determinant of health (Healthy Child Manitoba, 2001). Early childhood is defined as being from conception (i.e., prenatal) until age 6. During this time children require “proper attachments and stimulating, loving care” (Bhatti, 2000, p. 9). Gorin (2000) states that quality experiences in early childhood can act as buffers for the rest of the child’s life. Research has shown that it is this window of opportunity (preconception to age 6) that is crucial for brain development, and if optimal conditions are not provided, the consequences are severe and life long (Bhatti, 2000). As outlined throughout the other determinants of health, if coping skills and personal health practices are out of balance in conjunction with the other determinants of health it will be difficult for a woman to have a healthy conception and pregnancy.

There are studies that explore the reasons Aboriginal women do not seek prenatal care and the relationship between prenatal care and unhealthy child development (Sokoloski, 1995). Sokoloski in her study outlined several barriers that prevent Aboriginal women from attending prenatal care. Barriers range from being structural issues such as the lack of transportation and/or child care to personal barriers such as perceived prejudice, impersonal treatment and long waits to see primary care providers.

*Culture.* Illness and wellness are culturally defined. There are several different tribes of Aboriginal peoples all having their own languages, cultures and traditions (Ellerby et al., 2000). Nwoga (1994) states that illness is culturally constructed and is shaped by cultural factors governing perception, labelling, explanation, and valuation of the discomfoting experience (p. 471). Culture is one's frame of reference for relationships between individual behaviour, values and beliefs, and perceptions about health (Clarke, 1997; Leonard & Plotnikoff, 2000). Culture is learned in early childhood and remains unchallenged as long as it is the dominant culture (Leonard & Plotnikoff, 2000).

Braswell and Wong (1994) found in their study that many counsellors working with First Nations people believe that understanding cultural practices are very important to the counselor-client relationship, but 42% felt they knew very little about traditional practices. A recommendation of the study was to increase cultural diversity training. Similar studies have been done within the health sector and have found similar results (Benoit, 2001; Booteroff, Balneaves, Sent, Grewal, & Browne, 2001; Browne, 1995; Ellerby et al., 2000; Hodge, Fredericks, & Rodriguez, 1996; Leonard & Plotnikoff, 2000; Longclaws, 1996).

Anderson (1998) in her exploration of women and chronic illness determined that culture affects health but it cannot be taken out of the broader social and economic context. She states that poverty, employment and social status by far determine a person's ability to manage illness not their cultural background, as "people do not live out cultural beliefs independent of everyday realities" (p.17).

Culture is defined by Allen (1997) as:

An orientation towards reality shared by a group of individuals. Thus, culture refers to a group's interpretation of material conditions based on their lived experience of these conditions. This interpretation may or may not accurately reflect the material conditions, but it does play a casual role in the actions that individuals perform. (p. 233)

Government cultural designations may affect one's health. There are several types of Aboriginal people including: status Indians, non-status Indians, Métis, Inuit, urban Indians, off reserve Indians, Indians who are band members and Indians who are not band members, Bill C-31 Indians, those of mixed ancestry and women of another culture who have married a status-Indian and are now status Indians themselves, or men of another culture who have married an Aboriginal woman (Damm, 1993; Krosenbrink-Gelissen, 1998). Designation may affect access to health services. For example, Status Indians have access to the Head Start program, which is similar to a daycare; it includes a parenting component that benefits families immensely. This program is only available on reserve. Therefore, those people who live off the reserve, Métis or general population settlers, do not have access to this valuable resource. Another example, individuals who are of Indian status and reside off reserve, Métis and the general population need to hire their own medical drivers, even though they may live in the same impoverished conditions. They do not have access to any of the entitlements experienced by Status Indians who live on the reserve. Therefore, being a non Status person living in the same conditions as a Status person can be detrimental to one's health.

Culture is an important determinant in this study and in the health of Aboriginal people. It is culture that gives one a sense of belonging and a sense of identity. Culture and that sense of identity can be upset when people leave their communities. The

continuation of education or to seek employment opportunities may be examples of occasions when an individual may leave their community. Herberg (1995) defines culture shock as feeling stunned and unable to function in a new environment because the differences in culture are so great that it is difficult to proceed with life without an understanding of the new expectations and behavioural norms. Three things may happen in response to this scenario. First of all, the individual is able to acculturate which means they are able to take on the behaviours of the cultural group in which they now live.

The second outcome may be that the individual experiences culture conflict which means the individual rejects the new culture in which they have been exposed (Herberg, 1995). This often results in a conflict or struggle from within the individual trying to find their place in their new environment.

The third outcome would be that the individual demonstrates culture blindness which means the person ignores the new environment and continues to function as if there was no change (Herberg, 1995). The individual may feel a sense of loss in their new environment and the period of transition may be such that the ability to seek and succeed in education or employment is limited. This is a vicious circle because society often measures "success" by education and employment – hence social status, and if you are unable to obtain either, you fall into this void. Discontinuing one's culture has also been linked to high rates of depression, alcoholism, suicide, and violence with the greatest impact being on the youth (Kirmayer et al. 2000; Longclaws, 1996).

*Health service.* Historically, many people believe that it is the health care system that makes you healthy. It is only in the last few decades that health care professionals are recognizing the broader determinants of health. In the most recent community health

needs assessment in the North Eastman region, community members were asked what would make you healthy and many individuals listed services such as a doctor or a nurse practitioner. Although it is not the health care system alone that makes one healthy, we cannot ignore the contribution that the health care system does make (Poland et al., 1998). The health care system is an important contribution to health but it is far outweighed by the social determinants of health (Mann, 1996).

Benoit (2001), in her study of Aboriginal women living in Vancouver and their feelings about the health care services being offered, found that women wanted more informal programming. They wanted services that were more women-centred and with a stronger representation of Aboriginal women being included in the planning phases of program delivery. Ross and Ross (1992) also found in their study that health care had been planned for individuals with no input from the recipient. The care plans were often not culturally appropriate and were impractical.

The health care system needs to be viewed in two parts, the formal system and the informal system (Poland et al., 1998). The formal system consists of the hospitals and community programs. It is this system that we envision when we speak of the health care system. The informal health care system is the system that takes place within families and communities that is not formally organized by governing bodies. This may be the medicine men and women who practice or teach within communities. There may also be informal carers, who provide health services and education, that the system fails to reach or where the system is limited. These community carers complement the promotion of health.

*Gender.* Research has shown that, for some chronic illnesses, gender plays an important role (Dion-Stout, 1996). It can also be stated that women traditionally seek out medical attention more frequently than men. Logically speaking, if you seek out physician services more frequently, your health may be seen as poorer than an individual who does not seek medical attention (Roos et al., 1996). Aboriginal women have lived and continue to live through oppression by most of society. The topic of gender will be discussed in the following chapters.

*Biology and genetic endowment.* Many illnesses seem to run in families. Ghardirian et al. (2001) found in a study of over 200 clients with Multiple Sclerosis that family history was the greatest predictor of contracting this debilitating illness. Illnesses, such as diabetes (Kue Young et al., 1999), heart disease (Kue Young et al., 1999), haemophilia (Seeley, Stephens, & Tate, 1992), and osteoporosis (Pickard, Imbach, Couturier, Lepage, & Picard, 2001) are a few examples of illnesses that are more prevalent in Aboriginal women compared to their non-Aboriginal female counterparts. Biology may be defined as the innate ability to maintain balance. An example of biology affecting health would include those individuals who never seem to become ill. Their immune system is so strong that they are able to combat germs. On the other hand, some children, for example, have continuous allergies and are frequently ill in their first years of life.

Aboriginal women are prone to diabetes, heart disease, stroke, and many other illnesses. Aboriginal women have shorter life spans than Canadian women as a whole (Donner, 2002), by as much as 8 years and are three times more likely to die young

(Martens, 2002). One must question the role of biology versus the role the other determinants may play in this situation.

*Other determinants.* Other determinants found in the literature include: family structure, lack of voice and feelings of not being connected. Lipman, Offord, and Boyle (1997) found in their study of 9,953 eligible participants in Ontario that being a single parent negatively influenced health. They found that single mothers, regardless of income levels, seek more mental health services and have a higher prevalence for Affective Disorder. Avison (1997) agreed with the Lipman et al. (1997) study and suggested that being a single mother had many inherent burdens and concluded that family structure should be considered a determinant of health.

Another determinant acknowledged was a “lack of voice” or feeling of connectedness (Gerrard, Russell, & Jones, 2001). This determinant was prominent in a study done by the Prairie Women’s Health Centre for Excellence (2001). Eleven participants were interviewed who were actively involved in workshops that were able to influence policy. These women felt that they had a voice and this heightened their connection to the community and it boosted their own self-esteem as well. Because of economic constraints, this program ceased to exist and some farm women in particular no longer have access to the training that enhanced women’s economic, social and political power and face a resulting negative health impact.

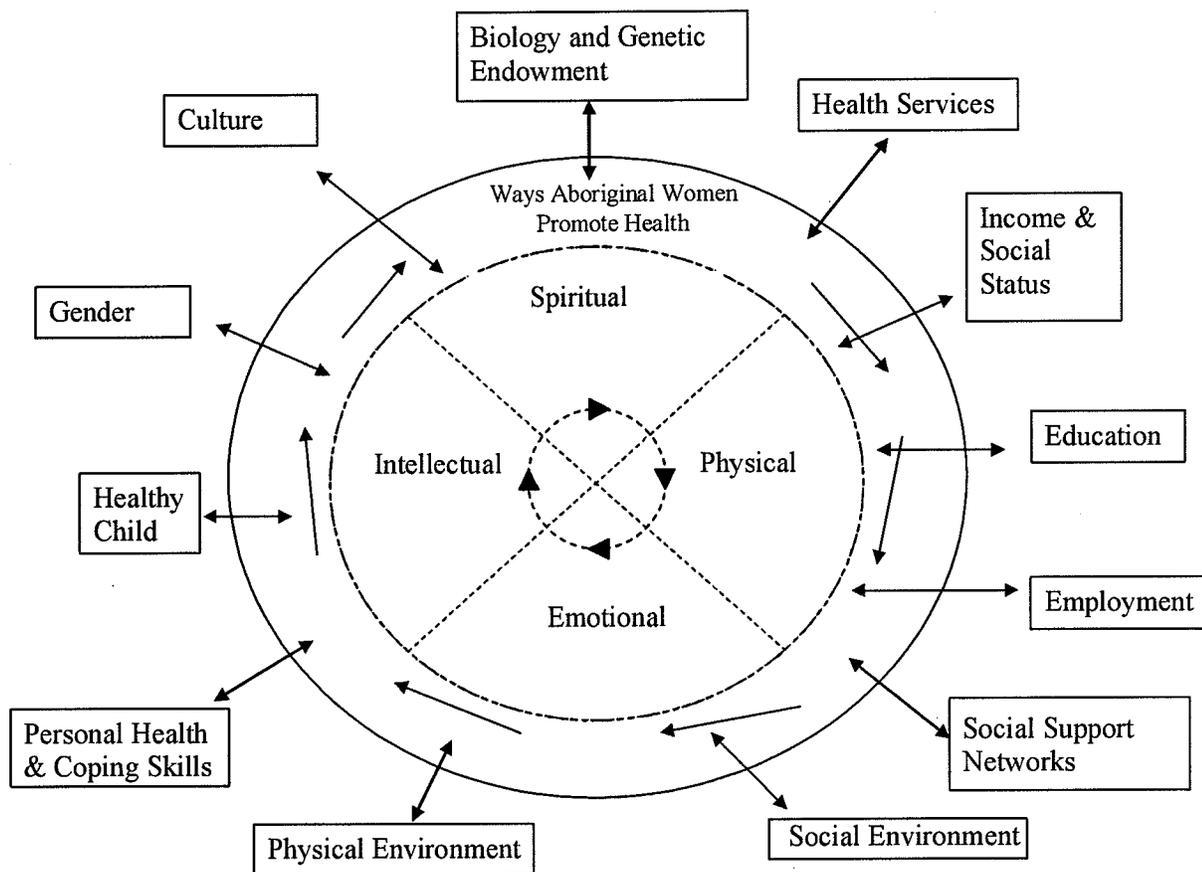
Mignone (2003) states that social capital is a determinant of health. Social capital is defined as how well or poorly communities interact within the community and with other communities. In his study of social capital he looked at bonding within the

community, bridging to other First Nations communities and linkages to institutions such as federal and provincial government departments, or public/private corporations.

### *Wheel of Health Promotion*

The conceptual framework used for this study is shown in Figure 2. The determinants surround the medicine wheel. Each determinant should not be viewed in isolation but rather as a matrix. The determinants affect each other and in turn each affects the four quadrants of the wheel. It is the behaviors of the individual, the family and/or the community that influence the balance of the wheel. If you are in balance on this wheel, this will also greatly affect the determinants of health. For example, if you are out of balance in any quadrant, it will greatly affect your ability to maintain personal health and coping skills, employment, and education, etc. The reverse is true as well. If you are living with an addiction, unemployed or far away from health services, this will greatly affect your balance on the wheel. Balance is individually defined and is a visual depiction of what determines your health (12 determinants) and the meaning or definition of health (physical, emotional, intellectual and spiritual) and the health promoting actions that promote health.

## Wheel of Health Promotion – A Conceptual Framework



*Figure 2.* Wheel of Health Promotion – Conceptual Framework used to illustrate the relationship between health promoting actions, the determinants of health and health.

I have entitled this model the Wheel of Health Promotion. When observing the model, one can see that the determinants of health greatly influence the medicine wheel that represents the person, family or community. The two-headed arrows demonstrate how the determinants of health affect the medicine wheel and how the wheel affects the determinants. The literature, as well as my experience as an Aboriginal nurse working with Aboriginal people, has taught me that there is a connection between health as portrayed by the medicine wheel and the determinants of health. Health and the

determinants of health influence each other. The ways in which they influence each other are shown in Figure 2 as the arrows that surround the medicine wheel.

This study explored what influenced health, and if they reflect what has been recorded in the literature. The relationship and connections in this dynamic framework are illuminated as a result of the interviews with Aboriginal women. The conceptual framework is a visual depiction of how the determinants of health reflect the health of Aboriginal women and their families and their communities. The framework also can be used to illustrate the ways Aboriginal woman promote health. This conceptual framework also illustrates how the medicine wheel, the determinants and the health promoting actions of Aboriginal women fit together, each influencing the other.

### *Chapter Summary*

In this chapter I have presented my conceptual framework, the Wheel of Health Promotion. The conceptual framework provides the template for organizing the literature and is used to organize the study findings. The conceptual framework was developed using the medicine wheel and the determinants of health. The medicine wheel demonstrates how each component (physical, emotional, intellectual and spiritual) is equally important. I also provided a thorough overview, from the literature, of the 12 determinants of health and how they affect one's ability to be healthy. I also discussed the determinants of health that are found in the literature but are not included in Health Canada's (2003) list. This chapter has depicted the matrix of the determinants of health and the integrated role they play in determining a person's health status. This chapter, in relation to the definition of health, depicted how a person may be physically healthy but,

from a medicine wheel perspective, may be out of balance and therefore be deemed unhealthy spiritually, emotionally or intellectually.

### Chapter Three: Literature Review

#### *Overview*

A literature search was conducted using CINAHL, MEDLINE, PsychINFO, Cochrane, and Social Work library databases. When searching through the university databases listed above, the terms *Aboriginal / First Nations / Indian / Native Women* and *Health Promotion* resulted in only 17 articles and yet women's health gave a return of 17,553 articles. The health promotion articles present often were written from an illness perspective (e.g., Benard, Lee, Piper, & Richardson, 2001; Chang et al., 2003; Coughlin, Uhler, & Blackman, 1999; Grunfield, 1997; Henderson & Ainsworth, 2000; Hodge & Caskin, 1999; Hunt, Gless, & Straton, 1998). Positive articles that outline the strengths of Aboriginal women and their role in promoting health within their families and communities were absent in the literature. The literature reflected the women as having poor health promoting behaviors and poor illness prevention behaviors resulting in their high rates of chronic disease and their overrepresentation in the health care system.

Very few studies (Eyler et al., 2002; MacLeod, Browne, & Leipert, 1998; Mill, 2000; Thompson et al., 2002) addressed the determinants of health as possible barriers to optimum wellness. Studies that considered the determinants of health as the key to a balanced wheel focused on the determinant of culture as being the *be all and end all of factors that affect one's health* (Henderson & Ainsworth, 2000; Solomon & Gottlieb, 1999) rather than the matrix that the determinants encompass.

Illuminating the determinant of culture as a sole factor affecting health contributes to the racial sickness that currently exists within our society. For example, being *Aboriginal* predisposes one to a grim future including being at increased risk of a

sedentary lifestyle, diet high in fat, diabetes, heart disease, suicide and other illnesses.

The more comprehensible approach would be to look at all the determinants that affect an individual, a family and/or a community's wheel, not just their culture or race.

In this chapter, I discuss the barriers to achieving health, the history of Aboriginal people and the history of First Nations women. In the second half of the chapter I review the literature as it applies to Aboriginal Feminism and storytelling.

### *The Health of Aboriginal Women*

Aboriginal women have higher rates of chronic illness when compared to their non-First Nations counterparts. When compared to the Canadian average, Aboriginal women are 5.3 times more likely to have diabetes, 2.5 times more likely to suffer from hypertension and/or heart problems and 1.5 times more likely to have arthritis (First Nations and Inuit Health Branch, 1999). Although Canadian non-Aboriginal women live an average of 8 years longer than Aboriginal women (Martens, 2002), it is interesting to note that, as of 1995, life expectancy for Aboriginal women surpassed Canadian non-Aboriginal men.

A recent report on the health of women in Canada reported that smoking rates of Aboriginal women are double the national average, alcohol dependency is twice as common among Aboriginal women and, of those women dependent on alcohol, Aboriginal women are much more likely to experience depression (Canadian Institute for Health Information, 2003b). This report also states that Aboriginal women are at greater risk for chronic illnesses such as cardiovascular disease, diabetes, arthritis, rheumatism, and cervical cancer. The report goes further to state that Aboriginal women are at a greater risk of completing suicide, and are at a much greater risk for being victims of

sexual assault. Other reports support the claim that Aboriginal women are at a greater risk of being victims of violence (First Nations and Inuit Health Branch, 1999). Some reports claim as many as three quarters of all Aboriginal women experience family violence in their lives (First Nations and Inuit Health Branch, 1999).

Adolescent Aboriginal women and girls are more likely to become pregnant (First Nations and Inuit Health Branch, 1999; Royal Commission on Aboriginal People, 1996). Girls under the age of 15 living on reserve have pregnancy rates that are 18 times greater than the Canadian average (First Nations and Inuit Health Branch, 1999). According to the First Nations and Inuit Regional Health Survey, 54% of Aboriginal women breast feed compared to 75% of their non-Aboriginal counterparts, but after six months of age 39% continue to breast feed as compared to 24% of their non-Aboriginal counterparts (MacMillan et al., 1999).

Aboriginal women are better educated than Aboriginal men (Royal Commission on Aboriginal People, 1996). The most studied field recorded by the Royal Commission on Aboriginal People was commerce, business and management followed by health and then education. Even though Aboriginal women have higher education rates than their male counterparts, they are no more likely to hold a job. The average annual income for Aboriginal women in the years included in the study was \$11,900 which is significantly lower than the \$17,400 average annual income recorded for Aboriginal males (Royal Commission on Aboriginal People, 1996). The types of jobs that Aboriginal women are employed at are predominately clerical (27%) and in the service sector (25.9%).

The literature shows that there is a range of cultural and social affiliations among Aboriginal people (Waldram et al., 1995). Aboriginal people may be employed or

unemployed. They may live in urban areas, rural areas or on reserve. They may be gay, straight or bi-sexual. Aboriginal people may be Christian, non-Christian or Atheist. There is also a range of life experiences by Aboriginal people as well. Aboriginal people may be rich or poor. They may have been a victim or a perpetrator of abuse or may not have experienced any abuse.

Therefore, when making blanket statements such as Aboriginal people used to hunt buffalo would be a false stereotypical statement. The Plains Indians, such as those communities found in Manitoba, used to hunt buffalo but the Iroquois settlements of southern Ontario may never have seen a buffalo as they were more likely to be fishermen and gatherers (Waldram et al., 1995). As Waldram and colleagues portray in their book entitled *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives*, there are more similarities between the French and English language than there are between the Mohawk and the Ojibway languages. Different sub-cultures are reflected within the same reserve. Some families may choose to live a traditional life while others may choose to follow a Christian life. Both families may be from the same tribe/clan and may even be siblings but their traditions and cultural practices may be very different.

However, having said this, there is commonality within the social, economic and political sectors as an end result of colonization (Kirmayer et al., 2000). Many First Nations people share values which have come from similar experiences of colonization and also from their connectedness to the land (Damm, 1993).

### *Barriers to Achieving Health*

There may be many reasons why individuals may not be able to achieve health.

The proceedings from the Canadian Population Health Initiative held in November, 2002 listed five barriers to achieving a healthy community. The five barriers identified are:

1. Individual and interpersonal challenges which include addictions, negative attitudes, grieving, negative effects of residential schools, intergenerational conflict, low self-esteem, stigma of mental illness;
2. Community level challenges which include poverty, unemployment, high cost of living, weak economic base, weak infrastructure;
3. Capacity needs which include insufficient education, training, research and services, greater political capacity;
4. Governance issues which include paternalism, fragmentation of services, jurisdictional disputes, Indian Act; and,
5. Health outcome evidence which includes irrelevant indicators and absence of data (Canadian Institute for Health Information, 2003a).

Ellerby et al. (2000) outline the following barriers that impede access to care; “language, lack of cultural competence among health care providers, problems of transportation and communication in the service delivery to remote communities, and institutional discrimination.” (p. 846). Communication is often listed as a barrier to receiving adequate health care (Anderson, 1998; Boston et al., 1997). Communication can take the form of language (Ellerby et al., 2000) or it may take the form of other misunderstandings (Anderson; 1998). Gregory et al. (1999) explored the experience of urban Aboriginal people living with Type 2 Diabetes. They found that being treated in a

supportive manner by being given information and education and then having the power to accept or reject the information was cited as more helpful than being given ultimatums or strict rules, as so often is the case.

