ABORIGINAL WOMEN: PROMOTING SELF, FAMILY AND COMMUNITY HEALTH

BY

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A Thesis
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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, Gariepy, & 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 Goeppinger 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.

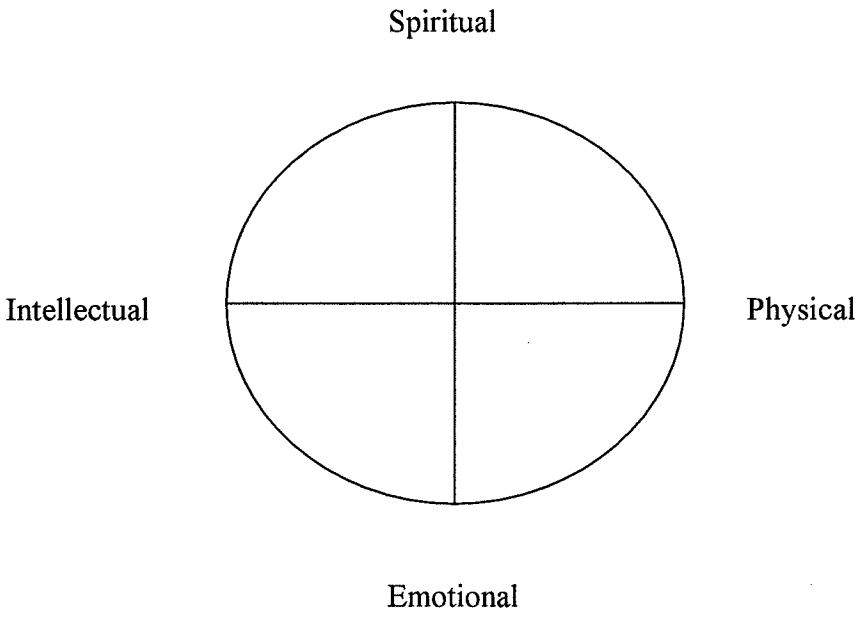

Figure 1. The medicine wheel used as a conceptual model to define health as being holistic and having four equal quadrants.

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. Strictland (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