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URBAN FIRST NATIONS GRANDMOTHERS:
HEALTH PROMOTION ROLES IN FAMILY AND COMMUNITY

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BN, University of Lethbridge, 2006

A Thesis
Submitted to the School of Graduate Studies
of the University of Lethbridge
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Faculty of Health Sciences
University of Lethbridge
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Abstract

Urban First Nations grandmothers: Health promotion roles in family and community

The purpose of this participatory action research study was to gain an awareness of the meanings of health for urban First Nations grandmothers, and how they promote it in their families and communities. Active participation of 7 urban First Nations grandmothers in the research process involved 4 group and 1 individual interview. Meanings of health included maintaining balance in all areas of life; physical, mental, emotional, and spiritual. Control imposed through the residential schools resulted in secrets kept, yet the survival and resiliency of the grandmothers were identified as part of being healthy.

Personal health was linked with the health of their families and communities, and an awareness of living in two cultures vital in the intergenerational transmission of knowledge. Relationships with grandchildren were catalysts for change, and the grandmothers described working to “turn it around” throughout their challenges in health and life, as one strategy for health promotion.

Acknowledgements

I am in the care of the Creator, as reminded by the group of grandmothers I have grown to admire, and am thankful for this every day.

I am grateful to the group of First Nations grandmothers who shared their time and expertise with me on a range of topics. This research project would not have occurred without them.

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Urban First Nations Grandmothers: Health Promotion Roles in Family and Community

Chapter 1

Introduction

First Nations grandparents have been identified as having traditional positions of influence within their families and communities. First Nations grandmothers frequently perform care giving roles and are therefore in unique positions of opportunity to define and promote health in their families and communities. Urban First Nations grandmothers occupy essential roles in health promotion for their families and communities away from reserves. This introductory chapter presents the context for the study, including the theoretical framework and literature review of relevant concepts, and then identifies the research questions that were explored. The research design, including the sample, will be introduced.

Grandparents' Importance in Society

Grandparents have been identified as having an essential place in family and society (Bengston, 2001; Kemp, 2004; Woods, 1996), living to enjoy an average of five grandchildren over their life-spans (Kemp, 2003). Using data from the 2001 Census of Population and the 2001 General Social Survey, Milan and Hamm (2003) reported there were 5.7 million grandparents in Canada in 2001, with an average age of 65, and the potential to influence their families: "Whether they are primary or occasional caregivers, reside in the same household or not, live nearby or on the other side of the country, grandparents have the potential to be very influential in the lives of their grandchildren" (p. 7). With advancements in prevention and treatment of chronic illness, grandparents may be experiencing increased quality of life; one result being more opportunities to

influence and nurture their grandchildren. Many grandparents take on roles as care givers, which can result in increased complexities in relationships with grandchildren compared to those grandparents in traditional grandparenting roles (Bunting, 2004; Kemp, 2007; Leder, Grinstead, & Torres, 2007; Musil, Warner, Zauszniewski, Jeanblanc, & Kercher, 2006; Reitzes, & Mutran, 2004).

Some grandparents may not possess adequate health to properly care for their grandchildren (Fuller-Thomson, & Minkler, 2005) experiencing stress with care giving (Leder, et al., 2007; Musil, & Standing, 2005; Pruchno, & McKenney, 2002). Though grandparents may find care giving overwhelming, grandmothers have been shown to adapt with well-being to becoming care givers (Goodman, & Silverstein, 2002), displaying emotional health benefits such as increased self-esteem and decreased depressive symptoms (Grinstead, Leder, Jensen, & Bond, 2003; Reitzes, & Mutran, 2004; Whitley, Kelley, & Sipe, 2001).

First Nations Grandparents

Statistics Canada's 2006 census reported 1,172,790 people with an Aboriginal identity in Canada (<http://www40.statcan.ca/101/cst01/demo38a-eng.htm>). Indian and Northern Affairs (www.ainc-inac.gc.ca) reported fifty percent of Canada's Aboriginal population living in Canada's larger urban areas. There are more than 586,000 Aboriginal people living in larger urban areas, which does not take into account those living in smaller urban areas. Guimond, Robitaille, and Senécal (2009) have reported "the Aboriginal population growing substantially faster than the non-Aboriginal population, especially in Canadian cities" (p. 16).