Lack of understanding of cultural sensitivity was an area for improvement identified in a study using a participatory action framework to look at the understanding of diabetes in James Bay (Boston et al., 1997). Boston et al. quote a study participant's feelings in regard to living with diabetes, "we were told to eat a lot of salads. It is so different from our traditional diet...eat more tomatoes, eat more celery, eat more pears...we don't even have Cree words for those vegetables" (p. 8).

Tookenay (1996) also listed cultural barriers as a place to target in order to improve the health status of Aboriginal people. If health care providers do not understand traditional practices they may label individuals as non-compliant or they may ask individuals to go against a traditional practice. For example, Sakokwenokwas (1990) writes about traditional Mohawk practice and pregnancy. If a woman is pregnant she should get out of bed early each morning and she should keep busy during the day. If a woman is prescribed bed rest, she will run the risk of being labeled lazy. Laziness is also believed to be passed down to one's children. Anderson's (1998) research with women and chronic illness raised the point that women were more likely to follow a treatment plan if the care provider explained the plan with words that she could understand. If the woman fully understood her illness, then the determinants that would affect her ability to be "compliant were life circumstances, workplace conditions, economic resources, and decisions about how resources should be parceled out in the family" (p. 15).

Lack of understanding with regards to living conditions may also be a barrier to “compliance” with prescriptions from health care professionals (Rivenbark, 1997). In the area in which I work, there is a nit-free policy for all children attending daycare and schools. I received a call from an elderly gentleman who is raising his four-year old granddaughter alone. The gentleman has poor vision and his granddaughter had been refused admission to a day care for several days because she was not “nit-free”. The man first of all had difficulty seeing the nits in her hair and secondly he did not have access to a washing machine or a vehicle. So to simply go home and wash the entire bedding, etc., is a much larger task than many health care professionals realize. The nearest Laundromat is an hour away. As health care professionals, we need to be cognizant of the determinants of health and their impact on families. The help that families may require may fall outside the traditional role the health sector has played. In the previous example, this man needed assistance for his granddaughter to become “nit free”. The assistance needed to come in the form of “nit picking” and assistance with washing bedding.

Prejudice, or perceived prejudice, is a reason cited for not obtaining health care services (Sokoloski, 1995). This may take the form of long waits and rushed visits, impersonal treatment, and high turn-over of medical professionals (Rivenbark, 1997; Tarrant & Gregory, 2003). Health care professionals in isolated areas move on to other postings frequently and may leave an impression of prejudice. This makes the continuity of care, important in the more urban areas of our province, non-existent in remote areas. Gregory et al. (1999) also found that rushed visits with limited time for discussion were perceived as a barrier in their study. A few of the study participants commented that they

were given a pamphlet and this was seen as less desirable than having the opportunity to discuss their health conditions with their primary care provider.

Tarrant and Gregory (2003) in their study regarding First Nations communities and immunization found that missed opportunities were the greatest barrier for study participants. Missed opportunities were a result of misinformation by health care providers and First Nations women regarding true contraindications for childhood immunizations.

Often First Nations communities are located miles away from tertiary care facilities and physician and pharmacy services. This requires individuals to travel to seek health care. There may be a nursing station or health centre present within the community but, in many circumstances, community members need to seek health care services outside of their community. Transportation issues are often cited as barriers to obtaining health care (Sokoloski, 1995; Tookenay, 1996). The communities in which I work are 45 minutes to an hour away from the nearest physician. If a family does not own a vehicle, it will cost between \$60-\$75 to hire a driver. One can see how dressing changes three times a week can cause families to be financially burdened.

Other personal issues that may not be First Nations specific but were listed as barriers include: lack of child care (Sokoloski, 1995; Tarrant & Gregory, 2003), fear of medical procedures (Sokoloski, 1995) and Federal-Provincial jurisdictional issues (Tookenay, 1996). Tookenay goes further to say that it is these political issues that are linked closely to health. Many families have three or four children less than 5 years of age. Even if one does have a vehicle, the energy that is required to make this trip is great.

If you are visiting a doctor from my area, you will wait an average of one to three hours in a waiting room filled with hard plastic chairs.

Federal provincial jurisdictional issues are often seen as a barrier for receiving health services. Many First Nations communities are wary of the Federal government's commitment to provide adequate health services to their communities (Cohen, 1994). As First Nations communities are looking to the federal Health Transfer Policy to provide health services that are band run, the communities are concerned that the federal government is trying to offload responsibility for the provision of services to First Nations bands (Cohen, 1994). In order for the communities to be successful they require adequate funding, in other words the dollars must not be decreased when the transfer takes effect.

Rapid changes in culture have been linked globally to depression, alcoholism, suicide and violence (Kirmayer, et al. 2000). It is well known that First Nations people have undergone many rapid cultural changes, as discussed previously, and have high rates of alcoholism, high rates of suicide, and high rates of violent crimes.

To access the formal health care system is often difficult for many Aboriginal women. There are gaps and barriers to Aboriginal people seeking health care (Smylie, 2001). Our system is inherent with high levels of exclusion of Aboriginal persons from cultural misunderstandings to structural barriers. We exclude First Nations women from many of our provincial programs as they are to access federal programs that are supposed to mirror the provincial programs. This is often not the case. Frequently, the community programming that is offered within the First Nations communities is limited. In urban

areas such as Winnipeg, the jurisdictional issues may not be as prevalent but the cultural barriers still exist.

Poverty and the associated health problems, from addictions to family violence to ill health, are prevalent in many First Nations communities. Some reserves are no further advanced than many third world countries. Some homes do not have running water and living conditions are such that more than one family must reside together. Many First Nations communities are located away from other major centers and this, combined with poverty, results in geographical isolation. This is the case in Manitoba where many First Nations communities are accessible only by air. In such cases, employment and education opportunities would only be available if individuals left their homelands to move to urban areas. The problem with this situation is that unless there is a connection to the large urban center the individual may lose their identity and experience culture shock. Even if a person is well connected to a support network within a large urban centre, urban lifestyles are much different than living in northern Manitoba. Despite the obvious differences in physical environments, one would be far away from their home, family and friends. A person could fly from Winnipeg to Las Vegas for the same price that it costs to fly to northern Manitoba, due to small airline services that cannot offer the reductions offered by larger airlines.

Phipps (2003) in her review of the literature on poverty found that the relationship between individual income and health is non-linear. Longer measures of average income have larger associations with health than measures of current income; long duration poverty has larger negative health consequences than occasional episodes of poverty. As

stated, Aboriginal people are much more likely, especially women, to be poor than non-Aboriginal people and one must consider poverty as a barrier to health.

### *The Past*

It is difficult to move forward in the present without giving some attention to the past. There are some events that stand out in history and warrant some discussion. The first event that has impacted the history of the First Nations people was the creation of reserves between the years of 1871 to 1877 (Carter, 1996). The location of the reserves, the grouping for residence on the reserves, and the bureaucratic control was all done by the federal government. Little thought was put into what was good for the people. People were sent to reserves and were separated from their family and friends. The Inuit, for example, were relocated to the far north to protect Canadian Sovereignty. Natives were banished to undesirable pieces of land that were far away from the "White" society (Kirmayer et al., 2000). Cohen (1994) in her study found that the relocation of people to what is now known as the Peguis reserve in 1908 resulted in changes in lifestyles. Changes included a shift to a more sedentary way of life, the conversion to Christianity, loss of their native language, and exposure to infectious diseases.

To date, one of the most detrimental events that has impacted on Aboriginal culture was the creation of residential schools. First Nations communities did not have a formal education system in place and it was believed by the White society that the children needed education. Residential schools were established and Aboriginal children were forced to leave their homes from age 5 until the age of 20. This was seen by the White society as a chance to have Aboriginal people learn how to assimilate into mainstream society. These schools were in existence for over 100 years from the mid

1800's with the final school closing its doors in the 1970's. During the 1930's peak of their existence, 75% of Aboriginal children were attending residential schools (Anderson, 2001). This phenomenon has impacted Aboriginal culture as traditional ways of life were not passed down through the generations. Languages were not learned. The once prominent and celebrated "Sundance" was not taught in residential school and was almost lost in time. In fact, government policies were put in place that forbid any "sacred" practices or rituals from taking place as they were often seen as being "offensive" (Beck et al., 1993). People were employed as "Indian Agents" and their job was to ensure that laws were followed in hopes of achieving complete assimilation. And very much like the African Americans of the United States, male and female Indians were punished by 50 lashes if they did not submit to "White laws" (Beck, et al., 1993).

Aboriginal people lost so much of their cultural roots and yet they were unable to assimilate into the new White culture to which they had been thrust (Hodgson, 1990). Residential schools were created so the children would be able to adopt the "White way" of living, not because the community members were seen as bad parents (Kirmayer et al., 2000). What resulted was too great for anyone to predict. There was hurt, anger and generations of children growing up without their parents and thus not learning crucial life lessons. There were no role models from whom to learn how to parent. There was not the stability and love that is provided by one's own home. Some children were abused physically, mentally, sexually and/or spiritually which only compounded the damage that had already been done.

The provinces are not free of mistakes either. When they took control of education and Aboriginal health and welfare, the focus became child neglect. Neglect

meaning that children living in poverty were not having their needs met. Rather than working with families and providing preventive counseling as was provided to other nationalities, the children were taken away and placed in foster homes and, on occasion, adopted out (Kirmayer et al., 2000). This did not occur that long ago. Kirmayer et al. state that by the end of the 1960's, 20-40% of children in care were Aboriginal as opposed to the 1% in 1959 which was prior to the federal transfer of responsibility. In Manitoba today, Aboriginal children account for 78% of the total number of children in care (Aboriginal Justice Inquiry, 2001). Recently, an Aboriginal Justice Inquiry has been struck and four divisions of child health and welfare have been established. These four divisions include: First Nation's Child and Family Services south, First Nation's Child and Family Services north, Métis Child and Family Services and the general Child and Family Services. This new restructuring of Child and Family Services will also place a greater emphasis on the prevention of child abuse and/or neglect rather than the apprehension of children.

### *Women of First Nations*

The history of Aboriginal women is not well documented in the literature. The history that is recorded is flawed as it was not written by Aboriginal women but rather non-Aboriginal men such as fur traders and clergy (Royal Commission on Aboriginal People, 1996). Aboriginal women throughout history have been depicted as either the "Indian Princess" or the "squaw". Steckley (1999) outlines the Indian Princess as being like Pocahontas, beautiful and intelligent, fighting for the beliefs of her people. The squaw, on the other hand, has no voice of her own and is at the beck and call of her husband. The squaw, Steckley states, was used by early settlers to reinforce that natives

were brutalistic savages, as the title is a degradation of native women. Green (1976) states that Aboriginal women were portrayed as a mother figure and being “exotic, powerful, dangerous and beautiful – and as a representation of American liberty and European classical virtue translated into New World terms” (p. 703). Green goes further to state that this mother-queen had a dark side, the savage squaw. Anderson (2001) states:

Native women have been historically equated with the land. The Euro-constructed image of Native women, therefore, mirrors western attitudes towards earth... The Euro-Canadian image of Native women has been constructed within this context and has evolved along with the evolving relationship of European people to this continent. (p. 100)

Anderson further states that Native women portrayed in relation to the land are “easy, available and willing” (p.101) for the white man.

Anderson (2001) and LaRoque (1997) echo Steckley’s (1999) dichotomy of First Nations women as either belonging to the Indian Princess category or the degradable “squaw”. LaRoque (1997) goes further to say that First Nations women have lived a doubly oppressed life. They are from a minority group and they are women. Hungry Wolf (1997) equates the oppression of women with the coming of Christianity. She states that when Christianity replaced traditional beliefs, this coincided with women losing their equality. Hungry Wolf goes on to state that women and men have always had a different role to play, but this by no means meant that one role was less important. With Christianity came the story of Adam and Eve. It is because of “Eve” that mankind has lost everlasting happiness and, as we know; Eve was a woman and therefore all women are upheld in the same regard (p. 78). Van Kirk (1980) writes that the lives of Indian women changed within the days of the fur trade. She stated that women played a vital role in the fur trade initially as a liaison between men. As circumstances changed and

many of the women became attracted to the European way of living, the women's role changed and they became less involved in the fur trade.

Van Kirk (1980) goes on further to discuss the life of Aboriginal women in the early days of settlers as being responsible for moving the camps as the lifestyle was very nomadic. She also states that the women had responsibility for the children as they were seen as the property of the mothers. Van Kirk discusses how the fur traders believed the lives of these women were deplorable and felt they had few liberties when compared to their European counterparts, thus further justifying the need for colonization to protect women from their lazy savage partners.

Carter (1996) and Anderson (2001) state that women were depicted as lazy and gossipy by the governments of the early settlers as a means to divert attention from their own inadequacies, conscientiousness and prejudices. Carter (1996) cites an example of Aboriginal women being portrayed as dancing on the dirt floors of their tents and raising dust that led to high infant mortality with the spreading of germs that lived in the dust particles. Aboriginal women were also depicted as not teaching their children according to European beliefs and were thus seen as being neglectful and indifferent to their children (Anderson, 2001; Carter, 1996). Women were called dirty, yet they had no soap or wash basins in which they could clean and no means to acquire any of these things (Anderson, 2001). They were living in tents with mud floors covered with hay. The shortage of yarns and material to make clothing was also a point Carter (1996) discusses. This was interpreted by the settlers as the women being lazy and of loose morals, thus they were not properly clothed nor were their children. Therefore, as the Aboriginal people adopted some facets of European lifestyles, they did not and were not able to

adopt all facets, yet they were judged for this. In other words, with the introduction of the settlers, the lives of many Aboriginal people became more sedentary and less nomadic. Carter (1996) also discusses the abuse of Aboriginal women during this time by many of the European settlers. The *Toronto Globe* (as cited in Carter) published articles about the loose and/or lack of morals of Aboriginal women. This did not bode well for the many women who charged men with rape as their cases were simply dismissed (Carter, 1996). Cruel behaviour of Aboriginal women was not acknowledged and at times encouraged by the media of the time. The people in power felt that these women were deserving of this harsh treatment and their accusations were seen as 'just trying to cause trouble, after all, they were just savages'. As a result, many women were raped and abused during this time (Anderson, 2001).

A strong positive description of Aboriginal women is absent from the literature. The fact it was the food harvesting of the women and the child rearing that has contributed significantly to the existence and future existence of Aboriginal people today was neglected. Instead, when reading about First Nations communities one reads about the hunters and the warriors that had moved the population forward (Peers, 1996). Without acknowledging Aboriginal women's contribution to life, a significant piece of the picture is missing.

In contrast and in reality, Aboriginal women hold the values of life and family in high esteem (Bastein, 1997; Dion-Stout, 1996). Women are also "the holder of stories, property rights, and names...privileged to be given the gift of Life-Giver" (Mckay, 1990, p. 130). Therefore, to be a woman is to be respected and honoured (Mckay, 1990). The woman is the center of life and the caretaker of life (Bastein, 1997; Malloch, 1989). It is

the woman's responsibility to nurture the spiritual and mental health of her children (Malloch, 1989). Bastein (1997) states it beautifully when she declares "one of the major roles of Indian women has been to maintain 'tribal identity' for their children and their children's children" (p. 127). It is the women who teach the children how to form relationships with self, others, community and the Creator.

The literature describes attributes of Aboriginal women (Allen, 1997; Anderson, 2001; Dickson, 2000; Dion-Stout, 1996; Ellerby et al., 2000; Hodge et al, 1996; Rivenbark, 1997; Sokoloski, 1995) that have been identified. It is important to note that the attributes are very general and were not always present in the Aboriginal women that participated in this study, nor would they be present in many women in general. Upon introduction, some Aboriginal women may appear shy and often will not give direct eye contact. This is a sign of respect (Dickson, 2000; Hodge et al., 1996; Sokoloski, 1995). Many Aboriginal women are told from a young age not to cry out in pain unless it cannot be helped (Rivenbark, 1997). Humor is, for the most part, very much a part of life (Dickson, 2000). Humor is often used to demonstrate that one is not perfect, and, if one can laugh at oneself, it shows that we do not consider ourselves too important (Beck et al. 1993). It may also be considered a coping mechanism. These are examples of cultural differences that are often interpreted by other health professionals as being noncompliant, aloof and even deviant (Allen, 1997; Hodge et al., 1996).

Traditionally, the Aboriginal woman's role in the family was, and remains today, very important. Family includes not only those in one's immediate family but includes extended family and even the community at large. Decision-making is not done alone but discussed with one's family and often the community (Ellerby et al., 2000). It is the

woman in the family who brings forth this discussion. The woman's role is a central one, one of a nurturer, a carer, a teacher and the bearer of life (Dion-Stout, 1996).

Sokoloski (1995) in her exploration of First Nations women and their beliefs about pregnancy reports that women questioned the value and the need for prenatal classes as teaching and educating is the role of the family, especially the grandmothers. So what can and has been interpreted as a "not caring about prenatal care" is actually a misinterpretation. The women do care about their pregnancies. It is the prenatal classes that are viewed as unimportant.

Child-rearing and parenting is a community initiative, not an individualistic task (Mckay, 1990; Sokoloski, 1995; Steckley, 1999). It is not uncommon to see children living with extended family. Children are a gift from the Creator. They are not owned (Mckay, 1990). An example would be giving a child to a childless couple so they will not be lonely. This would not be seen as not caring for the child, but rather as caring for the community. Anderson (2001) reaffirms that child rearing is a community responsibility. Men also have their roles to play and are not exempt from child rearing. But one interesting statement that Anderson makes is that it is the absence of traditional grandmothers who were the nurturers and counselors that has led to the breakdown of many families and, in essence, many communities. When the grandmother role is left empty, for whatever reason, the family is likely to collapse as there is nobody to fulfill this important role.

Aboriginal women over time have been abused – physically, emotionally, sexually and spiritually – and have not been given the same rights and privileges as their non-Aboriginal female counterparts, nor have they been given the same rights and

privileges of their male counterparts (Moore, 1993). Yet, this oppressed group of individuals is taxed with the responsibility of upholding culture, raising children and being the centre of family and community. A summary of the words of Chief Joe Mathias as written by Sayers and MacDonald (2001) refers to the Indian Act as being a conspiracy resulting in many losses including the loss of children, culture, land membership, and traditional roles. They state that residential schools and the banning of ceremonies are responsible for these losses.

For many women, this history is a large mountain to overcome. To many others, it has made them stronger and to cry out for justice. More and more women do not want to remain silent. The past few decades have witnessed the establishment of several Aboriginal women's organizations that want to be the voice of women and stop the oppression. These include: Native Women's Association of Canada, Aboriginal Nurses Association of Canada, the National Action Committee on the Status of Women, and the National Métis Women of Canada just to mention a few (Green, 1993). The year 2003 also has not only seen several female chiefs but also a woman in opposition for Grand Chief. This is certainly a step forward for Aboriginal women.

Manitoba Health (1999), Health Canada (2003) and several different organizations throughout the country (Canadian Institute for Health Information, 2003c) have taken notice of the health status and barriers that many First Nations women face on a daily basis. Poole (2001) states that the Women's Health Bureau of the British Columbia Ministry of Health is devoted to improving access and quality of health care treatment received by Aboriginal women. Aboriginal women are also identified as a target group at the Center of Excellence for Women's Health in Montreal (Dallaire,

2001). This centre develops practical objectives and interventions that enhance the health for women of Montreal. This centre is also affiliated with l'Universite de Montreal, where many research studies are conducted and many programs are put into place to address community needs. The data gathered are used to influence policy.

Manitoba Health has a division of their department dedicated to women's health – the Women's Health Unit. This division of Manitoba Health works very closely with the Prairie Women's Health Centre of Excellence located in Winnipeg. The Prairie Women's Health Centre conducted a survey with women from Manitoba and Saskatchewan. Four priorities emerged from the data and an action plan was developed. They include:

1. Reduce poverty among women and address the impact of poverty on women's health;
2. Improve conditions for unpaid and paid caregivers;
3. Respond to the specific health needs for Aboriginal women; and
4. Address violence against women.

A 12-point plan has been developed and it is hoped that this plan will impact policy decisions over the next few years and in turn improve the health status of many Aboriginal women (Prairie Women's Health, 2001). There are more Aboriginal women in Manitoba and Saskatchewan per capita than any other province. It is the plan to empower Aboriginal women to re-design health services to reflect their culture and their traditional beliefs. Access to health services is a large barrier for Aboriginal women and this is a key issue that will need to be addressed. The focus on healing rather than treatment is key to providing women-centred culturally-based services. The plan also recommends increasing the social economic status of Aboriginal women and providing

housing and community supports for older Aboriginal women within their communities (Prairie Women's Health Centre for Excellence, n.d.). The 12-point plan has been adopted by the Women's Health Unit. The Women's Health Unit has been moving the plan forward. The Women's Health Unit recommends that gender inclusive analysis take place in all program planning and that awareness campaigns that highlight the importance of gender as a determinant of health be under way (Manitoba Health, n.d. b). The Prairie Women's Health Centre has recently published a workbook titled *Including Gender in Health Planning: A Guide for Regional Health Authorities* and they are hosting workshops throughout the province to raise the awareness on the importance of women's health when planning health services. The Women's Health Unit also is recommending that more women be appointed to the Regional Health Authority boards so that women have a voice in the delivery of health care services (Manitoba Health, n.d.b).

Another initiative Manitoba Health has been working on is midwifery. Manitoba Health in partnership with Manitoba Education and Training and Nunavut has received funding to develop a four-year degree Midwifery program for Aboriginal students (Manitoba Health, 2005). This will allow Aboriginal women to deliver babies in their community with the assistance and teachings of Aboriginal midwives. Historically, Aboriginal women, often the grandmothers, would assist women to deliver their babies (Sokoloski, 1995). In recent years, Aboriginal women, both urban and rural, deliver their babies in Winnipeg hospitals.

Manitoba Health (1999) in their document, *Quality Health Care for Manitobans: The Action Plan for the New Millennium* has outlined an Aboriginal health strategy to address the growing health concerns of First Nations people. This strategy includes the

development and implementation of an Aboriginal Health Unit. This health unit will develop programs to fit the needs of Aboriginal people. They will also be responsible for the preparation of a provincial Aboriginal health strategy. This strategy will include the use of traditional healers and practices. In this document, Manitoba Health also declares the formation of a Women's Health Advisory Council that will look at the health needs of all women. To date, the Aboriginal Health Unit has been established in Manitoba Health and they act as a resource and in an advisory position for Regional Health Authorities within the province. The Women's Health Advisory Council has been formed and they are a strong voice for women in the province of Manitoba and they work very closely with the Manitoba Women's Health Unit (Manitoba Health, 1999).

This study explores how Aboriginal women promote health within their communities. Women have and continue to hold a pivotal role within Aboriginal society, one that is not well documented or given much recognition. Aboriginal women can be strong leaders with a nurturing undertone – one that is crucial for the survival of Aboriginal culture. The study documents how Aboriginal women contribute to their own health, the health of their families and their communities. The data are analysed for underlying themes. These themes are compared to the literature to determine if the health promoting behaviours and roles which currently exist are congruent with what has been written in the literature.

#### *A Lesson From the South*

In the process of completing the literature search for this study, when the word 'Aboriginal' is used, literature is uncovered that is written regarding the Australian Aboriginal people. It is interesting to note that many of the issues that are present in

Canada exist in Australia. Could this be related to any association with the term 'Aboriginal'? Freeman (1994) explored health promotion in Aboriginal communities and outlined a culturally orientated, community-based and community-controlled approach to health promotion. It offered suggestions to reach community residents in such a manner that is successful. Culturally based, community-controlled and community-based health care does not seem that different than what First Nations communities are striving for in Canada – transfer dollars to have health care managed at a band level.

In Canada, and more specifically Manitoba, health promotion that is community-based, community driven and culturally relevant is given a lot of lip service, but is often not delivered as clearly as it is outlined on paper. Often, seeking community input is a manipulation tactic and consultation is merely tokenism (Allen, 1997). Yet, community-driven programs are the ones most likely to succeed, especially in geographically compact and culturally strong communities (Hood & Benson, 1997). Hopefully, when all First Nations communities are given control over their health care, they will receive enough money to make health care sustainable, ensure programs are community-driven and those offering the programs are sensitive to community needs. Hopefully the program decisions of implementation are not left to band councils alone without seeking true community input. Often the Chief, who may live miles away from the community, does not know the programming needs of a young single mother with four children. Kirmayer et al. (2000) recommend, in their study that reviewed the mental health of First Nations people, that community development and local control of health care systems and services would greatly improve the mental health of many First Nations people. This would be the result of self-pride, control and collective efficacy.

### *Oral Traditions*

To understand Aboriginal culture and tradition one needs to look at the culture and the expression of culture. Aboriginal stories are passed down through generations in the form of oral teachings (Ellerby et al., 2000; Hodge et al., 1996; Reynolds Turton, 1997). Malloch (1989) states that it is difficult to even discuss Indian medicine without relating it to culture and life. This way of life, as Malloch puts it, is spoken and practised but not written. Reynolds Turton (1997) credits health choices and essentially survival to the legends, stories and role models that have existed over the generations. Kirmayer et al. (2000) state that myths and storytelling are “emblems of identity that circulate among Aboriginal peoples, providing opportunities for mutual understanding and participation in a shared world” (p. 10). Kirmayer et al. go further to say that storytelling is a way for people to make sense of their lives. Historically, Aboriginal people relied on storytellers to maintain stability within tribes and it was through oral teachings that sacred rituals were passed on through the generations (Beck et al., 1993). In other words, it was through storytelling that Aboriginal people received and maintained the instructions of how to live life.

Storytelling is a gift from the Creator that not all Aboriginal persons possess. A good storyteller pays particular attention to style, delivery, speed, tone and volume. Although there are many good storytellers, when people are dependent on oral teachings, history may very easily be or have been lost. We have all played the telephone game at some point in our childhood, where one person whispers a sentence into the ear of the person sitting beside them. That person then whispers what they heard into the ear of the person beside them and this continues until the last person hears the sentence and then

states it out loud. The sentence usually becomes so distorted that it is difficult to believe that it was actually the same sentence. Oral teachings may therefore become inconsistent between storytellers as stories are open to interpretation. Each time the story is told, the storyteller may add or delete knowledge. Are good storytellers hard to find? As stated previously, good storytelling is more than words, it is a gift from the Creator. Storytellers often receive their wisdom through dreams or visions (Beck et al., 1993).

Storytelling has traditionally been very much a part of parenting. At a workshop I attended, an Elder spoke of traditional parenting. The children were not abused physically nor were they put down. If a child needed to learn a lesson, it usually came in the form of a story. At some point in the story, the child would recognize their error and then be given the wisdom to change their behaviour (E. Courchene, personal communication, November 2001).

How do Aboriginal women promote health for themselves, their families and community? To do this topic justice, the research design is women-centred interviews, a qualitative approach. This allows for the richness of the stories to flow naturally. Stories are gathered through interviews that consist of semi-structured questions designed to elicit the perspective of Aboriginal women. A copy of the questions can be found in Appendix A.

To address the gaps that are currently present in research about Aboriginal women, researchers need to adopt methodologies that are culturally appropriate (Dion-Stout, Kipling & Stout, 2001) and based on Aboriginal concepts. In this study, the Aboriginal concepts of holism and health are adhered to and the use of women-centred

interviews is culturally appropriate as it allows for the practice of storytelling to remain the means of education.

### *The Feminist Paradigm*

Feminist research means different things to different researchers. The literature varies in description of feminist theories. I will provide a very simplified overview of a variety of writings and belief systems. The feminist paradigm arose out of criticism of traditional research. Traditional research has been dominated by White middleclass men and therefore not representative of the population, as women's voices are essentially not represented (DeMarco, Campbell, & Wuest, 1993). Chinn and Wheeler (1985) define feminism as a "world view that values women and that confronts systemic injustices based on gender" (p. 74).

Essentially, there are four schools of thought that encompass the feminist paradigm. These include the following; liberal feminist, Marxist feminist, socialist feminist and radical feminist. Liberal feminists argue that oppression is rooted in legal constraints as women are seen to be less intellectual and less physically capable than men (Tong, 1989). They believe that oppression can be overcome by providing legal rights and opportunities for women and men (Chinn & Wheeler, 1985).

The Marxist feminists believe that there needs to be a move from Capitalism to Socialism if we are to ever be liberated (Tong, 1989). They believe that feminism originated with the introduction of private property and women and children became the property of men (Chinn & Wheeler, 1985).

Socialist feminism is a school of thought that is present in some of the literature. This categorization has a strong emphasis on cultural institutions such as the patriarchal

family, motherhood, housework and consumerism playing a major role in the oppression of women (Chinn & Wheeler, 1985).

The radical feminists focus on biological origins of oppression (Tong, 1989). To end oppression in this belief is to end all institutionalized gender discrimination and all gender roles (Chinn & Wheeler, 1985). Therefore there would be an acceptance by humanity that women and men are equal in all aspects of life.

### *Aboriginal Feminism*

I will adopt the Aboriginal feminist thinking in my study as discussed by Dion-Stout (1996). Dion-Stout states that Aboriginal feminism differs from mainstream feminism in that:

We reject the over-emphasis upon personal success and achievement that is embodied in such sayings as 'it will all be because of me', focusing attention instead upon the ways in which women's oppression is linked to the wider domination of all men and all women. Still, given the pain that Aboriginal women have suffered at the hands of Aboriginal men, it is unlikely that the practice of Aboriginal feminism will be free of contradiction and conflict, and indeed Aboriginal women are often told that, by challenging women's oppression, we are betraying our womanhood, and diverting attention away from the larger, and by implication more important, struggle for self-government. (1996, ¶ 23)

Aboriginal feminism looks at the equality of Aboriginal people *and* the equality of Aboriginal women compared to Aboriginal men. Other authors refer to this as Tribal Feminism (Deerchild, 2003). With the beginning of the women's movement and the rising of feminist groups throughout the country in the early 70's there was a strong focus on sex discrimination by many women's groups (Krosenbrink-Gelissen, 1998). When Aboriginal women first began standing up for their rights, historically the Aboriginal men and other Aboriginal women viewed them as slowing down the process for self-government.

Although many Aboriginal men may argue that women have been treated as equals, one does not need to look very far for the striking inequities. Native women are seldom in leadership roles such as that of Band Chief, for example. Very few Council seats are held by women and, to date, there have been no female Grand Chiefs. This year, 2004, however, marks the first year for a female leader to campaign for this position.

A disparity that occurred as a result of government policy was in relation to marriage. In 1857 an Act was established to encourage the gradual civilization of Indian tribes to the provinces and it was known as the Gradual Civilization Act (Royal Commission on Aboriginal People, 1996). With the marriage of Aboriginal women to non-Aboriginal men there was a loss of the woman's treaty status. To lose one's treaty status meant that you were not entitled to any treaty rights including that of living on reserve. One can see the dilemma when a treaty woman lost her treaty status through marriage and then divorced. Where would this woman and her children live? Could they return home – as many other non-Aboriginal people do to live with their family? This was not permitted. What really added 'fuel to the fire' for many Aboriginal women was when a non-Aboriginal woman married a status man. The woman became status and, even in the event of a divorce, she was permitted to keep her status and live on reserve. As one native woman stated, she was not allowed to live in a home close to her family, yet their neighbour was a White woman with no native ancestry and she was allowed to stay.

Women were outraged and a few cases (Lavell and Bedard) challenged the Canadian Bill of Rights (Krosenbrink-Gelissen, 1998). The Native Woman's Association of Canada (NWAC) became very interested in the outcomes of these cases. Even though

this organization was born just a few months prior to the cases being filed, it really gave them a direction in which to focus their efforts. The cases were defeated by a narrow margin of 5-4 in favour of the Indian Act (Krosenbrink-Gelissen, 1998). The only way to affect change now would be to open the Indian Act. At the same time as this was taking place, the predominantly Aboriginal male *Indian Brotherhood*, who were solely responsible for deciding treaty status, saw the defeat as a victory for Indian Rights (Krosenbrink-Gelissen, 1998). This is where the Indian movement and the women's movement collided. The Assembly of First Nations also saw NWAC as an opposing force (Green, 1993). The only solution would be to open up the Indian Act, but to open the Indian Act was seen by the Aboriginal men and also many Aboriginal women as tampering with their treaty rights (Krosenbrink-Gelissen, 1998). Aboriginal men portrayed NWAC as a "bunch of feminists" who was only interested in the rights of women and not in the right of Indians (Green, 1993; Krosenbrink-Gelissen, 1998; Moore, 1993).

The Native Women's Association Council claimed that the Indian Act itself is full of gender discrimination and was the very reason for NWAC's existence – to fight for the rights of Aboriginal women. The Indian Act was established to;

1. Establish the rules of governance which bands must operate under;
2. Define who is and who is not recognized as an "Indian" (Congress of Aboriginal People, 1998).

Sandra Lovelace, a First Nations woman, lost her status through marriage to a non-Aboriginal man. When their marriage began to dissolve, she wanted to return home to her family and was informed that she was not permitted to reside on the reserve

(Moore, 1993). Ms. Lovelace, having no legal right to return to the reserve as defined by Canadian law, filed a complaint with the United Nations (UN) Human Rights Committee in Geneva (Krosenbrink-Gelissen, 1998; Moore, 1993). The federal government was so embarrassed by this incident that they promised the UN they would rectify the situation, hence the enactment of Bill C-31 (Castellano, 2002; Krosenbrink-Gelissen, 1998; Moore, 1993). It looked as though there would be some changes as women who lost their treaty status through marriage were now permitted to be reinstated. Even though a woman was reinstated through Bill C-31, however, the Bill still left decisions to be made at a local band level (Krosenbrink-Gelissen, 1998). Therefore, in most cases, the woman was still not permitted to partake in any of the rights inherent to those who live on reserve nor was she permitted to move back to the reserve. These laws remain in existence today.

So what does all this mean to feminist research with First Nations people today? The term feminist carries a wide range of perceived definitions. It may be viewed as negative by some people, both males and females. It may be seen as interfering with the progression to self-government, with the tampering of treaty rights, and anti-Indian. These thoughts and perceptions must be known and acknowledged and the oppression of Aboriginal women must also be viewed in the context of the oppression of Aboriginal people.

Aboriginal feminism sees all people as having an important role within life. No role is stronger or more powerful, just different. And why is it important that women have a political voice? When you think about where decisions are made in Aboriginal governments, it is crucial to the existence and health of Aboriginal people that women have a voice within their communities. With decisions regarding the funding programs,

the listing of community priorities, the allocation of this year's budget, etc., when women have no voice, it is difficult to see progression. In the words of Gail Stacey Moore (1993)

We have disproportionately high rates of child sexual abuse and incest. We have wife battering, gang rapes, drug and alcohol abuse-every kind of perversion imaginable has been imported into our daily lives...Men rarely speak of family violence. Men rarely speak of incest. Men rarely speak of gang rape and what they are doing about it. (p. 23)

Although men rarely speak of the violence, incest, rape, etc., it does not mean they do not suffer. Oppression of Aboriginal women is rooted in biology, as women are the child bearers. Oppression is rooted in history – whether it was with the coming of Christianity or the coming of the fur traders, or maybe even the knowledge of a different way, there became a point in history where woman became oppressed and continue to remain marginalized.

Aboriginal feminist theory may be compared to the writings of Bell Hooks (1984), an African American feminist who takes into account the years of oppression and colonization that many Black women have experienced in the United States. Bell Hooks was one of the first feminists to challenge existing feminist theory. She stated that feminist theory was developed by middle to upper class White women who decided they wanted more to life than a husband and children. Hooks goes on to state that for women from minority groups to achieve equality with men does not mean it will affect their social status very much. The men within minority groups are oppressed as well and therefore are not much better off than their female counterparts. Men, whether they are a minority or not are always more advantaged over women.

Emberly (1997) states that as the feminist movement geared forward, the voice from Aboriginal women was absent. Feminists, for the most part, are academically

privileged and often fought for the rights of White middle-class women giving little attention to their Native counterparts. As this group of individuals has been dually oppressed (Dickson & Green, 2001) there is much merit in a feminist approach to research. This study was conducted with Aboriginal women. It was not about Aboriginal women and as Oakley (1999) stated in her writings, "feminist qualitative researchers argue that the p's they are interested in do not concern the probabilistic logic of statistical p values, but the value of people" (p. 36).

### *The Feminist Research Criticisms*

Feminist research claims that it is by women for women (Parker & McFarlane, 1991). However, if you are to separate women from men and their culture, you are saying that women's health is independent of men and the structures dominated by men (Thorne & Varcoe, 1998). This point hardly seems like a point in this study. When looking at the conceptual framework that I developed, the assumption that *any* facet of a women's life can be studied independent of the matrix in which she lives is impossible. As stated previously, health in the Aboriginal community is synonymous with living and cannot be separated out as a resource. It is measured by the mind, body, soul and spirit of a person (Braswell & Wong, 1994; Ellerby et al., 2000; Malloch, 1989). The wheel represents the individual and the determinants of health or life are factors that influence one's balance. To promote health is to positively affect the determinants.

### *Chapter Summary*

The literature clearly is missing some of the positive health promoting actions or behaviors engaged in by Aboriginal women. In this chapter, I have discussed the history of Aboriginal women from the time of early settlers to present. The traditional role of

Aboriginal women has been depicted. I also discussed the importance of storytelling and oral traditions.

Feminist research was discussed and Aboriginal feminism was defined. The reason why feminism among some Aboriginal women is shunned was explored through the literature. In the methodology chapter that follows, the research design and methodology for my study are discussed.

## Chapter Four: Methodology

### *Introduction*

I obtained ethical approval to complete this study from the University of Manitoba Education / Nursing Research Ethics Board (Appendix B). This qualitative study allowed for a richness of data gathered through storytelling. The data or the stories are a window into the meaning of health and health promoting behaviours of Aboriginal women who were interviewed. Feminist theory was the lens through which this study was viewed. The stories or data collection were gathered by women-centred interviews (Levy & Hollan, 1998). This research design allowed for the women's stories to be told as their participation in health promotion was explored. Content analysis (Waltz, Strickland & Lenz, 2005) was used to make sense of the data.

### *Feminist Methodology*

Methodology may be defined as "a technique and analysis of how research does or should proceed" (Harding, as cited in Campbell & Bunting, 1991). I am not a feminist scholar although I claim to be a feminist. Feminist methodology was useful to this study. The women's stories and experiences are a resource for determining questions to be asked and theories to be developed (Thorne & Varcoe, 1998). To qualify as feminist methodology (the literature varies) but some form of the following identified criteria or principles must be present. These criteria include:

1. The principal investigator is a woman. Although some of the literature states that the principal investigator should be a woman, other literature stresses the importance of understanding the participant's experience (Bernick, 1991) as

understanding of a participant's experience cannot be achieved solely by being of the same sex.

2. Feminist methodology is used. This is determined by one or more of the following: interaction between the researcher and the participant, non-hierarchical relation between the researcher and the participant, expression of feelings and/or concern for values. There is a clear recognition that there are ideologies, structures and interpersonal conditions that oppress women.

3. The researcher is focused on the experience of the woman. This is defined as having to do with how a woman lives through the topic of research. Therefore there is a valuing of women and a validation of their experiences, ideas and/or needs. There needs to be the recognition that not all women's experiences are the same but vary as women's lives are affected by all the determinants of health, not just gender.

4. The purpose of the investigation is to study phenomena important to women.

5. Bibliographic references to feminist literature are included.

6. Non-sexist language is used. The goal is not to further oppress women (Campbell & Bunting, 1991; Denzin & Lincoln, 2003; Hall & Stevens, 1991; Parker & McFarlane, 1991).

Feminist methodology is a good fit with who I am as a researcher. This method was also a good fit with the study participants. The methodology allows for reflexivity, which is, locating my experiences and thoughts while engaging in this process (DeMarco et al., 1993; Hall & Stevens, 1991; McCormick & Bunting, 2002). This research was designed to be a positive experience for the study participants as it was done with them

not to them (Thorne & Varcoe, 1998). My study adds to the body of knowledge in many areas such as nursing, social work, family studies, women's studies and other disciplines that are interested in the positive role that women of Aboriginal descent play in promoting health within themselves, their families and communities.

### *Epistemology*

Epistemology may be defined as a theory of knowledge. Epistemology is what guides methodology. Epistemology answers the questions; what is truth and who can know it? It guides the criteria that must be met before information can be accepted as truth (Campbell & Bunting, 1991). Characteristics of epistemological acceptance include:

1. Women's experience can be a legitimate source of knowledge-women can be knowers;
2. Subjective data are valid;
3. Informants are experts on their own lives;
4. Knowledge is relational and contextual; and,
5. Definitive boundaries between personal and public or personal and political spheres are artificial, as are sharp distinctions between theory and practice (Campbell & Bunting, 1991).

Harding (as cited in Olesen, 2000) has identified three types of feminist inquiry which include feminist empiricism, standpoint theory and post-modern theories. Feminist empiricism looks at how to make theories of knowledge less susceptible to gender bias. The belief of this inquiry is that one could capture and explain a social world where gender bias does not exist (Campbell & Wasco, 2000).

Standpoint research assumes that no single objective truth can be found. A person's understanding is rooted in their class, race, gender and sexual orientation (Campbell & Wasco, 2000). This feminist inquiry also assumes that marginalized individuals are in the best place to understand social reality. Research that is done from this framework engages participants in reflecting on how their gender, race, social class and sexual orientation shape their experiences in the social world (Campbell & Wasco, 2000). As the researcher, reflection on my own social situation influences my interpretation of data.

Post-modern theories also suggest that there is no single truth or reality and question if there could be a feminist science (Campbell & Wasco, 2000). This type of inquiry presupposes that the construction of knowledge is inherent and subjectively bound because science is rooted in text and text is not a natural reflection of experience (Campbell & Wasco, 2000). Therefore, the construction of knowledge is limited by language and subjectivity. Post-modern theories look for commonalities and differences in the lived experience.

Although it may be useful to categorize studies into these three categories (feminist empiricism, standpoint theory and post-modern theories), many studies are a blend of the three different types (Olesen, 2000). In this study there are multiple realities not just one single truth. In this study, gender, class, race and history affected how the women understood and expressed their reality. The findings are analyzed with respect to the commonalities in their experiences as well as their differences arising from their experiences. Therefore, this study does encompass the feminist inquiries of standpoint research as well as post-modern theory.

### *Method*

Method may be defined as “a technique for (or way of proceeding in) gathering evidence” (Harding, as cited in Campbell & Bunting, 1991). Techniques for gathering evidence can include observation, listening or questioning study participants or examining records (Campbell & Bunting, 1991). In this study, women-centred interviews were used to generate data. Levy and Hollan (1998) define women-centred or person-centred interviews as a “mixture of informant and respondent questions and probes” (p. 334). The interview was a conversation between the study participants and me, the researcher.

### *Sample*

This study explored the ways Aboriginal women define and promote health. A convenience sample of 16 women over the age of eighteen who self-identified as Aboriginal was interviewed. All the women were interviewed once and the interviews were one hour to an hour and a half in duration. The interviews were tape recorded and transcribed verbatim by a professional transcriptionist.

According to Pyett (2003) there is no magic number of participants required for a qualitative study to ensure the study has reached data saturation. She further states that to be “counting responses misses the point of qualitative analysis” as it is the quality of the responses gained not the number of respondents that share that response. Morse (1994) states that no less than six participants should be recruited when trying to understand the essence of experience. To achieve “thick data” or rich data, data saturation should be achieved. Saturation is the “repetition of discovered information and confirmation of previously collected data (Morse, as cited in Streubert Speziale & Rinaldi Carpenter,

2003). In other words, themes or patterned data should begin to emerge (Morse, 1994; Pyett, 2003).