Aboriginal identity includes "a person who reports that he or she identifies with, or is a member of, an organic political or cultural entity that stems historically from the

original persons of North America. The term includes the Indian, Inuit and Métis peoples of Canada” ([www.statcan.gc.ca/Englishconcepts/definitions/First Nations.htm](http://www.statcan.gc.ca/Englishconcepts/definitions/First%20Nations.htm))¹. The definitions of elder vary within the large number of First Nations across Canada but their functions include ensuring that traditional values and teachings are passed down, and providing instruction in how to live (Indian and Northern Affairs Canada, 2007). Elders are identified by members of their community; grandmothers may not always be Elders. However, when citing other studies which use the term Elder, the meaning of Elder was inferred to mean a grandmother. For the purposes of this thesis study, the term grandmother will be used, as it denotes more intimate meaning than the term Elder. Finally, in this study, a First Nations grandmother refers to an individual who acknowledges either consanguine (related by blood) or fictive kinship (adopted) ties with their families.

Historically, First Nations grandparents have held complex responsibilities and places of honor within their families and communities. Today, First Nations grandparents are described as supporters, advisors, keepers of traditional knowledge, and keepers of community (Barusch, & Steen, 1996; Loppie, 2007; Robbins, Scherman, Holeman, & Wilson, 2005), and frequently perform care giving roles for grandchildren. Fuller-Thomson (2005) compared First Nations grandparents to other grandparents raising grandchildren and described them as “disadvantaged—more likely to be living with a disability, to be poor, to be unmarried, to be providing more hours of childcare and of housework, to be raising two or more children, and to have not completed high school;

¹ First Nations is the term used throughout this research study (at the request of the grandmothers in the study) except in instances when authors are cited using other terms such as Aboriginal, Native, North American Indian, Indigenous, etc. that may reflect the era or originating country of the document.

[yet]—resilient caregivers who often are raising their grandchildren in the context of extreme poverty and ill-health” (p. 340).

Poverty and ill health can produce marginalization which is more than economic and includes exclusion from everyday amenities that many others take for granted (Harding, 2005). This marginalization affects women in myriad ways, who have been described as “universally disadvantaged in terms of poverty and exclusion, although they contribute greatly to the survival and wellbeing of families. Special efforts are essential to ensure the participation of older women in development initiatives” (World Health Organization, 2002, p. 16). This participation should not be obligatory, but First Nations women should be recognized for their contributions to the wellbeing of their families. An editorial by Tait (2008) has identified marginalization occurring because of Canadian health care policy, emphasizing health and personal responsibility, with “an increased burden placed upon Aboriginal women to be responsible not only for their own health but also for that of their families and communities” (p. 2). Exploration of issues of marginalization in health promotion were important aspects of this research project.

Urban First Nations Grandmothers

With an awareness of the crucial roles both grandfathers and grandmothers have in First Nations culture, this research focused on urban First Nations grandmothers, as both urban First Nations and health needs of women and children (Young, 2003) have been identified as under-represented in the literature. The role of First Nations women in healthy living has also been identified as an area requiring further research (McNaughton, & Rock, 2004). A study of grandmothering among White Mountain Apache using loosely structured in-depth interviews with 13 grandmothers, four adult

daughters, a medicine man and an Anglo elementary school teacher described grandmothers as more influential than anyone in the community, including grandfathers.

To the degree that anyone is truly responsible for the future of the Apache society and culture, I believe it is the grandmothers. More than the tribal politicians, the medicine men, the teachers, the local celebrities or the upwardly mobile migrants to urban America, it is the local grandmothers who anchor the heritage and, very often, the physical well-being of the Apache people. (Bahr, 1994, p. 242)

Though First Nations grandmothers are characterized as maintaining well-being within their communities, they have been identified as having poorer health and more chronic diseases than First Nations men (Bourassa, McKay-McNab, & Hampton, 2004; Young, 2003). Despite their own health challenges, First Nations grandmothers can occupy places of health promotion in the lives of others. Grandmothers are willing to “make life changing transitions for the welfare of their grandchildren and families. As a resource, grandmothers are flexible and generous, and they rely on their life wisdom in helping their families” (Standing, Musil, & Warner, 2007, p. 630).