After each interview I made notes regarding any impressions I had after the interview. For example one of the participants was ill and it did not come across as strongly in the interview with her words but I knew by her body language that she was in a considerable amount of pain. I asked the participant if she wanted to stop the interview and we could continue at another time but she wanted to continue. I made a note of this as I thought this piece of information was important to the analysis of her responses.

The tapes were given to a professional transcriptionist for transcription. I read and reread the interviews to find similarities within the data. As each new interview was read, data patterns began to emerge. For example one participant spoke of growing up with a father who was an alcoholic. The next participant spoke of using drugs. Another participant spoke of addictions being a barrier to health and so on. The theme of addiction as a barrier to health emerged. This was the process that was followed and several themes emerged. Data saturation was evident with the 16 interviews completed as many of the stories had similar data patterns and these data patterns lent themselves to clustering which resulted in themes.

### *The Setting*

Interviews were conducted at a Family Resource Centre in rural Manitoba. Fontana and Frey (2000) suggest that the following be considered when preparing to interview study participants:

1. The setting – The setting was one of the participants choosing that was quiet enough and comfortable enough to allow for a conversation to take place. All

interviews took place at the family resource centre as per the participants' choice. No participants opted to have the interview take place within their homes or alternate locations.

2. Understanding the language and culture – All the study participants spoke English. There were variations in cultural practices, which I discuss in the findings chapter; all participants' cultural practices and beliefs were respected.

3. Presenting myself – Prior to the interview, I reviewed the consent form (Appendix C) with each of the participants. I explained that I was an Aboriginal nursing student completing my Master's degree in nursing and as part of my educational fulfillment I have chosen to complete a thesis. I explained what my thesis was about and gave the women time to ask any questions they may have had at the time.

4. Gaining trust – I had hoped that my past connections with the community would have helped in establishing a trusting relationship. Of the 16 participants, only 4 participants were aware that I had worked in the area prior to meeting me for the interview. I believe that because I am an Aboriginal woman, I was able to quickly gain the trust of the participants. I also discussed confidentiality and what this meant. I believe knowing that they would remain anonymous allowed for the freedom of information sharing without the fear of repercussions.

5. Establishing rapport – the goal of this thesis was to tell a story and in order to do that I had to understand what the participants were saying. For the women to be comfortable and to share with me some very intimate details of their life, a trusting relationship had to be established. Rapport with the participants was important for the

study to be successful. I believe I gained rapport with the participants quickly and for the reasons listed above they shared their stories freely.

### *Recruitment of Participants*

The Family Resource Centre is a grassroots community non-profit organization that offers many programs and services to the communities within rural Manitoba. A letter was sent to the Family Resource Centre for assistance in recruiting participants (Appendix D). The programs offered include a pre and postnatal home visiting team, a breakfast program within two schools, parenting classes, and drop-in programs within the building and they also do outreach to surrounding communities. The centre also has a second hand store and coffee and nutritious snacks Monday through Friday. Last year the centre had over 5000 interactions with local community members. At least 85% of the participants are Aboriginal and of this 85%, approximately 80% are women of varying ages.

Participant recruitment took place in the following ways:

1. Posters were displayed throughout the Centre and were also distributed to other community contacts to display (public health nurses, Child and Family workers, community development workers and social workers). This included my contact information so the women could contact me directly or they could leave their name and contact information with the staff of the family resource centre. The posters requested Aboriginal women volunteers who would be interested in participating in a study that would be exploring ways in which Aboriginal women promote health for themselves, with their families and communities (see Appendix E).

2. The staff of the Family Resource Centre announced recruitment information during their various programs. The outreach worker and the director were briefed on my study and provided a script which they read out to their program participants. The script included a description of the study, the commitment it entailed, and the provision of an honorarium. The staff recorded identifying information such as names, and phone number/way of contacting. The staff then contacted the participants with the dates that I was going to be at the Centre and participants were offered a ride and child minding in order to attend the interview.

I attended the Centre on five separate occasions and received a total of 16 volunteers. The participants were given a twenty dollar honorarium for their time. All participants signed two consent forms (Appendix C) that were read aloud to them. One signed copy was given to the participant for their future reference and a signed copy remained with myself. The participants were given the option of participating immediately or they were told they could take some time to think about it and were given dates when I would be returning to the community. Seventeen women in total had indicated a willingness to be in the study. Sixteen women agreed to the same day interview and one woman decided to come back at a later date. This woman returned and informed me that she no longer wished to participate. Although the women agreed to participate, they were told that if at any time during the interview they would like to stop we would stop and they would still receive their honorarium. A tear off request for a summary of study findings was attached to the consent form (Appendix C) and 12 of the 16 participants requested a copy of the summary of the findings.

Although I did not directly recruit the participants, it was thought that many of the participants might know or be aware of me through my previous work as a public health nurse in the area. In my discussions with the participants, I ascertained that four of the participants were aware of me as a former public health nurse. I stressed that participation in the study was voluntary and if they chose not to participate it would not have affected the relationship of the participants to me, the Regional Health Authority or the Centre. I was no longer providing direct client service to the residents in this area at the time of the interviews.

### *Ethical Considerations*

Participant recruitment was done by the Centre staff. This was to ensure that participation was obtained without the pressure of having to participate or being coerced to participate. Having a second party responsible for recruitment addresses the ethical concerns of respect, beneficence and justice (Clarke, 1997). Once the women agreed to the first step of the recruitment process, the staff contacted me and I gave them the dates which I would be at the Centre. The women were then contacted by the staff and given the dates that I would be at the Centre. Originally three dates were "booked" but two additional dates were added to meet the needs of the participants. The women came at their scheduled time and the first thing we did was go over the consent form. We discussed each point and I answered any questions the women had. The women were given the choice between having the interview at that time or at a future date. Sixteen women chose to complete the interview immediately following the consent process. One volunteer declined as she did not have enough time. She took the consent form and stated she would come the next time I was at the Centre. The Centre staff called the volunteer as

a reminder the day before I was to come to the Centre and she stated that she no longer wished to participate.

After informed consent was obtained, the interview proceeded with the questions found in Appendix A. If the woman needed to stop and leave and then return to finish a second interview would have been scheduled. The extra interview was not needed for any of the participants. A summary of the findings was be distributed to the 12 women who signed the request for a summary sheet. There will also be a community presentation of the study findings at the Centre and all study participants will be invited to attend. There will also be an open invitation to the women of the community to ensure anonymity of the study participants. The women were given the opportunity to choose the interview location as discussed previously. They were informed that the interview would be taped and that they could stop the tape or the interview at any time. They were informed that the purpose of the study was for fulfillment of my thesis and the goal of my study was to determine what Aboriginal women do for themselves, their families and in their communities to promote health. Privacy and confidentiality were two other ethical concerns that needed to be addressed (Olesen, 2000). The women were told that the study may be used in future journal publications and that their names would not be used to protect their identity. A further step of changing details of the data so that anonymity would be protected would be done as well. Also, when using exemplars or when discussing any of the study participants, pseudonyms have been assigned to each of the participants. A consent form was signed (Appendix C) by all participants. The women were provided with a small honorarium of \$20.00 for taking the time to participate in this

study. All the study participants were offered child minding services and transportation if needed to participate in the interview.

### *Data Collection*

The women were asked if the interviews could be taped. All 16 participants agreed to have their interviews taped. The women were informed they could stop the tape recorder at any time and the recorder was placed within their reach. The taped interviews were transcribed verbatim by a professional transcriber. The transcriber signed an oath of confidentiality to ensure anonymity to the study participants. The transcriptionist provided the researcher a paper copy and a disk of each of the interviews. When she was completed transcribing, the transcriptionist deleted all the interviews from her hard drive. The interviews were checked from the tape to the transcription for accuracy by the researcher.

Prior to asking the interview questions, the women were encouraged to tell their story as it related to promoting health for themselves, their families and communities. The demographic information as presented in Appendix A was collected. The demographic information provided data including residence, education level, number of children, age, and employment and so on. The demographic information told a story on its own as it includes many of the determinants of health.

A semi-structured interview consisting of demographic and open-ended questions then took place with each of the participants. The interview was more like a conversation than a formal process and the questions allowed for "going off topic" conversation (see Appendix A). Probes were used to guide the direction of conversation and to verify the meaning of some of the statements being made. The "off topic" discussions provided an

opportunity for data that may not otherwise have emerged. The interviews took approximately one hour to an hour and a half to complete. The participants that came with their children received child minding services and transportation when required. The child minding services and the transportation removed two barriers that often prevent women in these circumstances from being able to participate in such events.

### *Trustworthiness*

Davies and Dodd (2002) state that rigor refers to the reliability and validity of research. Reliability in traditional research means the same results can be found each time the test is preformed. Davies and Dodd (2002) state that for a qualitative study to be reliable it should be based on consistency and care in the application of research practices as well as in the analysis and conclusions. In this study, the same open ended questions were asked consistently and the same analysis method was used to analyze all the data.

To ensure trustworthiness of the data, the women's stories needed to be credible, transferable and authentic (Scruby, 1999). Streubert Speziale and Rinaldi Carpenter (2003) state that the question of rigor in qualitative research is moving beyond the positivist convention of reliability and validity. They further state that qualitative research should consider the criteria of credibility, dependability, confirmability and transferability when demonstrating rigor. I believe this study is credible as I did confirm my participants' responses during the interview. After each interview I took field notes so I could remember points that may not have come out in the interview. I gave the example earlier of one participant who was ill during the interview. Body language, mood, appearance, comments made after the interview was complete are examples of the type of data that was contained in my field notes. I reviewed each of the transcribed interviews

and compared them with the taped interviews. This ensured accuracy in terms of what was transcribed was what was said. To be authentic is to be one's true self. I believe the women were authentic in their stories as they shared openly and willingly. The study is dependable as I did achieve data saturation and common themes emerged from the data. Common themes were identified as study participants began stating the same thing. The themes did echo my literature review. To increase the confirmability of my study, my thesis supervisor reviewed participant responses and together we came to consensus on the themes that were emerging from the data. The definition of health, the health promoting behaviours and the barriers to health promotion and wellness will be useful to people working with Aboriginal women for the purpose of understanding and program planning. "Transferability refers to the probability that the study findings have meaning to others in similar situations" (Streubert Speziale & Rinaldi Carpenter, 2003, p. 39). This study has transferability as the study findings may also be useful to the participants and other Aboriginal women as a source of validation and knowledge to know that many Aboriginal women have had similar experiences. The findings of this study add to the limited existing literature regarding health promoting activities of Aboriginal women. For these reasons, I believe my study has transferability or has the appropriate "fittingness" (Streubert Speziale & Rinaldi Carpenter, 2003).

### *Data Analysis*

The data were analyzed through standard content analysis. Boyatzis (1998) refers to this analysis as thematic analysis and defines it as a way of seeing or finding a pattern or theme in what appears to be random information. There are various methods of content analysis outlined in the literature (Ryan & Bernard, 2000). I used a process as outlined by

Burnard (1991) with slight modifications. The aim of the analysis is to “produce a detailed and systemic recording of the themes and issues addressed in the interviews and to link the themes and interviews together under a reasonably exhaustive category system” (p. 462). The process used was as follows:

1. Field notes were recorded after each interview. These notes served as “memory joggers” for the interviewer and also included any thoughts regarding possible ideas for themes;
2. Reading through the transcripts for any general themes;
3. Open coding was done; headings or categories freely generated and accounted for almost all of the interview data, with the exception of “dross” (unusable fillers);
4. The categories were grouped together by higher-order headings in order to reduce the number of categories through collapsing existing categories resulting in categories with sub-headings;
5. The new categories were examined and similar categories were collapsed;
6. Transcripts were re-read and checked against the categories to ensure all meaningful aspects of the interview had been covered;
7. Categories and sub-headings were coded according to the list of category headings and different highlighting markers were used in each of the interview transcripts to distinguish data;
8. Text was cut out (on the computer) according to the color schemes; and,
9. Same colored text was pasted (on the computer) together under sub-headings and categories.

At times it was necessary to go back to the taped interview to hear the context of what was being said by the participant. During the writing up of the findings the transcripts remained available for cross referencing.

An executive summary of the findings was disseminated through the mail to each study participant who requested a copy or, if requested, the findings were delivered in person. Also, a community forum with the presentation of the findings is being organized and will be held at the Centre. All the study participants as well as any women from the community who wish to attend will be welcome. An article will be submitted for publication and all identifying criteria will be removed so the study participants will remain anonymous.

### *Power*

The feminist paradigm is one in which power (Moradi, Mezydio Subich, & Phillips, 2002) and objectivity is given considerable consideration when researching populations, especially vulnerable populations. Feminist research recognizes the power that has been present in traditional research designs. Feminist research strives to eliminate or at the very least, decrease the power inequities that are embedded in traditional research (Parker & McFarlane, 1991; Thorne & Varcoe, 1998). Issues of power have been addressed as much as possible in this study. Power was decreased by interviewing women at a site of their choosing. All participants chose to be interviewed at the Family Resource Centre. The tape recorder was placed in front of the participants thus giving them control over what was and was not recorded. The participants were informed that at any point during the interview they could stop the tape. They were also reassured that by stopping the tape it would not affect their honorarium. Another point of

power as a researcher came when some of the women were clearly vulnerable during the narration of their stories. They became emotionally distressed to think back to certain points in their life. As a researcher I validated their feelings and reminded them how far they had come since this point in their lives. Also, with three different participants, after the interview was over, I did recommend that they contact various health professionals to help them address the issues that had arisen. I had no direct power in the workplace over these women, but I had power as a researcher and a graduate student.

I believe this research study has been an empowering experience for the study participants. The interview provided several of the participants a reason to reminisce and be proud of their many accomplishments. In the words of Madeline VanderPlaat (1999)

The ability to be empowering or to support somebody else's capacity to be empowering grows out of mutual recognition that all of us can contribute to the construction of knowledge and social change but that, in that process, all of us have a lot to learn. In a truly empowering process, everyone changes. Empowerment always is mutual. (¶26)

The women were informed that their stories would be used to learn from, to build upon and to increase understanding.

#### *The Development of a Relationship – Insider Knowledge*

Feminist methodology allows for the development of a relationship. In Oakley's work (as cited by O'Neill, 1999), she became involved with her study participants which resulted in a depth of data that would not have otherwise happened. Other researchers also stress the importance of establishing a rapport with interview participants as critical to the depth and specificity of information that is shared (Hall & Stevens, 1991). The non-hierarchical structure of feminist methodology allows for the researcher to invest personal identity in the relationship (Parker & McFarlane, 1991). I have previously

worked as a public health nurse in the off reserve areas in this area. This means that I have either worked in the area where participants reside or I have worked close to where the women reside. In any instance, it was my assumption that many of the participants would probably know of me if they have not had previous direct dealings with me themselves. It was also my assumption that, for the most part, it would be a positive factor and would allow for an increased comfort level of the study participants when speaking to me. I also assumed that there may be individuals who would not volunteer for this study for the same reasons as cited above. Of the participants, 4 women knew me as a public health nurse and the remaining 12 women did not know me at all. Therefore prior to beginning the interview I spoke of my time in the area. Throughout the interview, I would also use my knowledge of the area to add my understanding to the interview. For example, when one of the participants was speaking about living on the south side, I commented, "Wow that is a long way from the store and the school". If I was not familiar with the area, hearing that somebody lived on the south side would not have had the meaning that it did for me and I was then able to ask about transportation.

Another factor that researchers need to be aware of is our own attributes. When researchers over-identify with study participants it can raise the question of subjectivity (Olesen, 2000). Subjectivity is the researcher's ability to know where the research ends and her own value system begins. I am an Aboriginal woman. It was my assumption that being an Aboriginal woman combined with the fact that I am familiar with the communities would increase the likelihood that I would be able to obtain a great wealth of information. During the interviews, I did feel that I was accepted by the participants very quickly. I believe that it was because I am Aboriginal and this gave me some

credibility with the participants. Traditional researchers may see this as being biased. I argue that this is rich data. It is what Nancy Scheper-Hughes (as cited in Olesen, 2000) calls “the cultural self”.

Being able to strongly identify with study participants because of one’s own attributes should be seen as a resource rather than a bias (Olesen, 2000). Reflexivity, the ability to locate one’s own experiences and thoughts while engaging in the research process (DeMarco et al., 1993), is a technique in increasing scientific rigor. Hall and Stevens (1991) state that researchers need to examine their own values, assumptions, characteristics and motivations to see how they align with the theoretical framework, the literature, the interview process and the interpretation of the findings. Le Hir (2000) when discussing Bourdieu’s theory of practice in cultural studies defines reflexivity as being “a point of view issued from a particular position within a particular field itself structured in a particular way at a given moment in time and in relation to other points of view,” (p. 131). Therefore, acknowledging all the various points of view without ignoring one’s own increases the strength of the study. In empirical research, researchers are taught to suppress their feelings and attitudes to avoid research bias. As stated in feminist research, suppression of feelings and attitudes is seen as impossible so therefore should be recognized and used as study strength (Hall & Stevens, 1991).

#### *Generalizability, Adequacy and Quality of Feminist Research*

A criticism of feminist research is that it would be difficult to generalize the study results (O’Neill, 1999). The characteristics of feminist research that make this method strong are also considered a criticism as not all researchers can develop a trusting relationship that will allow for the same information to flow freely and then interpret the

results in the same manner. One does not always develop a trusting relationship with every participant either. In this study, I was able to develop a trusting relationship with each of the participants.

Hall and Stevens (1991) state that a standard that may be used to judge adequacy would be coherence. Study findings can be said to be coherent if they are “well founded in and consistent with the raw data, systemically connected in a logical discourse, and faithful in principle and interests served to the stories women tell, the behaviours they demonstrate and the sentiments they communicate” (p. 23). This also goes hand in hand with consensus as outlined by Hall and Stevens (1991). Consensus is the consistency or congruence of verbal and nonverbal behaviour when telling their stories. I kept field notes after each interview. I compared my field notes to the participants’ transcripts and believed there was congruence between the actions of the women and the stories that they told. There was also congruence between many of the stories. Some of the participants had similar experiences. Common themes were found in the data increasing data accuracy.

Hall and Stevens (1991) also state that complexity can be used to test study rigor. They define complexity as the “degree to which research reflects the complexity of reality” (p. 23). In other words, when interpreting the stories I always kept in mind what my experience and feelings were in relation to the data. I also looked for similarities as well as differences in the women’s experiences. I also referred to my field notes as well and on two different occasions I referred back to the taped interview to listen to the tone in which information was presented. I organized the data according to the determinants of health and my conceptual framework.

During the interviews, I always assured that the timing was good for the participants. I asked how they were today to determine what other issues may be coming into play during the interview. An example of an interview that had other issues coming into play was with "Julia".

Julia came to the Centre to be interviewed and as we were going over the consent form she had to put her head down and take a break. I asked her if she was feeling okay and she said no she was ill. She had just returned from receiving her chemotherapy treatment for cancer. She was nauseated and her head was pounding. I suggested that we postpone the interview and Julia stated no. She wanted to tell her story today. This was important to her. We took frequent breaks and I brought her some water and crackers.

#### *Recognizing the Importance of Culture*

Aboriginal feminism was used as the methodology for this study. Aboriginal feminism recognizes that Aboriginal women are dually oppressed because they are women and because they are Aboriginal (Krosenbrink-Gelissen, 1998; Moore, 1993). Using the feminist research paradigm recognizes culture and the role culture has in this study (Clarke, 1997). When conducting research studies, researchers need to be aware of cultural values and these values ought to be respected. First Nations people have seven teachings that are followed as a way of life. These seven teachings were respected throughout the study and include humility, knowledge, love, respect, bravery, integrity and truth. These seven teachings can be found grounded within traditional Aboriginal teachings of any tribe or clan.

*Invisible Work Invisible Leaders*

This study is for Aboriginal women to have the opportunity to share their stories of the “work” that they perform invisibly in their communities. This work is done to promote the health, well-being and life of the residents. This work remains invisible but crucial to the survival of the Aboriginal people.

*Chapter Summary*

This was a qualitative study. Feminist theory guided the foundation for this study and women-centred interviews were used to collect the stories/data. Trustworthiness, transferability, power and insider knowledge have been discussed as have ways to decrease power inequities. Culture was a determinant that needed to be acknowledged when conducting this study and the seven teachings that are so important to Aboriginal persons have been outlined. Aboriginal women have been invisible for so long that this study is another opportunity for their voices to be heard. I have explained the process that was used for recruitment of study participants and ethical considerations have been presented.

I interviewed 16 Aboriginal women. I read through the transcripts repeatedly, pulling themes from the transcripts and comparing the themes to the literature. The literature and the transcripts have many similarities as well as a few differences. The results will be disseminated to as large an audience as possible. The largest audience would be through publication for professional staff and through a community forum for Aboriginal women.

## Chapter Five: Findings

The interviews were conducted over a five month period on five separate occasions at the Family Resource Centre. Sixteen women participated in the interviews. To ensure confidentiality and anonymity, the names of the participants have been changed and the data have been masked when appropriate. The participants were all within a 20 minute radius of the Centre. Of the 16 participants, five participants currently lived in a First Nations community and 14 of the participants had lived previously in a First Nations community. Thirteen of the participants stated that they had treaty status and the remaining three participants self identified as being of Métis descent. The average age of the participants was 33 years of age and the range of the participants was 18 years of age to 63 years of age. Fourteen of the sixteen participants had children and the average number of children based on the sixteen participants was 3.25 children with a range of zero to 13 children. The average age at the birth of the first child was 16 with a range of 12 to 22 years of age

Half of the participants were married and half of the participants were single. Of the 8 married participants, 4 had been married twice. The average age at first marriage was 19 years of age with a range of 16 years to 20 years of age. The participants had an average education achievement of Grade 9.

Three of the participants graduated from high school and one participant did not attend school. Nine of the participants were unemployed, five worked in support services within the health field and two of the participants worked in minimum wage jobs.

Based on analysis of the data provided by the 16 Aboriginal women, five major themes were derived from the interview data. These themes and sub-themes can be seen together in Table 1.

Table 1. *Major Themes and the Sub-themes*

Major Themes	Sub-themes
Health defined.	Lifestyle choices
	Physical, emotional, intellectual and spiritual
	Healthy self
I need to be me. The importance of self-care.	Promoting my health
	Having Faith
	Hopes and dreams
Barriers to being healthy.	Shame
	Racism
	Addiction
	Domestic violence
	Abuse
	Teenage Pregnancy
	Poverty
Promoting health in my family.	Healthy family
	Taking care of my children
	Perceived social supports
Promoting health in my community. It takes a community to raise a child.	Healthy community
	Strong leadership
	Employment, housing, education and safety
	Lack of available services

### *Theme 1: Health Defined*

When discussing health, the participants often spoke about health in three differing voices. The first concept they spoke of was healthy lifestyle choices. This included activities such as diet and exercise. An overwhelming 15 participants spoke about eating healthy as one of the most important actions they could take to improve their health. The second most recorded answer was the importance of exercise to staying healthy. Food and exercise were seen by the participants as factors that could be influenced by a healthy lifestyle. Therefore, a healthy lifestyle was seen as influencing

health and health was seen as being able to adopt a healthy lifestyle. One of the study participants, Lynn, stated:

Chicken breasts and baked potatoes. Brown rice or white rice. Long grain rice. Not minute rice and all that. My God eat healthy foods. No canned foods, we don't allow canned food in our house. And frozen vegetables. We love frozen vegetables. We always try to eat healthy.

This was a change for Lynn. Growing up she stated that her family did not eat as healthy as she would have liked and therefore she had to learn how to cook in a healthier fashion. She shared the following information during the interview:

Because my husband would say, oh my, you're really unhealthy. I was laughing at him because when I first got married he said, um, I gave him bread. We'd have breakfast in the morning, toast. And I put a whole bunch of butter on there. And he's like, ooh, get sick and gonna have a heart attack right away. Things like that. I stopped eating like that. We're laughing how much butter my mom uses because she'd just put it on like just like, icing, so we were just laughing at her. They know it's wrong. Bad habits I guess.

Other lifestyle factors that could influence health was to live drug and alcohol free, have friends to share your life, live in a safe environment, get an education, and become employed. These factors were commented on by about half of the participants when discussing the definition of health.

When discussing the meaning of health further, the second concept that participants spoke of was holistic health. Fifteen of the participants in this study stated that mental health and spiritual health were just as important if not more important than physical health. One participant did not believe spiritual health was very important. She could not give a reason for her beliefs; she just stated that it was not as important as physical or mental health. Intellectual health was considered to be important by all

participants but, when specifically probed, comments and stories, positive or negative, were not offered as much as they were when discussing spiritual and mental health.

Spiritual health was defined by the participants as having faith in something. This faith could be in God, the Creator, Aboriginal ceremonies, church, and/or self. Faith was seen as being a buffer or a barrier when absent, to one's health by several of the participants. Lisa spoke of her faith in God:

When I think about it now if I wasn't going to church I wouldn't have any faith in being healthy because I thank God for all the walking I did. I don't want to get hurt because everybody will lose their limbs you know and it's hard to heal when you're diabetic.

Jane thought that mental health and having a positive mental outlook was more important than physical health.

I think your mental health should be more [important] than the actual physical health. Like learn to open up more.

Carol echoed Jane's comments stating that mental health was a very important component of being healthy.

If you're not mentally healthy things that aren't so bad seem really, you know, you're not able to deal with life stresses so easily.

The third concept in which participants commented on the meaning of health was in terms of themselves. Six of the participants considered themselves to be healthy and 10 participants considered themselves not to be healthy. The 10 participants who considered themselves to be unhealthy was most often due to living with a chronic illness. With a few of the participants it was related to addictions and or life circumstances. If a participant had an illness when hearing the word health they thought of their own chronic illness. Three of the participants were living with diabetes. Lisa spoke humorously about her experience living with diabetes.

I don't use sugar in my coffee or tea or else I want donuts or chocolate. Before I found out I had diabetes I was eating chocolate bars so much. Me and my friends would eat chocolate bars and a bag of chips. One bag in two days.

Q: Is that the hardest thing about living with diabetes the lifestyle changes?

A: Well I haven't really changed my diet. It's just that trying to lighten up on the sweets and stuff like that.

Ann's experience was quite different from Lisa's story. When discussing her experience Ann became quiet tearful.

I had to phone (my partner's) mother and say, I, I don't know how to make pie crust again, could you tell me. And she tells me very patiently. My blood sugar's very high, you better get to the hospital, we don't need you in a coma. I asked my husband why did she say she doesn't need me in a coma. And he said to me, I want to sit you down and tell the kids to come in here. And he says, I never wanted to tell you this but the doctors told me, your blood sugar's too high and if it keeps continuing, and that's why I cried myself to sleep.

Betty felt that her diabetes got in the way of her being healthy.

I'm not healthy because I got sugar diabetes. And so does my husband. Welfare told me they would cut me off if I went to hospital. I was there all summer. I say that I don't wanna go. The doctor says, I gotta go. No, I'm not gonna go but I'm gonna ask somebody to help me [instead of being admitted to hospital].

Another participant, Julia, described herself as being healthy. Julia had recently been diagnosed with cancer. The cancer was seen as a part of her and affecting her long term health but not her ability to stay healthy.

I am healthy ... Things are meant to happen. I believe that it's [cancer] there. It hasn't bothered me to say that. I don't think I have a long time. I do have my time. I believe mine will come yet. But not right now like, you know, in the future. And, I believe that it will come when he wants me home. I'm not mad, angry or anything like that.

June, who also described herself as being healthy, felt that personal perception was an important indicator of health. She stated that a person could have an illness and not know about it and therefore continue their life in a positive manner.

...lot of times people don't know it [that they are ill], if they don't know it, how do they know they're unhappy about it. Like maybe that's something that's missing in their life but they don't know it because they've never stopped and thought or looked at it or followed it.

*Theme 2: I Need To Be Me. The Importance of Self Care*

Self care or promoting one's health was identified by all of the participants as being important for maintaining health. Personal beliefs systems or having a strong faith were seen as having a positive influence on health by all the participants. Personal belief systems evolved around religion or the church and / or traditional Aboriginal rituals. Also having goals regarding education and employment opportunities were seen as a way to better one's health.

Promoting one's health was identified by all of the participants as having the ability to change their lifestyle to promote their own health. When asked what health promoting behaviors they could engage in to better their health the participants had many suggestions. The most common response stated by 15 of the participants was to change one's diet. Eating healthy was seen as a way to promote one's health.

Karen stated that if she had a house she would have a garden as this would be the best way to promote her health:

I just think if somebody has a house they can make their own garden and grow their own vegetables and I don't know why they don't do it. Some people do and some people don't. I think somebody told me that, like, Indians are hunters or gathers. But I don't know. Or they're farmers or something. Whatever. And if they had a garden I think then they wouldn't need to go grocery shopping that much if they had their own fruits and vegetables like home grown.

Another strategy the participants thought could be used to promote their health would be to exercise. Nine of the participants identified exercising as a way to promote their own health. Joan stated that she would like to exercise but does not know how to get started:

Like I'm, I know I'm overweight. I should exercise more. And I want to but I, again I don't know how to go about doing it.  
Most of the participants stated that being addiction free is important for self care.

June stated that being drug and alcohol free was important for self care,

It's how you live your life, if you're going to be healthy or not... Drugs and alcohol free. Eating properly, you know. Can't say there's anything really norm in the normal family now because there's so many different things that there is no norm. So, I don't know as long as we're healthy and happy and we've got each other, that's most good.

Half of the participants also believed that if they were to quit smoking would be a way to promote their own health. Janet had a list of changes she could make to promote her health including quitting smoking:

I guess walk more and go to bed earlier instead of watching that one last show which never ends up being one last show. Because by the time I get to bed its 12 and the kids are yelling at 6, 7 o'clock in the morning could eat less but I just love food. Doesn't matter what it is, I just love eating. I could quit smoking.

One of the participants stated that to promote health in oneself meant she needed to look after the environment. She suggested that if each person did this, we would not have the high cancer rates that currently exist. Partaking in this aspect of self care will promote the health of women, their families and communities.

Kid(s) are too heavy. But that's the chemicals traveling around this world. It's man destroying themselves, not God. Man that's destroying the world and all that stuff that they produce that's how I see it. Pollution everywhere you look. The whole world is unhealthy... Man is healthy but doing the damage all these chemicals go up in the air and all of a sudden the world is ruined all kinds of chemicals... It's too far gone now to stop.

...Chemicals in food, air and ground and water. Everything. Just to make a buck.

In this study, 7 of the participants described themselves as being Christian, 3 of the participants described their belief system as traditional Aboriginal and the remaining 6 participants blended the two paths and therefore described themselves as Christians who also participated in traditional Aboriginal rituals. Four of the seven Christian participants described traditional Aboriginal rituals in a negative light stating they did not follow such rituals. Betty grew up in a Christian home. Her granny used to tell her stories about those who believed in sacred fires and such.

Do you know what they know? They know things like where wind comes from, that's what they say but my dad and my grandma they say that is bad. How do they know where wind comes from? A lot of things she (my granny) tells me. She says what not to do. Especially bad things. Don't try and learn bad medicine or how they do things, they're not following religion that's bad medicine; you should stay away from that.

Several of the participants had undergone hardships in their life and credited their faith in a Higher Power or their participation in an Aboriginal ceremony with helping them overcome these hardships. Karen, a young Aboriginal woman with five small children spoke about her struggles to stay drug and alcohol free. Karen grew up in a Christian home and learned about traditional Aboriginal rituals such as Sweats, Pow Wows and smudging as a young teen. She believed that by partaking in the Aboriginal tradition of entering a Sweat, she was able to maintain sobriety.

There was closeness with my culture, it was more about me. Well it was about myself but I was myself, I would feel good about myself. But I feel like I know who I am... I like (it) better than in the church. I feel like I can stay away from drugs and alcohol. And it's something that I wanted to do. (I feel like) I made it, not messed up my life. That's what I thought. It would have helped me lots (to continue). It would have helped me lots if I could go to Sweats. At least when I like going to Sweats I feel connected I smell sweet grass in there and makes me feel good. I just like it.

Karen's family does not believe in Aboriginal rituals and often criticizes her choice to partake which leaves Karen feeling disappointed and shunned. Karen has gone to church but feels that the Christian beliefs and the rituals such as praying does not work for her, not in the same way partaking in a Sweat does.

My family goes to church and I used to go to church and help out in Sunday School but then I quit because I started doing other stuff like Sweats and I didn't want to go to church anymore. Like I want to learn more my culture than I do in church. that's how I feel like my culture and I want to do more in that way but then I can't because I don't want to upset everybody again so I don't do anything.

Carol was familiar with traditional Aboriginal rituals and stated that she would smudge to cleanse herself but was reluctant to state that she was following the Aboriginal path in life.

There's a lot of people that go to sweats, that have sweats. But, I don't go because I think if you're going to be on the red row glow, you're on the red row. You're not on during the week and then jump off on the weekend. That's why I, at this point in my life, don't go. Because I believe you follow it all the way or not at all. You know, I might smudge or something once in a while. But I'm not ready to go there and say that OK, I'(m) never gonna have a beer. I'm not going to. So that's why I don't openly practice right now. It's not something you jump on for the week and off on the weekends. You either follow that way of life or you don't.

Sue discussed growing up in a Christian Métis family. She was one of the many participants that believed faith is a determinant of health.

I grew up in a Christian family. So our belief is we're Catholic and, to be spiritually healthy you have to believe, you know, like [in a] soul. I think that's a very big, [part of] health. Like it has a lot to do with your health.

Mary recalled her experience with traditional Aboriginal beliefs and medicine men. She told the story about her cousin. When he was a young man he had attended a party and had tried some drugs. The drugs caused the young man to lapse into a coma.

Her uncle consulted a medicine man and Mary felt the medicine man gave her uncle false hope.

My aunt and uncle were getting into it [traditional beliefs] a bit there cuz the medicine doctors did come and look at him. But they would have three opinions. When getting three different opinions [my uncle] he went to a medicine man and at that time they did tell them that, he was going to get better, that he was doing it, in a coma, to make himself a better person cuz he wasn't that good when he was OK. And he wanted to be a whole totally different person... it's been 8 years and still no change in him. He's still the same. Any time we go there he is still like he was when he was found [in a coma]... so I know a lot of people that do [believe in traditional healers] but I don't know.

When discussing health, some of the participants discussed having long term goals and future plans to improve their health. Six of the participants thought that attending university would be a good way to improve their health. Five of the participants had hopes and dreams of becoming a nurse one day. Joan, a young mother of two, spoke about becoming a nurse.

I am still interested in the nursing thing, I don't know. I think I'll try the health care aide first and then. But, I have to get funding. If I want to go through Métis Federation I have to get a whole bunch of stuff like their documents and stuff that they need. So we'll see how this goes and like if [my boyfriend] makes it in school we should be OK. And if I want to pursue nursing after maybe we'll have the financial [ability] to do it.

Besides nursing, one participant thought becoming a nun would be her dream and another participant thought that obtaining a university degree in anything would be a great achievement. Half of the participants did not discuss any hopes or dreams regarding education but four participants did discuss their hopes of leaving the community to relocate to another area or return to a former home. Nancy spoke about returning to a former home in Ontario to live closer to her mom.

I'm thinking of it (moving home), It's nicer over there. There's a lot of things to do. There's a place where you go play volleyball, basketball,

baseball, oh there's broom ball in the winter. Ice fishing. Fishing on the lake. Going hunting. There's a lot of things happening over there. And it's a lot more things for everybody. Like everybody's the elder, so they're people with kids. All the things to do are for kids too.

Karen spoke of the importance of self and looking after oneself:

I guess it's all up to the women, and what they want to do with their lives. Like I know that I used to think my old man he was everything and everything was about him. Like too busy trying to please your family then yourself. And I think women should just like think about themselves too you have to take care of yourself first before others.

Therefore, to promote the health of oneself the women believed this was done through self care. Self care was defined as caring for oneself physically through diet and exercise and healthy lifestyle practices, mentally through taking time out for oneself and engaging in activities that were fun and relaxing, intellectually by furthering one's education and spiritually by being a positive role model for their children or children that resided in their community, and having a belief in a Higher Power.

### *Theme 3: Barriers to Being Healthy*

Although the women in this study agreed that self care and lifestyle choices were important determinants of health, there were many barriers that often got in the way. The barriers included: shame or feelings of not fitting in, addiction, domestic violence, abuse and being a young single mom.

Some participants described not fitting in to the community because they were shameful of who they were. The participants described this feeling as not being spiritually healthy. Shame was felt when the participants were of a different race or culture than the majority population. For every participant who grew up as a minority, the woman spoke of feelings of shame or desire to be like the majority population.

It's a predominately white community and I'm dark skin and dark eyes and dark hair and my nickname was Black Barbie because I was native and I hated it. I left as soon as I could... (it) was never taken into consideration that my mom was blonde hair and blue eyes. It was what I look like and I find that people, children are very, cruel and at that time, 20, 30 years ago, people were really ignorant about race and racism. And it was pretty common for everybody to be racist and openly racist. It wasn't nothing that you put behind closed doors where, like now, someone's racist, they don't admit it, admit it openly. So, I didn't like growing up there... I wished to be white. I really wished to be white.

Janet grew up on a reservation but left her home to attend school in a nearby community. She also wished that she could be of European descent.

There's a white thing. I used to go to high school and I was one of the first to ever make it to high school so there wasn't very many of us in a white high school. And there was a special bus for us. Well not, I shouldn't say special because all the (First Nations) people got on one bus and they all went to (a nearby town) I went to (the town school) which is like 20 minutes from where I lived. And, I used to stay in the house all day cuz I was scared to get brown. I talked to my friends on the bus but once I got to school I didn't know who they were. Talked to all of my white friends. And again after school, the natives are still there to be my friends at the end of the day. And, I'd say, no, I'm not native look! Because I used to be white. Honest to God. I used to be white as whites.

For Carol, she felt shunned and threatened by a few of the community members for standing up for what she believed in. She took a stance that was not popular and felt that she was alone in the community. Carol felt that being disconnected from the community was a very difficult time in her life.

Many of the participants spoke about their challenges with addictions. Addiction was seen by all the participants as being the largest barrier to being healthy. Addictions included drugs, alcohol as well as the sex trade and Bingo. Several of the participants either had overcome addictions themselves or had watched a family member(s) struggle with an addiction.

Chris grew up with a father who abused alcohol. She dreamed about the day she would be able to leave and escape her home. She spoke about her experience and discussed how she hated being around her father when he was drinking and how she would never do the things he had done,

I just took off to Winnipeg and I never wanted to drink. I never wanted to do drugs or anything like that. And that's exactly what I did do. I turned to alcohol and drugs and I ended up living with my boyfriend, and ended up staying with him for 4 years. Living the type of life I never really wanted... And that's all I ever used for my pain was alcohol and drugs. And then after I, had my daughter and I needed to do something, better myself.

Lisa recalled growing up where both parents abused alcohol. She began drinking regularly herself at the age of 10. It was several years of hardship before she was able to stop drinking herself.

Well I was introduced to alcohol at a very early age so I drank lots of alcohol and all that when I look back at the place. There was lots of alcohol. That's why mom and dad split up because of the alcohol and the fighting.

Ann had worked in the sex trade industry. She stated that the lifestyle was addictive. She worked in the sex trade industry to support her cocaine and alcohol addictions. She has many health problems today as a result of her past. When we were discussing barriers to health, Ann, became quite upset as she stated that it was her choices of the past that affect her health today which she felt were unfair.

The doctor told me yesterday I got a fractured nose still. And my fingers are going crooked from arthritis. And I often question why I did certain things. And I said this on TV. Don't choose the path. You're not given this path by anybody. You choose it yourself. Your children and your parents and your grandparents are nothing. You just go down that trail yourself and you find out that the drugs and the men and what they offer is the most important, but its not. Even when your best friend has just been killed or your best friend is locked in the bar bare naked from being raped.

A few of the participants considered Bingo an addiction but did not see it to be as harmful as the other addictions. Bingo was seen as an addiction but also as a social outing and for some, even an occasional source of income.

I like getting [baby] sleepers where they're comfortable at the toes, not their little toes all bent up. You know you could tell what cheap is. And I like going to Wal-Mart's and not Value Village. Shopping at Wal-Mart, that's where my money goes when I win at bingo and then, you know, people see me [shopping at Wal-Mart] and my kids' clothes.

Another participant stated:

I just go to bingo in the evening, in the evening... Sometimes with my girls and friends. Sometimes I go by myself and I meet my friends there.

Domestic violence was seen as a barrier to being healthy. Twelve of the participants had been in homes where domestic violence was an issue and seven participants were or had been in physically abusive relationships. Of the seven participants, one of the participants was an abuser herself. She recollects her experience when her children were young, just prior to the children being removed by Child and

Family Services:

When I turned into an alcoholic again. Like when my daughter was born... I told [my son], tell some of the young people [to help you] because they don't deserve to be abused. Like it's the abuse because that's what they saw – me beating up their dad. I was an abuser. And my husband would take it out on my kids... I beat up my husband and he got frustrated with my children. And I got frustrated. And then that's what I told my son – Tell somebody.

Julia describes her partner as being a good guy. He has had a lot of stress in his life and a lot of losses. She believes he does not know how to vent his anger and at times loses his temper with her. She tries her best not to make him angry:

And he just blows his top and then he was mad at somebody, he gets mad at me. Like he won't ever show that he's mad at them. He'll show that

he's mad at me because he'll come home and you know...I never know when he's gonna...when he's gonna snap.

One of the participants has lived with abuse all her life and has taught her daughters and her sons not to live the life she had. Her story of domestic violence follows:

He used to beat me up lots. He would wake me up and even when I wouldn't try and sleep in my bedroom I would hide with my kids so he wouldn't bother me. Grabbed my legs, pulled me down the stairs and kicked me, kicked me out of the house in my night clothes. And I had, uh, no where to go I go back home and then I try to stay quiet...the women [that my husband was having affairs with] really don't mind stuff like that...Like I thought maybe he would just leave me alone.

A few of the participants resented that it was assumed that all Aboriginal women were victims of domestic violence. There was also an assumption that the women chose to be victims and they enjoyed being beaten. One participant spoke about going to the emergency room with chest pain and the nurse asked her if her husband was an abuser. She wondered if it was because she was an Aboriginal woman or if they asked all women that came into the hospital experiencing chest pain the same questions. Another participant also voiced her displeasure with her beliefs surrounding Aboriginal women and domestic violence:

Aboriginal women are being abused, both physically and mentally. Like from their partners, from society, from everything. Because they have this stigmata that they like to be beaten, that's the way their life is, they're never going to leave them so just let it go. To me that's the way it is. But what people don't realize is, is getting beaten all the time is a sickness. It's something that they need to have in their life and they don't know how to live without it. So, you know, I think it's very hard for Aboriginal women. Not all Aboriginal women but a lot of them.

Abuse, in all its forms was also seen by participants as being a barrier to being healthy. As noted above, being in abusive relationships was experienced by almost half

of the participants. Many of the participants described other forms of abuse that had happened in their lives. The stories included historical accounts of sexual abuse and neglect as well as current abusive situations taking place within the community.

One of the participants recalled her experience as a child while in the care of Child and Family Services:

I was very lucky because my family, my sisters. My, not my real sisters, my cousins, the ones that raised me. They believed that I was the stronger one...in some of those houses, molested by, by the father, brother and then knowing that my sister laying beside me, she's sitting up because when the door opens, that's the one, that person is coming and get one of us and she takes my turn because they don't want me to be going through, having a kid with one of my uncles. Well one of my cousins had a kid with my own uncle, that's her dad. And this is a very norm. It was the norm like 10 years ago on this reserve and other reserves.

Another participant spoke of her relationship with her partner and recognized that this relationship was detrimental to her relationship with her daughter.

I'm just recognizing like all the stuff I missed out with, like that I could have been doing with my daughter when she was growing up. I could have spent more time with her, with her educational stuff ...I did find I had so much going on with my needs mentally, like my garbage, I didn't think that I even acknowledged my daughter there. But now that I, I've been doing so much healing and I'm actually noticing who I think is left out that I've missed with her and that I'm trying to do now with her. But she's so behind everything and, I could have helped if I could have spent more time with her learning. And, so now I'm hoping I can do that now with my son.