First Nations grandmothers living in urban centers are particularly needed in promotion of health for their families and communities. The social effects of urbanization in Canada include inadequate housing and homelessness, pollution, poverty, crime, and addictions, which in turn affect health outcomes of all Canadians (Filion, Bunting, & Warriner, 1999; Finkelstein, et al., 2003; Lopez, 2004; Miller, Donahue, Este, & Hofer, 2004; O’Connell, 2004; Smart, & Smart, 2003; Timmer, & Seymoar, 2005).

Effects of urbanization on First Nations communities are extensive, with off-reserve First Nations people experiencing poor access to adequate housing and culturally appropriate services, lower socio-economic status and increased health difficulties than those living on-reserve (Royal Commission on Aboriginal Peoples, 1996; Tjepkema, 2002; Young, 2003).

Grandmothers' Roles in Health Promotion

The Canadian Institutes of Health Research (2007) provides a definition of health.

Health is understood in a broader sense than the notion of bio-psycho-social well-being. In keeping with Aboriginal understandings of health, it also includes spiritual, cultural, community and environmental well-being. Fostering health in this sense includes enabling growth, balance, self-determination, reciprocity, relationships and peace. (p. 10)

Health promotion is defined by the World Health Organization as “a process of enabling people to increase control over their health and its determinants, and thereby improve their health;” and is guided by the following principles:

- Health as a fundamental Human Right and sound social investment
- Equity and Social justice in health promotion
- Social responsibility of the public and private sectors in promoting health
- Partnerships, networking and alliance building for health
- Individual and community participation as a pre-requisite
- The individual has a social responsibility over their own health
- Empowerment of the individual and communities for health promotion
- Development of infrastructure for health promotion
- Integration of health promotion activities across sectors
- Professional ethics and standards

(<http://www.searo.who.int/en/Section1174/Section1458/Section2057.htm>)

Traditional health promotion roles of grandmothers include passing down traditional beliefs about pregnancy and birth (Long, & Curry, 1998), to influencing important health decisions in their family's lives (Aubel, et al., 2001; Meleis, & Im, 2002). It was important to incorporate exploration of meanings of health for First Nations grandmothers as well as their families and communities in this research, as they differed from standard definitions or understandings of health. As well, non-First Nations definitions of grandmothers as “blood relations” differed from those which are accepted

in First Nations cultures and traditions. First Nations women's interactions with health care providers and health care services were identified as being not as accessible or equitable as for the general population. Traditional understandings of health and the role of grandmothers may not be well understood by younger generations. These factors all affect the influence of First Nations grandmothers in health promotion within their families and communities.

First Nations women have described themselves as health guardians and vital "in health development of our communities whether we are taking care of families, maintaining cultures, conducting research or assuming leadership roles" (Dion Stout, 2005, p. 18). Grandmothers are respected in their communities, but may not be accessed for education and support as readily in urban areas as in on-reserve areas (Drywater-Whitekiller, 2006). Reasons for decreased access in urban areas may include availability of many activities such as work, friends, entertainment, and other support systems which may not include grandmothers. Identifying areas of strength, and providing opportunities for connections between First Nations grandmothers and their families and communities in urban areas is crucial to enhance health promotion. Aboriginal women's positions in their communities are outlined by Wilson (2004):

As life-givers, care-givers and decision-makers, Aboriginal women in many ways are the health gatekeepers of their communities. Health care providers and policy makers should seek to strengthen Aboriginal women by acknowledging the value of the family and community roles and responsibilities they have assumed, by creating and supporting opportunities for them to work together, and by soliciting their input on service delivery and policy direction. (p. 22)

This concept of health gatekeepers is intriguing and was explored in this project.

Facilitating opportunities for continued strengthening of First Nations grandmothers is

essential and was realized by involving them in this research regarding their roles in health promotion.