Another barrier identified by the participants was being an adolescent single mother. The age range of the mothers that had their first child was 12-22 years of age. The participants often struggled with their lives and the responsibilities of children in addition to their own needs. Although several of the participants cited family supports when raising their children, others felt alone and felt as though they had no where to turn.

Lisa stated that she went to school until Grade 8 and then quit because she was pregnant with her first child. Others echoed Lisa's statement of having to drop out of school in Grade 10:

I've never completed Grade 9 all of it and most of Grade 10 because I got pregnant.

Nancy continued with school until she was 8 months pregnant. She did not have support from her father but her grandparents took her in and this allowed for her to complete the grade she was currently in at school.

Well I was living with my dad for 2 months and then I got pregnant. They kicked me out and I ended up living with my granny again. And then I went back to School.

Chris also had her children at a young age. She lived in Winnipeg and her family lived rurally. She discussed feeling alone and having no supports:

It was OK but without having family around for support I found it very hard to manage and being a single mother. Just with my two children, nobody else. It was very hard. All my family all live out this way. I was always phoning home to tell them I needed help... So they were always after me to move back home here. I just pretty much had it in the city. My son's father was no help to me. It was pretty bad. So I just had to get out of the city.

One participant who had her first child at a very young age did not want to give up her party years. She believed that youth was a time to have fun with friends, not stay in because you are pregnant. She confessed to drinking throughout her pregnancy in hopes of having a miscarriage:

My mom didn't let me have an abortion. She talked me out of having an abortion. I had him but I said, OK, I drank after he was inside [my stomach]; well I started drinking when I had him in there, when I was pregnant with him like around 7 months. My last 3 months with him I started again. Only because I had a few drinks before and I didn't like it that I drank, well I didn't have to have him and I didn't like it.

Joan felt that she had a lot of support from her mom and her family. Joan had a child when she was in her mid teen years and was able to finish high school. She credits her family with being there for her so she was able to successfully obtain her high school degree:

But like I knew once I had my baby that, I had to be responsible, grow up or whatever. And then like all the supports I had a lot to do with it [my success]...Like a lot of the people don't have the kind of support that I had.

Poverty goes hand and hand with being a single mother at a young age. Poverty is one of the greatest barriers to health identified by the participants in this study. Poverty was defined as not having enough money to purchase food for the family, not buying meat because it is more expensive, not being able to afford transportation, and living in substandard housing to mention a few examples. All participants in this study cited one or more examples of how poverty was a barrier to their health.

Nancy discussed the challenge of trying to feed all her children plus herself on her social assistance income. She stated that her children always have food and she tries to purchase vegetables for them as well:

Usually I feed my kids at breakfast. And then lunch. And then suppers, I eat at suppers. Not very much because I have to feed my daughter also.

She further discussed going to the hospital to see the nurse and the nurse would often give her some milk for her baby:

Milk is like 16, 18 bucks for the little cans and that doesn't even last. Like I have to buy so much to last a week. With going to the hospital is more better [it supplements what she is able to purchase].

Mary talked about not having enough money to purchase as many fruit and vegetables for her children as she would like to and as she remembers having as a child:

Well I like a lot of vegetables. I like all kinds of vegetables and that [for my children]... but probably cost [gets in the way]... I remember mom spending, my mom and dad would give us that every day we'd have our fruits. I guess we had it every day. And she'd have some vegetables and whatever... Like today, I think, I wonder how she managed with these 9 kids. And it's hard for me, when I have 4 of them. But back then, she must have had, like say if she'd cook Kraft dinner or something, it must have be two or three boxes.

Julia discussed that not all people are able to have food and purchase the foods that health care providers often suggest:

Many can't afford the luxury of a car or buying food and what they need and it's [why], and you get sick.

When discussing First Nations communities June felt that poverty impacted families in many ways:

I think they're unhealthy because, it's the norm to be that way and it's kind of acceptable. Like no running water. No sewer system.

#### *Theme 4: Promoting Health in My Family*

In this study, the participants identified family as being very important in one's quest for health. Families were defined in various ways. When discussing their family, all the participants considered their extended family to be included. This meant aunts, uncles, grandparents, siblings and in most cases it included cousins. A few of the participants considered community members who were not related by blood per se to be included in their family.

In this study, 6 of the participants were raised exclusively by both parents, 8 participants stated that their grannies were either solely or significantly involved in their upbringing, 6 have had no involvement in their lives from their fathers and 2 participants were raised by adoptive or foster parents.

Under the theme of family, there are sub-themes that arose from the data. These include; having a healthy family, taking care of children, and perceived social supports.

For the majority of the participants in this study, family was mentioned as being a support or a desired support. Almost half of the participants considered a family member to be their role model and all the participants spoke of extended family members when asked to define their family. Therefore, family was inclusive of extended family and not limited to the nuclear family. When asked if they considered their family to be healthy, 4 participants stated their families were healthy and 12 participants stated their families were not healthy.

Carol discussed that being family is bigger than being related by blood.

I don't have any family outside of Saskatchewan actually. So I don't have any relatives per se here but, you know, the kids upstairs are my sister-in-law's kids but they're actually her niece's kids but those are the, you know, those are mine, whether they're related or not.

Sue talked about growing up in a small community. She stated that she was related to a good percentage of the families in the community and would therefore consider a good percentage of the community to be her family.

A good percentage of them are [related], good percentage of the [community], would, you know. So, and we were all like all one big family just because there was so much of our one family. We all grew up...Like it's not a very big town and not very many people but we all knew each other. Close. Very close.

Janet considered her family to be unhealthy. She admired her sister for leaving the family and continuing on with her education.

My sister [is my role model]. She doesn't live on the reserve and she went out and finished college.

One participant considered her family to be unhealthy. She discussed some of the addiction issues and family disputes that take place and she tries to avoid.

Like my whole family especially my kids, I gotta worry about them. Worry all about things. And on my other side of the family, I get a lot of hassle from them. And I don't bother with them. I don't know why they bother with me... I've had arguments with him [my dad] and everything. I don't know. I just told him not to bother with me; I'm not going to bother with you. So we didn't talk for about eight months. My baby was in the hospital because she had low platelets... They [would] call me and [tell me] about their problems, and then I'm stuck listening to their problems. Somehow I got to sit there and listen and then whatever. It's like then I got my problems. Like a lot of people call me about their problems and I've got my own but most of the time, I hate phones. That's why I hate my phone. Like I don't want to answer it.

Mary considers herself and her family to be healthy. She spoke of the way her mother raised her and her siblings. The house was filled with love and good food. She tries to follow the same example with her children.

My mom and dad, now that they're older, they eat healthier and they want to eat healthier. And while we were still there, they'd want us to eat healthy too. Like, the kids, if their grandchildren don't want to eat their supper she'd try to cook healthy things they would eat just, or if she did have a treat she would promise it for after supper... Or else she'll say to them, come and have a good home cooked meal today. Smell that home cooking.

Taking care of one's children was a recommendation by all fourteen of the mothers in this study as a way to improve health in First Nations communities. Many of the mothers felt that they were doing their part by caring for their children.

Nancy spoke about being a mother. She stated that her biggest goal in life was to be a good mother:

Most of the time I worry about the kids. That's all I do is worry about them. And worry about going to school. Worry about if they're having food in the cupboard, whatever, things that they need... I think of [the] reason why kids can be healthy is their environment around them, being the role model for them.

Lynn enjoys spending time with her children. She is trying to give them a different life than the one she had as a child:

I said [to my children], I don't want you to have my bad habits. And they look at me and say, well mom, you shouldn't be having that now either. I'll say, OK, I shouldn't be having that. So I'm learning from my kids because I want them to be really healthy. I always cook a healthy meal for me and my husband all the time because he's the one that brought me up to cook like that. Always cooking healthy foods.

Perceived social supports were identified by over half of the participants in this study to be a determinant of health. This was particularly true if income was an issue. In other words, if the participants had a limited income they were often dependent on their support network for babysitting, assistance with food, and transportation. Very few of the participants spoke of a social support network for sharing, support and camaraderie. This type of networking was seen as detrimental to a few participants. Family members were identified by five participants as their social support system, three participants identified friends, two participants identified the church as their social support network and six participants stated that they had no perceived social supports.

Karen stated that her mom and sister were her supports:

Well mostly my mom helps me out. My mom, my sister, that's all I got. Nobody else to help. Oh yea, they sure help lots too.

Joan spoke of her grandparents and all the help they have given to her:

She's like always picking up boxes of diapers at her place but it's good. Have my own place. And plus I was just across the river and my mom and them are on this side so I would always want to come across. Sometimes we don't have the transportation, like when they weren't home and stuff...But like whenever I needed a ride, if they were home, they would give me a ride or whatever. But they weren't home and with the kids and then having a new baby and trying to go back and forth...She helps me all the time. Whenever I need a babysitter, she'll just take [the children].

Joan also spoke of the relationship she has with her sister and her children. They have a very close relationship and have been each other's support since she has returned after living in Thompson.

Like I felt like we were like really close until I moved to Thompson and then after that everybody, still talked and stuff every day but I think she felt like [alone], I never realized this until after I came back to live here I think she felt like I abandoned her last year or something. Even though I asked, I told her, you know, you can come with us if you want, you know. But she chose to stay down here... [Now that I am back,] I still feel I need to take them. I feel that need to take care of them or something like [that]. And when they're not there [I am] just always thinking about them, wondering, what they're doing or... And even her baby, it's really close to us, I'll ask him if he wants to go home and he says, no.

Mary enjoys her days to herself and really does not have any social supports that she identified. She states that she has relatives that live nearby and they ask her to do things but she really does not have the time or the desire to spend time with them.

I'm have, cousins out here that tell me just to phone and we can go out for coffee. But, like I said, I don't really have the time... I like the way my life is, where I just clean my house in the morning and then that's my time to spend with my little boys. The other kids come home for lunch. Then I have to make lunch. Then I put him to sleep and I lay with him when he has his nap, he likes that. And then again the afternoon comes by and I have to get up and get supper ready for them so like to me it's my schedule I guess that gets in the way.

Nancy receives support from her grandmother. She enjoys staying with her granny. She does have friends but they often spend their time going out to parties. Nancy does not enjoy this so is often left out of her support network:

That's the main person I liked living with is my grandmother. My mom, I don't know, I got everything what I wanted. I got bored so I left and came back. But OK. Now I'm living on my own I like it more... Like my friends that come over and they're like, oh do you want to go out, whatever. But that's not what I want to do. I do go out but I don't drink. I don't even do drugs at all. I don't.

One of the participants who is a victim of domestic violence stated that her friends were always there for her. She would call them when she needed to. They told her she could always call. This participant saw her friends as her support network and was grateful for them.

As stated, two of the participants considered the church to be their social support network. They both stated that in times where they needed help or a friend, they felt they could turn to their congregation for assistance or a listening ear.

When I think about it now if I didn't have church. Now I wouldn't have any faith in my being healthy because I thank God for the walking all that. Don't want to get hurt because everybody will lose their limbs you know and it's hard to heal when you're diabetic you know.

Another participant commented that the church was a strong social support for her:

I guess you could say I was like, being involved with the church at my age. I wasn't involved with anything else and I [have], never really done the things they done. I always kept to myself.

June had a differing opinion of who has wisdom within the community. She stated that the Elders are wise and have information, but the children are also wise and should also be consulted when looking at community planning.

Like when you think about it. You can ask the elders, OK, the running water situation. They could give you an idea. But when you go to the kids, who's going to be affected most by it. It's them. That's who's gonna, that's who's gonna have to live their life with that, whereas the elders have already lived their life, you know. And their advice and their knowledge is, is, is invaluable. It's just the same as kids. Like kids advice and information is just as invaluable to me. I mean I always ask my kids what should we do...

Two other participants stated that the Elders are wise and should be consulted when required. The problem they identified was that there was not the respect for Elders

and that even though their advice may be sought, it was not often followed. This was echoed by other participants as they stated there was a need for Elders who are positive role models within the community.

The Aboriginal women in this study promoted health in their families by providing personal care for their children throughout their life spans. Some of the participants cared for their grannies or parents when they had to. Therefore, the participants in this study promoted health to their families through care giving and nurturing. Care giving and nurturing was defined by the participants as spending time with children, teaching them how to live a healthy life, acting as a role model.

*Theme 5: Promoting health in my community. It takes a community to raise a child.*

All the participants stated that it was important to live in a healthy community. When asked if they believed their communities were healthy, only 1 participant answered yes. The remaining 15 participants believed that there needed to be a lot of healing that needed to take place before their community would be considered healthy. When asked what makes a healthy community the women stated: strong leadership; employment; housing that is available, affordable and well maintained; educational and recreational opportunities; a safe physical environment; and health services that are of a high quality and accessible. The participants also stated that to have a healthy community there needed to be healthy individuals and healthy families that resided in that community. These healthy individuals and families would also serve as role models for those who did not grow up in a family that was healthy. For example, the community was deemed unhealthy by many participants because of high rates of addiction and the lack of families working together to raise healthy children. Several of the participants commented that

children were being neglected, there was nothing for children to do and many were spiritually unhealthy. There was also a concern that children do not grow up respecting each other or Elders as had been the practice of the past. There was also a concern that the Elders were not always respectable people and that they were taking on a title that was not earned nor deserved.

Karen felt that an Aboriginal women's place in promoting health in the community is to first look after themselves and then raise healthy children:

Women need to do things that make them happy and then they can look after their children and the community will be healthier.

Nancy also believed that healthy communities start with the children. She stated that some families are not caring for their children in a way that is healthy:

A lot of things are missing. Everybody thinks about themselves, like not about their kids that's what I find. I've been looking at other kids and little ones. The kids are not even dressed for class [school] or for weather and they have nowhere else to go. I feel sad like I want to help them. It's like I gotta worry about my kids.

Jane felt that there needed to be more things for children and teenagers to do and for a community to be healthy, there needed to be less drinking. Julia also believed that addictions were a barrier to community health "Yeah. Lots of addictions... I see it in the adults and children. See it all over".

All of the participants in this study stated that strong community leadership was essential to a healthy community. Many of the determinants of health and barriers to health as listed above fall out of the control of individual community members to make a difference. Strong community leadership is needed to address the issues of: available and quality housing; employment and education opportunities that are close to home, as well

as community safety and available health care services that are culturally appropriate and available. Overall, very few participants considered their communities to be healthy.

Strong community leadership, as stated, was seen by most of the participants as essential to a healthy community. June commented that leaders may come in with the best intentions but have a difficult time reaching their goals:

I really believe that they've [former community leaders] had [good] intentions to change things and make things better but, I mean, it's hard to change things and make things better when you're hitting a brick wall, no matter which way [you are] turning, whether you're turning to the community of people or you're turning to the government or to whoever's there. Like it seems to me that First Nation people are always hitting a brick wall. If you have to get to the other side of the wall you have to climb it where most people just go around it I find they have to fight for a lot of the necessities in life like their health.

Lack of employment, limited educational opportunities and lack of housing were stated by many of the participants as being barriers to their community being healthy. Housing is not readily available and the housing that is available was identified by some participants as being moldy and in poor condition. Nine of the sixteen participants stated they had problems with housing. Nancy discussed the apartment that she was renting with her children. She considered her residence to be detrimental to the health of her children:

I don't like living there because there's mold in the building so my kids get sick all the time... colds and bronchitis or cough... I pay \$500 a month for just a little apartment like... two bedrooms and. it's very tiny... We don't sleep in our bedroom. We sleep in the living room, all four of us... I think so [that there is mold in the bedroom] because there's always a smell like moldy. I try to make my house all nice and all of a sudden there's this smell, like a different smell.

Housing was not only of a substandard quality but was identified as being limited. Joan just moved back into the community and had an opportunity to leave the community

for a few months but did not want to do it because she was afraid she would not be able to find a house when she returned.

Got a 1 bedroom apartment there. Back on welfare me and my kids so I don't wanna give that up because it's too hard to get a place already...there's no where, it's hard to find a place to live. There was nothing at all [when we came here].

Educational opportunities are limited to Grade 12. There are two high schools in the area; one high school on reserve and one high school off of the reserve. Students could attend the high school on the reserve or they could attend the high school located in a nearby community which is a French immersion high school. The students who live on reserve and who would like to attend the high school that is located off of the reserve must pay for their education which is done at the band council level and not an individual fee. Therefore, a student would need to be approved by the band if they were living on reserve and would like to attend high school that was not located on the reserve. In the nearby community there is also an Adult Education Centre that offers high school upgrading and it is also a site for distance education programs that are offered by Red River College. To attend university a student would have to relocate to Winnipeg as the commute would be too great a distance.

A few of the participants felt that educational opportunities were limited. Joan's partner had to relocate to attend school and, since all Joan's supports which she considers to be her family live in her community, she chose to live apart from her partner while he is in school.

Carol would like to take some extra schooling but finds it difficult to access. She suggests a virtual university:

We could have a virtual university or something close to home or we did have on the reserve and they shut it down, you know, like. You have to leave your community in order to go to school. Like I'd like, I'd like to go take my LPN, you know, which is only 15 months. But, you know, like in Manitoba it's not that, just because I want to go doesn't mean I'm gonna get in that, you know.

June finds the school system to be very supportive of her needs. She has a child who requires some extra support and finds the school system to be very supportive of her and her daughter.

The school system is awesome...Whereas anybody bothers my daughter at the school, the whole student body and teachers are just right on them. It's like they're awesome. Like I, I would never leave. You know if I had a choice to stay, you know, I would never leave for the fact that my daughter has such a good system in the school in place. Like I, I think they're really wonderful.

Personal safety was raised as an area needing to be addressed by a few of the participants. One of the participants, Ann feels that she is safe but stated that there are some unsafe areas where there tends to be more crime.

Nobody kind of bothers us. And we don't bother anybody. And if we accidentally sleep with the door unlocked, there's nobody bothering us... And people know I live in this house. And the police said too. It's strange that you're the only home that has never been broken into. And this is probably [because] people know that if they're crawling in their window, they don't know who's waiting... they wouldn't want [me] waiting on the other side because they'd be reporting a crime on their own time.

A large majority of the participants believed that resources were very limited in the area where they lived and accessing resources was difficult. Karen stated that there needs to be more resources available to First Nations communities to improve their health:

I don't think there's enough of anything on the reserve, resources. I don't think there is much they can do. Because they never do anything but like

bingo or something. Everybody's always trying to raise money for something.

A few of the participants stated that the services, programs and resources that currently exist have barriers attached to them. Transportation and child minding were seen as barriers to accessing current resources, but the largest barrier stated by several of the participants was confidentiality. June discussed her experience with confidentiality and living in a First Nations community:

In Aboriginal communities, I find a lot of confidentiality is very hard to, to guarantee these women because you're working with people within your community. And I, I know from my own experience living around here that things travel really fast, whether you're held by confidentiality or not. You hear all kinds of things and I know that good intentions are said when someone passes it on to someone else. But then you find that confidentiality is very hard for Aboriginal women to get. Like they may get it but they may not feel like they're getting it because of past experiences.

Lisa echoed June's comments regarding confidentiality. She stated that it is particularly hard to maintain confidentiality when you know the people who work in areas where there is easy access to personal information, for example at the health centre:

At the Health Centre I know all of them... so I wanted them to come out and see me because I didn't want everybody to know because it's private it's not anybody's business.

Nancy had a bad experience with the local hospital and her child had to be rushed to Children's Hospital in Winnipeg. She commented that being so far away from specialty services and not having her child sent to Winnipeg immediately could have resulted in the death of her child.

Sue stated that long wait lists and having to travel to Winnipeg was often seen as a barrier by many people to accessing services:

There's a lot of people that really need help but the help isn't here for them to get it. And, you know, they just aren't able to drive to the city to see someone or [when] they need help when they ask for it. Not an appointment two months later. Like the services just aren't here to help these people. Just like when people are addicted to something and they finally want to quit. Well, you know what; you don't just get into treatment like that. There's a waiting list. And just because you're ready for help that help isn't there.

Mary believes the programming that was offered through the Family Resource Centre, the parenting, the breakfast program offered in the school, the second hand clothing store and the drop-in groups were great resources to have in the community.

Like in the programs here. Like the nutrition program that comes on the school day, have the kids fruit available. I mean mine eat in the morning but still I come [here].

To promote health within the community, the women in this study stated they needed to promote the health of themselves and their families first and the community would become healthier. They stated that strong leadership was required to promote the health of the community at a higher level.

### *Summary of the Findings*

The women in this study ranged in age from 18 to 63 years of age. They all self identified as being Aboriginal women. Thirteen of the participants considered themselves to have treaty status and three of the participants self identified to be of Métis descent. All of the participants lived within 30 minutes of a rural reserve in Manitoba. Five themes emerged from the stories of the Aboriginal women that participated in this study, with twenty sub-themes. Most of the women saw health as being more than the mere absence of disease. A few of the participants that had a chronic illness believed they were unhealthy but they did see health as being more than the just the physical illness. They saw the chronic illness affecting their emotional, intellectual and spiritual health in

addition to their physical health. The participants also deemed self care and health promotion within oneself as important. Several of the participants believed self-care was required before they were able to care for anybody else. Most of the participants believed that caring for their children was the most important role they could utilize to influence the health of their family and the health of their community. They acknowledged that to engage in this role meant they needed to be addiction free and have hopes and dreams. They believed they needed opportunities for education, employment and a safe environment to live. Family was often seen or desired to be a social support in most cases but, with other participants, family was seen as detrimental to their health as they themselves were too unhealthy to be seen as a support. Having faith in “something”, whether the church, Aboriginal customs or oneself, was seen as an important driver required to keep oneself healthy.