Significance of the Research Questions

The Royal Commission on Aboriginal Peoples (1996) has identified Aboriginal women as significantly behind other women in Canada in many social, economic, and health issues. First Nations women may appear to have equal access to health care, but may not choose to utilize it, for a variety of reasons. My clinical career has demonstrated many misunderstandings within our health care system; I have heard health care professionals describe First Nations women as “unfit mothers,” based on perceptions that “these women” are prone to substance abuse, poverty, violence, and substandard living conditions. As a white female nurse, I must contemplate my own contributions to these racist attitudes, at times, prescribing society’s expectations and definitions of motherhood and health where they have not fit. I have worked with First Nations women in varying settings and roles, with opportunity to learn from them while observing their resiliency and strength, often in the midst of chaos. I have been able to share some of my own struggles with mothering, providing for, and protecting my children, and have found that honesty and shared empathy does much to increase self-esteem and confidence in the difficult role of raising children. Collaboration with urban First Nations grandmothers, gaining an understanding of what health means to them, and facilitating self-empowerment were all important aspects of this study.

One goal of this study was to provide opportunities for urban First Nations grandmothers to re-emphasize their importance in traditional roles of healing in their families and communities: in the words of a prominent elder, “women are the medicine”

(Morrisseau, 1998, p. 76). A second goal was to carry on culturally and community acceptable and sensitive research; while advocating for change within our present health care system which the grandmothers identified as meaningful for themselves, their families, and communities. A third goal was one of collaboration and giving something back so the grandmothers will benefit from the research of which they are the essential part. A fourth goal was to discover how and why First Nations grandmothers pass on knowledge about health promotion. These goals were explored with the sample which included urban First Nations women from Blackfoot and Cree tribes.

Research questions for the study included: (1) What does health mean to urban First Nations grandmothers? (2) How do they promote it in their families and communities?

Sample, Methodology, and Theoretical Framework

The community representative for the Aboriginal seniors program in Lethbridge, Alberta provided verbal permission for me to undertake this project in collaboration with a group of urban First Nations grandmothers. She has worked closely with Aboriginal seniors in Lethbridge, providing transportation for grocery shopping, physician's appointments, building health lifestyles programs, and organizing community events in conjunction with the First Nations Community Association in Lethbridge. The seniors have expressed their appreciation and respect for her invaluable role in the community. Using a participatory action approach helped ensure active involvement of the grandmothers. The use of group interviews, and individual interviews if the grandmothers wished, were also used in order to increase their comfort throughout the research process. We discussed the appropriateness of including any First Nations

grandmother living in Lethbridge, though when one of the grandmothers suggested going out to the reserve to talk to some of her friends there, that idea was welcomed, though did not occur as she did not get back to me about meeting, therefore, I did not pursue it.

Members of the First Nations Community Association (FNCA) in Lethbridge also invited grandmothers who they thought would be interested in the study after I met with them to discuss the research project.

Participatory action research was described in an integrative review by MacCaulay, et al. (1999) as having three primary features, including collaboration, mutual education, and acting on results developed through research questions relevant to the community being researched. Group interviews (as well as an individual interview) were conducted and an analysis performed with assistance of the grandmothers, that focused on meanings of health and how they promoted it among their family members and in their communities.

An acknowledgment and honoring of the wisdom held by First Nations grandmothers, as well as an awareness of the privilege of entering into their circle was recognized. The grandmothers identified other areas of interest and importance to them, guiding the study in a direction of their choice. One of these areas involved their experiences of surviving the residential schools.

One theoretical framework guiding this study was that of First Nations “ways of knowing” the grandmothers shared; and a belief in the connectedness of all things, including health and well-being, as well as community and family, and transmitted from one generation to the next (Bastien, 2004; Hungry Wolf, 1980; LaRocque, 2001). Knowledge First Nations people hold is “indigenous to this land. It sustained Aboriginal

cultures for thousands of years, enabling them to thrive and grow strong. Strangely, this fundamental truth eludes most Canadians, who seem to believe that knowledge arrived with the Europeans” (Cross, 1993, p. 1). In this study I honored the knowledge the grandmothers shared, and attempted not to impose colonial-based methods on them as I learned.

A second theoretical framework guiding this study was that of participatory action research, which has been described as both a method and theory. Participatory action research involves people inventing and applying ideas themselves rather than having interventions from outside sources placed on them (Whyte, 1982). Collaboration between the community and the researcher is essential, recognizing participants as co-researchers, anticipating empowerment for all involved, and implementing change through knowledge gained (Streubert, & Carpenter, 1999; Loiselle, & Profetto-McGrath, 2007). The grandmothers had a wealth of life experience and knowledge to share throughout this study and as they continue to promote health in their families and communities.

Summary

Urban First Nations grandmothers are an essential part of their families and communities. They have positions of honor and influence which reach further than their personal health or circumstances. This study sought to explore key roles urban First Nations grandmothers play in health promotion among family members and within communities. The next chapter will provide a review of literature justifying the importance of the study, and contributing to the discovery of where it fits into an existing base of knowledge.

Chapter 2

Literature Review

This chapter includes an overview of references relevant to the topic. A brief summary of the main points and general conclusions from the literature are offered. Gaps in the literature are identified along with implications for the proposed research.

The following literature review focuses on relevant issues including cross-cultural research and grandmothers, First Nations women and urbanization, the roles of First Nations grandmothers, and First Nations grandmothers and health.

Cross-cultural Research and Grandmothers

Literature which examined roles of grandmothers in other cultures had some relevant and applicable information for this research project. The importance of grandmothers is a theme across many cultures. For example, a convenience sample of 100 urban, low-income African American grandmothers raising grandchildren concluded that grandparents raising grandchildren is a widespread phenomenon, with these families needing health and social supports to thrive (Whitley, et al., 2001). Dunning (2006) described grandparents as an intergenerational resource in the United Kingdom and emphasized more resources are needed for care giving grandparents, including taxation pensions and employment.

Woods (1996) performed a cross-cultural study of grandmother roles in Indian, Japanese, and African American cultures and concluded: “In each of the cultures, grandparents assumed positions of authority and were respected for their knowledge and wisdom” (p. 290). Davis (2000) interviewed 15 Vietnamese women aged 21-67 years, using a phenomenological method to discover links between health and family. Themes

of connectedness were identified as raising children was shared among aunts, sister-in-laws, grown sisters, and grandmothers. “Values of respect for elders, connectedness, and individual subjugation for the good of the family provide the consummate formula for individual health and well-being...health is seen as more than physical and mental well-being, as it also includes spiritual and social connections” (Davis, 2000, pp. 151-152). These values appear similar to some First Nations cultures as do themes from the following study of African-American families. An ethnographic case study using videotaped interviews with 14 participants aged 17-72 years (Mosely-Howard, & Burgan Evans, 2000) revealed seven themes: reliance on tradition to raise children (transmission of traditions), the value of taking care of and maintaining a connection with extended family (kinship bonds), pride in cultural heritage, overt teaching about racism, negotiation between two cultures, education, and the role of spirituality/church. Other observations included role flexibility such as grandmothers raising grandchildren and welcoming of others into family groupings. “The respect of the elder is crucial to the family system; boundaries include the elder member and are dependent on their presence. Cultural transmission is enriched by their presence” (Mosely-Howard, & Burgan Evans, 2000, p. 433).

The theme of welcoming others into families was also demonstrated in a mixed methods study involving 120 African American grandmothers raising grandchildren testing the effectiveness of a year of interdisciplinary intervention (social work and nursing case management, monthly support group meetings, parenting classes, legal service referrals for custody or adoption) finding it positively affected their well-being. Their support group meetings resulted in mutual support networks, and recognition of

their strengths and competencies. The study suggested that “grandparents raising grandchildren provide an extremely valuable service to their grandchildren, as well as to the community” (Kelley, Whitley, & Sipe, 2007, p. 61).