The community’s health was seen by the participants as being in need of healing. Most of the participants felt their community was unhealthy. The women in this study spoke of the need for strong leadership to address many of the health needs at a higher level than they were able to influence. Issues such as poverty, housing, education and employment needed attention. The participants saw addiction being responsible for a lot of issues that are present within their communities. These issues included abuse, domestic violence and the breakdown of families. Also, many of the participants saw a lack of services within their communities. Services included drug and alcohol counseling, poor health care services, limited access to specialists, both doctors and allied health professionals such as Dietitians, and also businesses such as affordable groceries, childcare and transportation services.

### *Chapter Summary*

In this chapter I outlined the themes and sub-themes that were derived from the data collected from the study participants. Five themes emerged and the themes also had 20 complementary sub-themes. I have included many reflections from the participants in order to represent their experiences of being an Aboriginal woman promoting health within themselves, their family and their community. Barriers to health promotion were discussed as well as the participants' insight into what is currently in place and how it can be improved.

## Chapter Six: Discussion

In this chapter I discuss the findings of this study in relation to my conceptual framework, research questions, the data collection process, and previous research that has been done in the field of health promotion, in particular how Aboriginal women promote health for themselves, their families and their communities. I also discuss the findings of this study in relation to nursing research and education, policy development and areas for future research. A list of recommendations are provided.

### *Conceptual Framework*

#### Wheel of Health Promotion – A Conceptual Framework

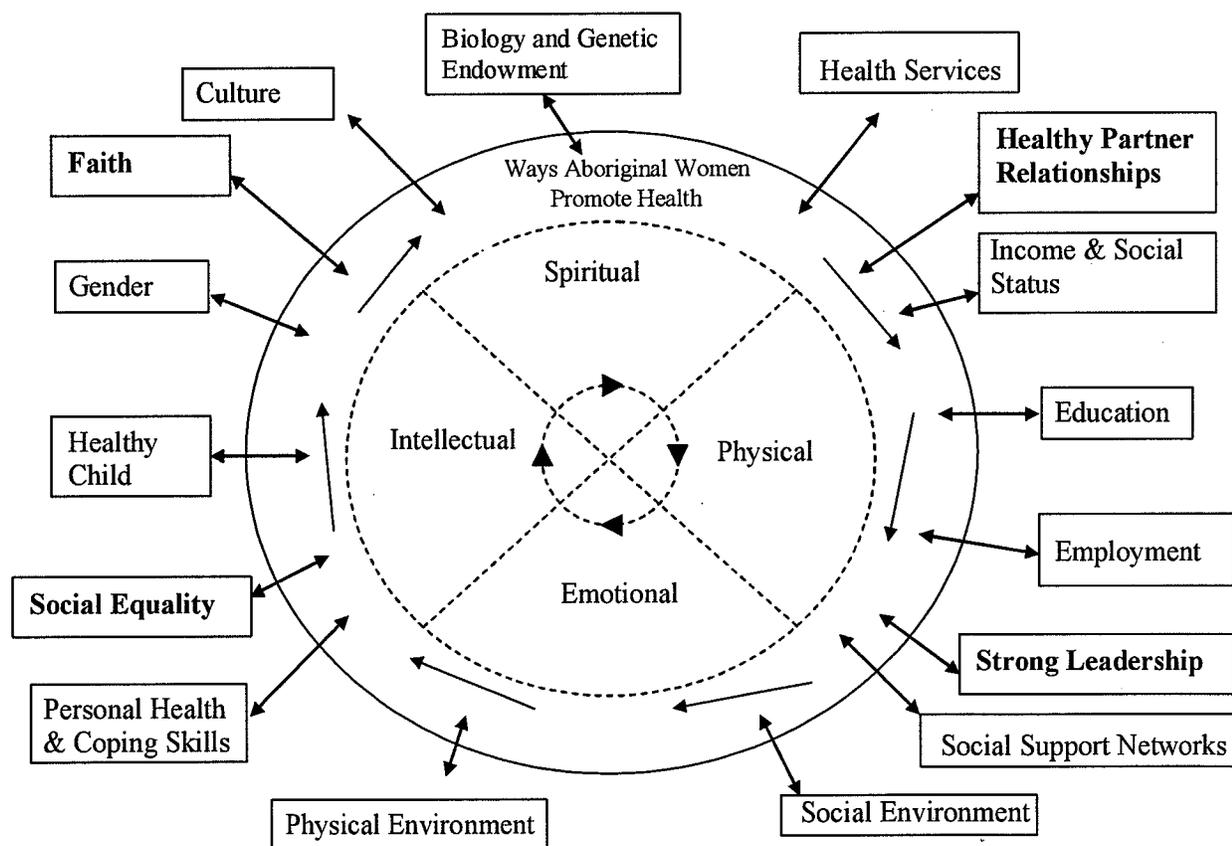


Figure 3: Wheel of Health Promotion With New Determinants

The conceptual framework (Figure 3) developed for this study is a combination of the determinants of health and the medicine wheel, which represents health. The dashed lines demonstrate the interconnectedness of the quadrants of health to each other and to the determinants of health. The literature states that health is holistic (Anderson, 2001; Bartlett, 2001; Dickson, 2000; Kirmayer et al., 2003; WHO et al., 1986) and more than the absence of disease. The medicine wheel depicts health as being an equal combination of the physical self, the mental self, the spiritual self and the intellectual self. Illustrating the quadrants as being equal in size shows that each of the quadrants of health is equally important. In this study, the medicine wheel truly depicted the participants' definition of health. Fifteen of the sixteen participants defined health as being holistic and more than the absence of illness. Only 6 of the participants referred to the medicine wheel by name, 8 participants did not refer to the medicine wheel when discussing health but did see health holistically.

The second component of the conceptual framework is the determinants of health. The determinants of health were also an appropriate frame of reference to use in this study as the participants all referred to the determinants of health when discussing health and health promoting actions that the participants did or could perform for themselves, their families and their communities. The determinants, when they were not favorable, were often seen as barriers to health. For the most part, all the barriers to health or promoting health could be classified within the existing determinants of health framework that has been identified by Health Canada (2003). There were a few barriers identified by the participants that did not fall within Health Canada's (2003) identified determinants of health and they will be discussed in terms of the research question.

### *Research Questions*

The questions I answered with this study were: What is health? What does being healthy mean to the participants in this study? What do Aboriginal women do to promote health for themselves? Do they consider themselves and their family to be healthy? Is there anything that they do to help their family to be or to stay healthy? Given their definition of health, what actions do they engage in to promote health within their communities? Are the determinants of health as outlined by Health Canada (2003) determining factors of health for Aboriginal women? What barriers stand in the way of health promoting actions? What services/programs would help to alleviate these barriers?

The participants, as stated previously, defined health as being holistic and being greater than the mere absence of disease. The definition of health provided by the participants in this study aligns with the literature (WHO et al., 1986). Also, the participants all spoke to the determinants of health as being key factors to the health of themselves, their families and their communities.

The study participants spoke about promoting their own health by having their own time. They felt personal time for self care as being one of the most important predictors for health. They also spoke of poverty, education, employment, personal health practices such as diet, exercise, sleep, smoking, and addiction, a safe clean environment, and having healthy friends and family. In addition to the Health Canada determinants (2003), they also spoke of having faith, social equality, healthy partner relationships and strong community leadership as additional determinants of health. Faith was a belief in a Higher Power, God for some, and traditional Aboriginal ceremonies for others. A few of the women participated in both traditional Aboriginal ceremonies as well as being

practicing Christians. Social equality was seen as being equal to all people of all cultures, genders and races. Several of the participants felt shame for who they were and wished they could be more like the majority population. The determinant of health that is linked with racism is social equality. And a fourth determinant not identified by Health Canada is healthy partner relationships. Most of the participants in this study were either currently in or had experienced a relationship in which domestic violence was occurring. Domestic violence could be grouped with strong social support networks but it was my feeling that this was a large barrier to health and it needed to be listed as a separate determinant as identified by the participants in this study. Strong leadership was mentioned by almost every participant in this study as being essential to a healthy community. The women felt that leadership needed to be transparent and strong to address many of the issues that are present in First Nations communities.

Table 2: *Determinants of Health*

<b>Determinants of Health as outlined by Health Canada (2003)</b>	<b>Additional Determinants of Health as stated by the participants in this study</b>
Income	Faith
Social status	Social equality
Employment and working conditions	Healthy partner relationships
Education	Strong leadership (governing bodies)
Physical environments	
Social environments	
Genetics	
Personal health practices and coping skills	
Healthy child development	
Health services	
Gender	
Culture	

### *Reflection*

Of the 16 women interviewed, 4 of the participants were aware that I had worked in the area as a public health nurse and all 4 participants had received services from me in

that context at least three years prior to the interviews. Therefore, the fact that I had worked in the area previously for five years was of minimal value in recruiting participants. Insider knowledge was true to the point that I knew a little bit about the community in which they resided. I knew a bit about the political structure and politics that did come into play and a bit about the barriers that they discussed. Insider knowledge did not give me an “edge” for developing a relationship with the women so they would share with greater confidence, openly and freely, for the most part. Although it was hoped that this insider knowledge would lend itself to richer data, I believe that the women shared openly and honestly with warmth and candor.

All of the women were recruited by the Family Resource Centre staff and were clients who visited the Centre. All women chose to have the interviews take place at the Centre, even though home visits as well as a third location of their choosing were offered as choices. Therefore, I believe the participants selected a location in which they would feel most comfortable. I also believe that by having the participants recruited by individuals who they trust and are comfortable with provided me with the opportunity to hear so many stories. I do not believe I would have had the response or the trust that I was given were it not for the staff from the Centre.

Other efforts to increase control over the study by the participants were made. All of the participants were given a consent form to read and sign. If the participants looked as though they were struggling I went over the consent form with them prior to having them sign. Participants were given the option of stopping the tape recording of the interview at any time. Although this never did happen, a few participants spoke with me after the interview was finished regarding a few further points they wanted included.

Therefore, I believe the women felt safe and free to share openly. When there were areas that were particularly sensitive for them, they still shared openly but chose to do so without a taped recording of their words. Any information given to me after the interview was kept as field notes and included in the analysis.

Time of interviews was adequate. Most of the interviews lasted approximately one hour while a few went as long as an hour and a half. Child minding services were provided by the Centre staff, if required, in order that the women could participate. With one participant, her son did not want to stay with the staff, making it very difficult for her to participate. We had to stop the interview several times to allow for her son to have his needs met.

Being an Aboriginal woman was an asset in this study. By being Aboriginal, and a woman, there was a mutual feeling of respect that I felt with the participants in this study. Although I feel being an Aboriginal woman may allow for trust to occur faster, it is really treating people with respect and being interested in what they have to share that really completes the trusting relationship. One interesting theme that arose in this study came when we were discussing hopes and dreams: 5 of the 16 participants stated they would like to take nursing in university. This could be that they are stating what they think I wanted to hear, this may be because Aboriginal women wanting to be nurses would be more likely to volunteer for a nursing study, or it may be coincidence.

This study was a great opportunity for Aboriginal women to share their stories. All of the women thanked me at the end of the study for doing this research. One woman commented that it was nice that somebody asked her about health as nobody has done that before. One of the participants had insisted on coming to do the interview after

receiving her chemotherapy treatment. She struggled with nausea and pain throughout the interview. I offered to give her \$20.00 for her contribution after 15 minutes and stated that she could come back another day, when she felt better. Despite signing the consent form she was unaware that she would receive any money for her time. She was doing the interview, she stated, because she wanted her story to be heard and she needed to do it "today".

### *Previous Research*

The findings of this study are compared with literature that has been written in the last 10 years related to the concepts of Aboriginal women and health promotion, including the importance of self care, having faith and hopes and dreams. The perceived barriers to being healthy included shame, addiction, domestic violence, abuse, teenage pregnancy and poverty. Health promotion in the family, taking into account the sub themes that arose from the data, included having a healthy family, taking care of children, and social supports. Promoting health within the community is compared to the literature specifically looking at what makes a healthy community. Strong transparent leadership, employment and educational opportunities, housing and safety, and the lack of available services within First Nations communities were the key areas identified.

The literature review completed in Chapter 3 of this thesis discussed historical events that have happened to Aboriginal women through time. Although in this study it was not within my scope to question the participants about the history of Aboriginal women, I wanted to capture the background from which Aboriginal women have come. Answers are often rooted in history and we often need to remember the history so we do not make the same mistakes in the future.

### *Aboriginal Women and Health Promotion*

Looking after oneself or promoting health for oneself was seen by the participants in this study as the first step in health promotion. Several of the participants commented that they needed to be healthy themselves before they were able to influence the health of their children, their families, and their communities. The participants defined the characteristics of being healthy and the barriers that get in the way.

*Importance of self care.* Self care and making time for oneself was discussed by the participants as being the first step to being healthy. Self care, as defined by the study participants, was looking after oneself and increasing one's control over one's own health. A few examples as identified by the participants included quitting smoking, taking time out of a busy life to read a book or take a warm bath, sitting on the couch alone after the children have gone to bed and watching television without having to fulfill anybody's needs.

There is literature regarding stress and self care (Lachman, 1996; O'Donnell, 2004), and self care and the care giver as it relates to nurses (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2004; Jackson, 2004) and others caring for ill family members. There is not as much research regarding self care and Aboriginal women. Although the literature is not abundant, the responses of the women in this study echo what the literature cited concludes, that is, the need for self care (Cohen-Katz et al, 2004). Fourteen of the women in this study are caring for children and other family members for extended hours, many of the women have witnessed trauma on several occasions, often have limited control over their current situation and are often dealing with pain and loss

in their communities. Most if not all of the women in this study are experiencing stress and are at risk of a burn out.

*Belief in a Higher Power.* Belief in a Higher Power was not something I viewed as a determinant of health prior to this study. Upon reviewing the literature, there are many articles written about faith and health (Dunne, 2001; Lin, 2003; McIlmurray et al., 2003) but the majority are in relation to palliative care. Most of the participants in this study define faith as a determinant of health and they viewed spirituality as a component of health. Faith is not a determinant of health as identified by Health Canada (2003).

Coyle (2002) in her analysis of the literature on spirituality, states that faith is not well defined. She associates faith with having meaning and purpose. She states that faith has a positive impact on health in that people who have faith have a positive state of mind which results in healthy behavior. She cites the 1998 Matthews and colleagues study that found those committed to a Christian organization were less likely to use alcohol and drugs. She also suggests that having faith in a Higher Power means that one is not solely responsible for their destiny which results in the ability to better cope with or recover from illness.

*Hopes and dreams.* Hopelessness and not having the ability to dream are seen as being very unhealthy for one's mental health. Half of the women in this study had hopes of furthering their education and several other participants had hopes of returning to another community to be closer to other family members. Feelings of hopelessness were not expressed by any of the women in this study. Having dreams and being able to think about oneself as having a future was an unbelievable strength of the women in this study. Many of the participants had survived abuse and addiction, violence and unhealthy

childhoods. The participants voiced and demonstrated resilience. Black and Ford-Gilboe (2004) in their work with adolescent mothers and health promoting practices found similar results. In their study, they found that resilience supported their study participants to cope with adversity and to have the ability to have healthier lifestyle practices.

### *Barriers to Health*

The participants were able to identify barriers to health at the individual, family and community level. The barriers identified were, for the most part, the same barriers at each level whether it was at the personal, family or community level.

*Shame.* Shame was expressed by several of the participants as being a barrier to health. Shame was felt because of the desire to be like everybody else, or because of perceived feelings of prejudice. A few participants stated they had felt reverse prejudice towards Aboriginal people at one point in their lives. Reverse prejudice as defined by the participants, is feeling prejudice towards one's own culture. The women stated they wanted to be more like the "white" population.

*Racism.* Racism is not acknowledged as a determinant of health by Health Canada's (2003) framework but, according to the participants in this study, it plays a large role in one's health. The literature acknowledges racism from health care providers as being detrimental to one's wellbeing (Rivenbark, 1997; Sokoloski, 1995; Tarrant & Gregory, 2003) or from society as a whole (Crichton et al., 1997). In Ritchot's (2004) PhD dissertation, *Becoming Whole: A Grounded Theory Analysis of Empowerment in Aboriginal Women Leaders and Professionals*, she found that all the Aboriginal women she interviewed experienced racism in their lives. She also noted that there were no questions in her study that directly explored the concept of racism, yet all the participants

felt the need to mention it. The participants in Ritchot's study stated that having experienced racism left them feeling "unworthy, unlikeable, or that they did not belong," (p. 94). One of the participants in Ritchot's study stated, "If you're visually Aboriginal: You experience racism, you experience discrimination: Just thought you weren't as worthy as other people," (p. 92). The literature is consistent with the acknowledgements of the participants in this study as several of the participants had referenced racism as being a barrier to achieving health.

*Addiction.* Addiction was cited by the participants in this study as one of the largest barriers not only to personal health but also to family and community health. Most of the participants either continue to or have overcome an addiction and most have come from families where there were family members who were struggling with addiction issues. The literature on addiction is overwhelming and it is clearly documented that addiction has a negative impact on one's health and well-being and the well-being of one's family, (Ross, 2004; Shah, 2004). It is also documented that communities that are over represented by families that have poor life skills and coping mechanisms such as addictions are unhealthy (Kirmayer et al., 2000). Alcohol abuse is usually the drug of choice and the risk for alcohol related problems in First Nations communities is two to six times higher in Aboriginal youth than non-Aboriginal Canadian youth (Shah, 2004). This is consistent with what the study participants reflected.

*Domestic violence.* Domestic violence against Aboriginal women is well documented in the literature (Bubar & Jumper Thurman, 2004; Canadian Institute for Health Information, 2003c, Dion-Stout, 1996; Green, 1976; Moore, 1993; Smith & Ross, 2004) and consistent with the stories of the participants in this study. The First Nations

and Inuit Health Branch (1999) claim three quarters of Aboriginal women have experienced family violence. A few of the participants did comment that providers assumed that all Aboriginal women were victims of domestic violence and this was seen as being presumptuous of the health care provider. Although I agree that it is presumptuous, it is not unreasonable. Almost half of the participants in this study were currently in or had been in a relationship where they were the victims of domestic violence. Seventy-five percent of the participants in this study had been raised in situations where they were witness to domestic violence. The literature does speak to domestic violence being cyclic (Bubar & Jumper Thurman, 2004) which is consistent with the findings of this study. In this study, none of the participants who were raised in nonviolent homes identified being in a relationship where domestic violence was present.

*Abuse.* Abuse of Aboriginal women is well documented in the literature (Green, 1976; Moore, 1993). It is written that through the years Aboriginal women have experienced abuse by society, their partners and at times their families. Abuse takes many different forms, verbal, physical and sexual. All the forms of abuse were referenced by the participants in this study and, often, more than one type of abuse occurred in the participant's lifetime. Abuse often was perpetrated by more than one person and with some of the participants' abuse was perpetrated by systems. Often women who grew up in abusive homes continued the cycle by becoming involved with one or more abusive partners. The experiences of the participants in this study are consistent with the literature.

*Teenage pregnancy.* Teenage mothers often have the challenge of maturing while they are parenting. The lives of teenage mothers are often complicated with low

educational achievement, lack of employment, limited peer support, and poverty (Avison, 1997; Lipman et al., 1997). In this study, 9 of the participants were teenage mothers. Of the 9 participants who had a child when they were adolescents, 5 had more than one child prior to the age of twenty. The literature regarding adolescents raising children supports the findings of the study. The adolescent mothers had a limited education, were dependent upon social assistance for income, had poor quality housing, and past issues with addiction. A few participants were victims of domestic violence, lacked transportation, had a lack of quality child care and were often struggling to purchase enough groceries for their families. Only one of the adolescent mothers was not currently in a strenuous relationship. Four of the nine adolescent mothers are still with the father of their first child.

Black and Ford-Gilboe (2004) in their study of adolescent mothers, resilience, family health work and health-promoting practices, found that despite adversity, adolescent mothers' levels of resilience, and healthy lifestyle practices were similar to advantaged adult women. They also found that a mother's level of resilience had a positive impact on the efforts to promote their own health as well as the health of their family and that social support was positively related to their health promotion efforts. The findings of this study are consistent with the responses I received from the participants in my study. Many of the participants in my study had overcome many adversities and their own health promoting behaviors, as well as promoting health within their families was quite remarkable. One area of question would be the levels of social support that was perceived by the participants in my study and the participants' health promoting efforts. It was the perception of a few of the participants in my study that they did not have a strong

social support network. It was also their perception that this was for the best as their network would be less giving support and more taking support. These participants opted not to take support in fear they would have to give more of themselves than they were able.

*Poverty.* Health Canada (2003) recognizes poverty as a determinant of health. It is represented by way of income and social status. The literature frequently states that poverty is the single most important determinant of health (Wilkinson, 2001) that negatively impacts health (Canadian Institute for Health Information, 2004; Crichton et al., 1997; Kirmayer et al., 2000), is associated with fewer support systems (Polakoff & Gregory, 2002) and can negatively impact early child development (Bhatti, 2000).

Aboriginal people and Aboriginal women in particular are much more likely to face poverty than their non-Aboriginal counterparts (Armstrong et al., 2003; Donner, 2002).

Poverty was mentioned as a determinant of health by participants in this study and is consistent with the literature. Although the participants did not specifically say they were living in poverty, poverty inversely affected their health. They did say that they were not able to afford transportation to medical appointments, shopping, etc. Several participants made reference to not having enough money for groceries. Money was also a barrier to recreation and leisure activities.

#### *Health Promotion Within Families*

Families may be defined as being nuclear or immediate or they may include the extended family. All the participants mentioned extended family when defining their own family. Many of the participants in this study stayed with or were raised by extended family members when growing up themselves.

The best way to promote health within their family, as identified by most of the participants in this study, was to take care of their children and raise healthy and productive citizens. The participants defined the characteristics required for a healthy family. Many participants spoke of the need to have social support systems and to be a social support for others. A few of the participants did not see that social supports were very important in their lives, mainly because the perceived support was not of a desired quality and it would be healthier to have no supports than the support that was being offered. Another way identified by the participants was to restore healthy Elders as it was believed that Elders no longer hold the position that they once held within families.

*Healthy families.* All the participants in this study placed a strong emphasis on raising a healthy family. For many, this was viewed as the most important job they could do for the betterment of society. Healthy families were defined by the study participants as not having addiction issues, spending time together, supporting each other through crisis, and loving each other. Many of the participants did not focus on physical health and focused more on mental and spiritual health.