Chamberlain (2002) shared narratives of Caribbean colonial childhoods with grandmothers revealed as strong, hard workers, links for family and kinship networks, providing continuity through the generations, and a “gravitational grandmother—a figure in the community to whom parents – and children – could turn for help... a reputation transmitted through networks of contact and support and through an acceptance that children could be as adequately reared by another as by their own kin or mother” (p. 193). The colonial view of West Indian society interpreted this as “looseness and weakness... a practice that contrasted with colonial ideology of family, which privileged a nucleated and autonomous unit as the key to social stability and privileged birth parents, the only adults responsible for the socialization of their children” (Chamberlain, 2002, pp. 197-198). This study suggested more research regarding ethnic and structural differences in grandmothers’ participation in families was needed.

A grounded theory study with 23 black custodial grandmothers used personal interviews to conceptualize how grandmothers create their place in society and identified three themes describing grandmother’s personal esteem. Adaptive pride was represented in accomplishments such as providing for and parenting grandchildren; self-reliance; and personal resources, identified as “knowledge and the abilities to seek assistance, to maintain an attitude of thankfulness, and to embrace their spirituality as a source of support and strength” (Stevenson, Henderson, & Baugh, 2007, p. 199). These grandmothers cared for their grandchildren with a scarcity of financial resources,

measuring their personal resources as their abilities and spirituality.

Many similarities exist between First Nations cultures and those cultures described here in regards to grandparenting and being a grandmother:

- grandparents raising grandchildren is a widespread phenomenon
- grandparents are an intergenerational resource
- grandparents are respected for their wisdom
- social connectedness is part of individual health and well-being
- health is more than physical and mental well-being
- transmission of tradition is important in raising children
- kinship bonds and extended family are important
- pride in cultural heritage exists
- negotiation between two cultures occurs
- welcoming others into family groupings is frequent
- the importance and strength of grandmothers is evident when providing for their grandchildren
- grandmothers provide links for family and kinship, even if they are not blood relatives
- grandmothers with scarce financial resources have well-honed personal abilities as resources (such as the ability to pass on knowledge gained from life experiences as well as from teachings of their own parents and grandparents)
- grandmothers consider spirituality an essential personal resource

First Nations Women

There are many historical points of harsh reality for Aboriginal women and their families in Canada, including the Indian Act², Bill C-31³, and residential schools⁴.

Turpel-Lafond, explained the continuing effects:

Our family structures have been systematically undermined by the Canadian State in every way imaginable—forced education at denominational residential schools, imposed male-dominated political structures, gender discrimination in determining who is to be recognized as an ‘Indian’, and the ongoing removal of First Nations children by child welfare authorities. (Turpel, 1991, p. 181)

“When the women heal, the family will heal. And when the family heals, the nation will heal” (Kenny, 2006, p. 551). This statement by Margaret Lavalley, an Ojibway woman in Kenny’s study exploring Aboriginal women’s views on policy development to improve quality of life, summarizes the importance of women and health promotion. The World Health Organization (www.who.int/hpr/ageing) has identified older women as resources for their families and communities into their old age, emphasizing the importance of acknowledging the contributions of these older women to society. Aboriginal women have been identified as an under-researched population, and are qualified to speak about health promotion in their families and communities (McNaughton, & Rock, 2004; Meadows, Lagendyk, Thurston, & Eisener, 2003).

² Indian Act – Was created by the government of Canada in 1876, defining who possessed “Indian” status. Many amendments were made to it, including Aboriginal and treaty rights. Women (as opposed to men) lost their Indian status (including fishing and hunting rights, property inheritance, education and health benefits) when marrying a non-Indian. Their children could not claim Indian status.

³ Bill C-31—these amendments to the Indian Act were passed in 1985 and became law in 1987. Women could no longer lose Indian status through marriage, but must disclose the identities of their children’s fathers in order to transfer it.

⁴ Residential schools – With goals of assimilation and education, a government/church (Anglican, Catholic, Methodist, and Presbyterian) partnership opened boarding schools across Canada. The removal of Aboriginal children from their homes and replacing traditional language and beliefs with European language and beliefs was an attempt at civilizing and re-socializing. Conversely, the results were horrendous, resulting in neglect, mistreatment, and abuse of thousands of children, reaching to future generations through forced removal of traditional values and bonds of parental love.