*Taking care of children.* Taking care of one's children was seen as a mother's responsibility by the majority of the participants in this study. They felt that mothers needed to prioritize the needs of their children over their own needs. The needs of the children included their physical needs of food, shelter and safety and also their emotional needs of love and presence as well as their intellectual needs by role modeling and assisting with education. Several of the participants discussed taking their children to Aboriginal rituals such as Pow Wows; others spoke about taking their children to church. This is consistent with the literature. Children have historically played a large role in

Aboriginal society and are often seen as equals in the family not as subordinates (Anderson, 2000).

At a panel discussion on the determinants of healthy communities in March, 2003, Dr Muhajarine stated that “neither income nor neighborhood is the sole determinant of poor outcomes in children; rather, he suggested that adequate income, good parenting, and supportive communities have been identified among the key factors associated with child outcomes” (Canadian Institute for Health Information, 2003 b, p. 5). Several of the Aboriginal women in this study seek to have these qualities for their children.

*Social supports.* Many studies and articles have been written that claim social support has a positive impact on health (Black & Ford-Gilboe, 2004; Eyler et al, 1999; Hurdle, 2001; Norbeck & Peterson Tilden, 1983; Weinert, 2000). Social support can include family, friends, and community service agencies. The participants in this study most frequently identified family as their social support system. Very few participants spoke to having friends outside of family members, or even desiring friends outside of family members. The literature on Aboriginal women identifies the importance of social support systems but does not identify if either family or friends would be the more effective support system. In First Nations communities an explanation may be that the families are often large and when you take into account that extended family members are included under the definition of family, there may not be a need to look outside one’s own inherent social network to find further support.

#### *Health Promotion Within Communities*

Who is family and who is community often are difficult to define considering the inclusive definition of family identified by the participants. The participants in this study

stated that it was difficult to promote health within their communities. They defined what characteristics a healthy community required and they defined the barriers to their community being healthy. The barriers, they felt, were not for them to change as their work was at the family and individual level, but many also stated, by doing their parts, and if everybody did their part, a community would be healthy.

*Healthy community.* In this study, only one participant considered their community to be healthy. The other participants viewed their communities as requiring healing. Healthy communities are defined by the participants as having educational and employment opportunities, recreational activities and facilities for all ages, safety, limited addiction problems, strong healthy leaders, and having community members who care about their families and their communities and who help each other when needed. Strong leadership is required to ensure the success of any company or organization and First Nations communities should be no different. To be a healthy community as defined by the participants in this study is consistent with the literature (Canadian Institute for Health Information, 2004; Gorin, 2000).

Social capital is starting to become more prevalent in the literature when discussing the health of a community (Gorin, 2000; Mignone, 2003). Measuring social capital in First Nations is a good predictor of community health as identified by the participants in this study. Social capital takes into account influences that were identified by the participants in this study as being a determinant of health. These influences include the broad range of social networks, organization, political parties, charitable organizations and sport and recreation groups. It also includes people's feelings and attitudes towards each other and their connectedness to their community (Gorin, 2000).

*Employment, housing, education and safety.* The participants in this study spoke of limited opportunities for employment, education and housing. They also spoke of unsafe communities. These findings are consistent when reviewing the literature from First Nations communities (Armstrong et al. 2003; First Nations and Inuit Health Branch, 1999; Martens, Sanderson, & Jebmani, 2005; Young, 1999).

A study done by the First Nations and Inuit Health Branch in 1999, found that the percentage of adequate housing in First Nations communities was 54%. Mold was also found to be of significant concern to the participants in their study. Mold is a significant issue as a result of poor ventilation systems combined with severe cold temperatures, tightly sealed dwellings and overcrowded living conditions. Several participants in this study voiced concern regarding housing issues and availability of adequate housing which is consistent with the literature.

*Lack of available services.* Access to community services is well documented in the literature as being under funded in First Nations communities (Kirmayer et al, 2000). Often it is in relation to communities accessible by air, but communities accessible by road are also under funded and services are not easily accessible. This may be in part due to the different funding model used to fund First Nations communities. Funding for health services is seen as a federal responsibility. The rest of the province receives funding for health services through the regional health authorities and the funding body is the provincial government. This often causes a barrier for First Nations communities and the Métis communities alike who have a difficult time accessing services as there gets to be a provincial/federal dispute over who is to provide what service and who is to access

what service. This results in limited access to services for people who live in these communities.

### *Study Limitations*

One limitation of this study was the recruitment process and therefore the sample that volunteered. All the study participants were recruited from the Centre which may have resulted in a sampling bias. The Family Resource Centre offers parenting courses, second hand clothing store, nutritious snacks, and pre and postnatal courses. Although the Centre is open to any who wish to attend, often those families who are seeking help attend. This may account for some of my demographics such as high numbers of children per family, high numbers of teen mothers, low incomes and low education.

### *Implications for Nursing Research*

The determinants of health framework as set out by Health Canada (2003) is an excellent way to frame one's thinking when it comes to health and the barriers to health. More research needs to be done on the implications of how these determinants affect the health of Aboriginal women and First Nations communities. There should also be further research to look at the determinants of health identified by the participants in this study to establish if they are determinants that affect most Aboriginal women or if they can be added to Health Canada's list of determinants. The determinants identified include faith, domestic violence, social equality and strong community leadership.

Many of the participants in this study had overcome many adversities in their lives that were difficult to comprehend. The ability to dream and the desire to be the best that they could be with what they had was remarkable. Further research that examines the

resilience of Aboriginal women and self and family health is required to gain further understanding of this phenomenon.

### *Implications for Nursing Education and Practice*

This study further adds to the knowledge of Aboriginal women and health. It is consistent with the literature regarding significant exposure to domestic violence, abuse issues, addiction issues and barriers to health that Aboriginal women face everyday. It is important that nurses and health care providers are aware of these issues and barriers. I believe that it is also important for nurses to be aware that, despite the barriers, many Aboriginal women persevere. It is important to note that every woman who was interviewed spoke of caring for their children. They spoke of doing the best they could, which included giving up their own food, so their children could eat. They spoke of self care and caring for themselves so that they were best able to care for their children.

Often Aboriginal women face many barriers when seeking health care services or when trying to promote their own health or the health of their families or communities. These struggles at times have resulted in health care providers deeming the women as noncompliant, not cooperating or not caring. The participants in this study have offered other explanations. To assume that a missed prenatal appointment or their yearly physical, for example, is due to non compliance is an erroneous assumption. The explanation may be lack of child care or transportation, or an ill child and no access to a telephone, which results in the missed appointment. Nursing students should receive cross culture education and training so they are able to understand how Aboriginal women define health and the barriers that they face when trying to promote health.

Another implication for nursing education and practice as demonstrated in this study is that Aboriginal women have many different belief systems. This would be content in cross cultural education. Many health care professionals make cultural assumptions that are erroneous. It should not be assumed that because an individual is Aboriginal that they would partake in Aboriginal traditional rituals. But it remains important to allow those who do follow Aboriginal traditional customs to practice such rituals. Health was viewed by all the participants in this study as being holistic. Therefore this also needs to be considered when providing care for Aboriginal women. Faith was considered to be an important determinant of health and, therefore, whatever implications this may have should be honored.

The role of extended family in the health of Aboriginal women has implications for health when in the health system. Often in our Centers we have rules that limit visitation. Nurses need to be cognizant of the important role extended family members may have in the health of an Aboriginal woman.

#### *Implications for Policy Development*

Often Aboriginal women who live in First Nations communities are not able to seek community health services or programs that are offered by the province. The reverse is also true, Aboriginal women who do not live in First Nations communities are not able to seek programming offered by the First Nations communities. This is difficult to determine because, as this study has identified, families are transient. They may move between communities frequently or, if they are living outside the First Nations community, their family may live within the First Nations community so who accesses services from whom becomes confusing. Often services are not provided equally and this

causes conflict between families and community members. Clear direction needs to be provided by the three levels of government in relation to education, employment, housing, and all government services, provincial or federal, that is available and should be shared equally.

There are several implications for policy development within the health care sector and also within the governance structure. When looking at the health of Aboriginal women, policy that addresses poverty needs to be considered. Often women who live in these communities pay a much higher amount for groceries and transportation than their Winnipeg counterparts. Also, access to educational opportunities and employment are limited. An example of the situation for the participants in this study is the cost of milk. A four litre jug of milk in a rural First Nations community costs almost \$6.00 when the same jug of milk in Winnipeg costs just over \$3.00. Residents of First Nations communities that are accessible by air pay over \$10.00 for that same jug of milk.

The communities in question span several miles and health care services are not within walking distance depending on where one lives. Transportation services that are available in larger centres are not available in this area. Public transit services such as buses and taxis are not available in this community. There is one bus that does travel into Winnipeg once per day but, again, is located miles away for many, is limited with access hours, and is costly for those living on a low income. Health care services that are outreach based will have a greater success rate and will increase access for the participants in this study. Organizations such as the Family Resource Centre which offer a transportation and child minding component have a much greater success rate than programs that do not offer these two services.

### *Future Research Considerations*

This study was completed with 16 Aboriginal women of various ages who attended the Centre. It would be interesting to know if the conceptual framework of the medicine wheel and the determinants of health would be true of other Aboriginal women that are not deemed "at risk", or for women in general. Do women from other cultural backgrounds view faith, domestic violence, social equality and strong community leadership as determinants of health? Do Aboriginal women from different First Nations communities define the determinants of health in a similar way to the participants in this study? What factors are present that allow Aboriginal women to overcome such adversity in their lives and yet continue to have hopes and dreams and provide for the best life possible for their children?

It would also be interesting to examine the concept of Social Capital as a tool for community assessment. Mignone (2003) has devised a tool to measure social capital in First Nations communities. The tool is a 99-item questionnaire that was devised by researchers to measure the three dimensions of social capital: bonding, bridging and linkage. Bonding refers to the relations within First Nations communities, bridging refers to ties between First Nations communities and linkages refers to First Nations communities and institutions such as government departments or public/private corporations. The bonding, bridging and linkages look at the dimensions of social capital which include; social relationships, social networks, social norms and values, trust and resources. Although complex for a first time user, I believe this tool would be a great asset when conducting community health assessments as it recognizes that a community does not exist in isolation but needs to be part of a bigger network including other

communities and institutions to be successful. The women in this study stated that the health of the community was important to their health and the health of their families. They also spoke of the importance of strong community leadership when discussing a healthy community.

### *Reflexivity*

This has been one of the most challenging and yet most rewarding accomplishments in my life. Here I am writing this section when the thought of being finished always seemed so far away and so unmanageable. Although the writing has been tough, the topic has always been dear to my heart. I had no difficulties with the recruitment process which is not something that is often heard of and I believe I owe the wonderful staff at the Family Resource Centre for allowing me to build upon their existing relationship with their clients who agreed to participate in this study. The women spoke so freely and told me stories that I never dreamed to hear. I feel so privileged to have been trusted enough by the women for them to share their stories of abuse, violence and hardship with me.

I have changed the names and a few details regarding the participants to make them unidentifiable. When statements were being made that were particularly sensitive in nature I excluded their pseudonym to ensure there could be no linking with previous statements.

Listening to the stories at times took my breath away and really made me think about my own life. Although I too am an Aboriginal woman, I did not grow up impoverished or with many of the barriers to health that many of the participants in my study did. After listening to a few of the stories I cannot help but wonder, How do you do

it? How do you get up in the morning and carry on? Reflecting back on my own life, being a young mother, young is very subjective, I was not 12 or 14 or even a teenager when I had my twins, yet I felt too young. Reflecting back, there were times when I felt very poor, yet I always had food for my family and did not have to go without anything to provide that. I always had a home and was fortunate enough to obtain a university education. I was fortunate enough to have I had a strong enough support system to allow for that to happen and to have lived close enough to an institution that made it possible. And because I have an education it is easy for me to find employment. The participants and I have different backgrounds but the same goal, to be the best that we can be.

### *Recommendations*

Based on the conclusions of this study, the following specific recommendations are offered. That:

1. Community health nurses recognize the assets, strengths and efforts of Aboriginal women.
2. Cross cultural education should be a mandatory course in nursing education.
3. Health care providers should partner with organizations such as Family Resource Centres to deliver programming to Aboriginal women who may not otherwise seek services.
4. More research done to determine if the four additional determinants of health expressed by the Aboriginal women in this study are also relevant for other First Nations people as well as other cultural groups.

5. Health care providers and First Nations community leaders are educated on the determinants of health at an individual, family and community level and use tools that can adequately measure how a community is faring in relation to their health. Tools such as ones that measure Social Capital as outlined by Gorin (2000) and Mignone (2003) be made available for First Nations communities to use.

6. A provincial review must be conducted of social assistance payments and take into account food, transportation and housing prices in rural communities.

7. Federal, provincial and band governments must sort out who is providing service for whom and adequate funding be provided to meet the needs of the community.

8. Aboriginal women should be consulted in health care planning as services are often planned for them without having a clear understanding of how we can best meet their needs and the needs of their families.

9. Nursing researchers continue to engage in qualitative studies with Aboriginal women and hear their stories of accomplishment and perseverance as they have much to teach us all.

10. Nursing researchers should engage in qualitative studies to hear the stories of Aboriginal men and their accomplishments.

### *Conclusion*

The purpose of this study was to explore the ways which Aboriginal women promote health within themselves, their families and their communities. The conceptual framework, a combination of the medicine wheel and the determinants of health was used to organize the literature and the findings of this study.

Health was defined by all the participants as being greater than the mere absence of illness and included physical, mental, intellectual and spiritual health. The determinants as identified by Health Canada (2003) were a good representation of the barriers that get in the way of being healthy. The participants in this study added four determinants to Health Canada's list, which include faith, social equality, domestic violence and strong community leadership.

This study provided the opportunity to hear the stories of 16 Aboriginal women, their definition of health, their hardships and how they promote health for those they care about. This was a positive experience for the women in this study as it was for me. I have included 10 recommendations for consideration and will continue to advocate for the health and well being of Aboriginal women.

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## Appendix A

### Interview Questions

Can you start by telling me a little bit about yourself?

#### Demographic Information

a) Which age category do you fall within:

18 – 24

25 – 34

35 – 44

45 – 54

55 – 64

65+

Children? How many and ages? Married? Single?

Where do you live?

Probes: Do you live here all of the time? Is this your community? What do you consider to be your community? Why?

Do you have a job outside your home? If so, where do you work?

Probes: do you like your job? Do you make enough money to buy the things you need such as food, clothing etc. If not, how do you manage?

What grade did you go to in school? University?

Probe: Did you enjoy school? Did you have to leave your community to finish? What was that like? If given the opportunity now, would you take any courses? What would you take? Or what stopped you from going to school was it leaving home, not important?

Who would you consider to be in your family?

Probes: Where does your family come from ie: recently relocate to area?

Children – ages? Do they live at home?

Did aunties keep (Raise) you or did you grow-up with your parent(s)? What was that like for you? Did you like being part of a big / small family?

If you need advice about something, who would you talk to?

Probes: elders in community, aunties, grannies, friends

If you are feeling really stressed out what do you do?

Probes: Some people meditate, others go for walks, what works for you?

What does “health” mean to you? Do you consider yourself to be healthy?

Probes: Do you think to be healthy means that you are not sick? Does it mean more than that? What are your thoughts about being healthy?

If you were to rate your health with a number and 10 being the most healthy you could be and 1 being the least healthy, what number would you be?

Now thinking about what we said health was, are there things that you can do to improve your health or make it better?

What about in your family

What about your community?

Probes: What things can you do to change the health in yourself, family or community?

What things or behaviours do women in your community including yourself do to promote health?

A) in oneself

B) in one's family

C) in one's community

Probes: Are you or other women in your community doing these things that you have just told me about?

What are the barriers or the things that stand in the way of being healthy?

Probes: Why are you not healthy or why are you not able to do the things that you have described above?

What services are available? Are these services acceptable? If health is more than just not being sick, what stands in the way of you being able to rate your health as 10 with 10 being the most healthy that you could be?

What needs to be put in place for you to be able to promote health?

A) government programs (child tax credits, CPNP)

B) leadership (position of council)

C) resources (examples daycare, transportation)

Probes: If I had a magic wand and I could grant you any wish you had in order to help make yourself healthy or your family or community... what would you wish for?

**Appendix B**  
**Ethics Approval**



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## APPROVAL CERTIFICATE

31 August 2004

**TO:** **Debbie Viel** (Advisor L. Scruby)  
Principal Investigator

**FROM:** **Stan Straw, Chair**  
Education/Nursing Research Ethics Board (ENREB)

**Re:** **Protocol #E2004:070**  
**"Aboriginal Women: Promoting Health within Families and  
Communities"**

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Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

**Please note that, if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

## Appendix C

## Participant Consent Form

**Aboriginal Women: Promoting Health within Families and Communities**

Researcher: Debbie Viel

Sponsor: Irene Norwich Foundation

**This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.**

The purpose of this project is to determine how Aboriginal women promote health in their families and communities.

I am agreeing to participate because I am an Aboriginal woman living within a First Nation's community. I will be one of ten to twenty participants enrolled in this study. If I agree to participate, I will be asked to agree to the following: To give 2 hours of my own time to be interviewed on one occasion by the researcher, at a date that is convenient. The interview will be taped but at any time in the interview, I can stop the tape recording. I can ask questions before and at any time during the interview. The researcher may contact me at a later date to ensure accuracy of the information that I provided her with.

I understand that this study poses no risk to myself or to my family.

I understand that the researcher obtained my name, address and phone number from (name of a Family Resource Centre) located in (name of a town) through one of their many outreach programs. (The Centre) will not be given any specific information about my responses. The services I receive from (the Centre) will not be affected in any way if I choose not to participate at any time. The services that I receive from the (Health Authority) will not be affected in any way whether I agree to participate or not participate.

It is my understanding that confidentiality will be maintained by the researcher who will not associate my name with my story / data. I understand that the researcher is conducting this study for her Masters of Nursing degree. I also understand that the researcher will be hiring a professional transcriptionist who will have access to my story / data. When an individual is obtaining her Masters degree she must work very closely with a committee of faculty members from the University and that her committee members will have access to the information collected. The committee members are: Dr. Lynn Scruby (committee chair), Faculty of Nursing, the University of Manitoba, Dr. David Gregory (internal advisor), Faculty of Nursing, the University of Manitoba, and Dr. Barbara Payne (external advisor), Faculty of Arts - Department of Sociology, the University of

Manitoba. When writing the thesis, the researcher may change small details of our interview to ensure that community members that may be familiar with my life events do not easily identify me. I also am aware that if I were to disclose any involvement with child abuse the researcher is obligated by law to report this to the authorities.

In any report writing and publication of the study, I understand that there will be no direct reference to myself and / or the agency where I work.

During my participation in this study, I will not have to assume any financial costs.

If I agree, the researcher agrees to send me a summary of her findings for my feedback. The researcher will also mail me a copy of her study findings if I so desire upon her completion. There is an attached form that I will sign if I would like to receive a copy of the study findings. The researcher will also call me when her thesis is complete as she will host a community presentation outlining her study findings which I will be invited to attend.

The benefits to participating in this study will include my personal contribution to the knowledge of Aboriginal Women and health promotion. There will also be a small honorarium of \$20.00 given in recognition for my time and an additional \$5.00 if I have to pay for child care and / or transportation.

**Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and / or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.**

The researcher is Debbie Viel, graduate student, Faculty of Nursing, The University of Manitoba. I can contact her by telephone @ xxx-xxxx (home) or xxx-xxxx (work). The thesis chair is Dr Lynn Scruby, professor @ University of Manitoba. I can contact her by telephone @ xxx-xxxx.

**This research has been approved by the Education / Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above named persons or the Human Ethics Secretariat @ 474-7122 or e-mail margaret\_bowman@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.**

---

**Participant's Signature**

**Date**

---

**Researcher and / or Delegate's Signature**

**Date**

**Aboriginal Women: Promoting Health of Themselves, their Families  
and Communities**

I am interested in obtaining a summary of the findings of this study. My  
mailing address is:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

## Appendix D

## Request for Assistance

Name of Centre  
Box x  
Town name, Manitoba  
XXX XXX

Attention: Ms. (name) – Director of (name of centre)

Dear (name of Director),

I am currently enrolled in the graduate nursing program at University of Manitoba. As part of my fulfilment for my Master's Degree in Nursing, I must complete a thesis, which is a research study. My research is titled *Aboriginal Women: Promoting Health within Families and Communities*.

As we have previously discussed, I will be recruiting ten to twenty Aboriginal women for face to face interviews that will take approximately 2 hours. If possible, my hope is to have women from across the lifespan. To be successful, the study participants should feel as comfortable as possible during the interview.

What I am requesting from (the Centre) is permission to put up the attached recruitment poster within your facility and a staff member (I have listed yourself / or XX) to record the names, ages and contact information of possible study participants. I will contact the participants at a future date. Since comfort is of great importance, I would appreciate the use of your building for interviews if the participant(s) so desires. The women will be given a small honorarium (\$20.00) for their time.

Your assistance with this study is very much appreciated.

Sincerely,

Debbie Viel  
(204)-xxx-xxxx – daytime  
(204)-xxx-xxxx - evenings

## Appendix E

## Recruitment Poster

An Invitation to Participate in a Research Project to Aboriginal women 18 years of age and older.

- Open to any Aboriginal women 18 years of age or older
- I want to hear from you about:
  - The ways you keep yourself healthy
  - Do you help to keep others healthy?
  - What does it mean to be healthy?
  - What prevents us from being healthy?

The information learned from this study will be used to complete my Master's Thesis. If you would like to participate in this study you will remain anonymous and you may withdraw your name at any time. The study consists of 1 interview that will take about 2 hours and can be done at a place and time of your convenience. A small honorarium of \$20.00 will be paid in respect to your time. If you are interested in participating in this study, please leave our name with (xx, or xxx at the name of the Centre), or if you would like more information about this study, please call Debbie Viel @ xxx-xxxx.