First Nations Women and Urbanization

Traditional ways of promoting health have undergone change with the increasing urbanization of First Nations people. Reasons for the movement of First Nations people into urban areas are varied and range from positive aspects of job and educational opportunities to negative influences of Bill C-31 on women's and children's rights (Barnsley, 2001; Communications Branch, 1995). Cooke (2002) reported a "disproportionate amount of poverty experienced by Aboriginal people in Canadian cities" (p. 41). Cooke and Belanger (2006) used interview data to develop reasons for the migration stream and reported remote areas have increased costs of living with less access to service and economic activities, limited employment opportunities, and limited housing and access to health care. Yet, a First Nations woman moving to an urban area for employment may be at a disadvantage. Data from the public use microdata file on the labour force activity of women in Canada was used in a comparative analysis. It concluded that "Registered Indian women are at a disadvantage concerning labour force participation. They have the lowest rates of participation and, when they do participate, they have a far greater likelihood of being unemployed than other Aboriginal and non-Aboriginal Canadians" (White, Maxim, & Gyimah, 2003, p. 410).

A quantitative study by Tjepkema (2002) concluded that Aboriginal people living off-reserve had greater odds of experiencing poorer health (including lower self-perceived reporting of health, as well as a higher prevalence of arthritis, high blood pressure, and diabetes) than those living on-reserve. A Canada West Foundation report on urban Aboriginal issues conducted by Hanselmann (2001) reported:

The socio-economic comparison of urban Aboriginal people to the non-Aboriginal population in six large cities in western Canada shows that, on a

number of important indicators of personal and community wellbeing, many urban Aboriginal people live in disparate conditions. In short, many urban Aboriginal people face challenges well in excess of those faced by the general population. (p. 19)

Decreased connections to the land for Aboriginal women living in urban centers have been identified, which may negatively affect health and well-being by decreasing connections with mother earth (Wilson, 2005). These disconnections may be viewed as challenges which urban First Nations women can balance and manage in other ways such as respecting the earth. Connections to the land can be maintained even in urban centers. Anderson and Denis (2003) emphasized the importance of recognizing urban Aboriginal communities as growing, still connected to the land through tradition, and “the source of new forms of culture, association and self-perception—both individual and collective—about what it means to be Aboriginal” (p. 385). Urbanization has therefore positively and negatively affected First Nations women and their families in various ways.

Spirituality and Health

Spirituality has been recognized as essential in regaining identities following removal through colonialism’s history with First Nations people; “the characteristics of the dimension of spirituality include relationship, unity, honor, balance, and healing” (Struthers, & Low, 2003, p. 268). A grounded theory study using semi-structured interviews with 18 participants and 2 community members from the Sto:lo Coast Salish of North America explained spirituality as a way of life, part of everything, not an organized religion, with teachings of Elders contributing to knowledge about health. To be healthy means to be balanced: “Balance is walking mentally, spiritually, physically... You have to have a good understanding of what it means to yourself and everything around you...like the ground, nature, and the family” (Labun, & Emblen,

2007, p. 211). Some of the questions used in Labun and Emblen's study were helpful in eliciting meanings of health from First Nations grandmothers in this research study.

Examples included: What does being healthy mean to you? Is spirituality part of good health? Could you describe that to me?

A case study by Fleming, et al. (2006) involved 4 Aboriginal females aged 14-18 years and used rapport building, focus groups, one-on-one interviews, and an art project, identifying body image/health in young Aboriginal women. Spirituality was identified as helpful in coping with stressors such as conflicting cultures, thereby improving mental health; with clear links between emotions and health. A personal account by Begay (2004) portrayed her bodily experience of pregnancy and childbirth as connected to spirituality and health. Following the traditional ways of her people, she described letting go of old ways would have been letting go of her own self. Begay described spiritual connections for her and her child "include many generations of parents to provide comfort, support, knowledge, and respect for all that was experienced and endured to create a single baby to carry us into the future" (p. 565). Strength can be found in spirituality passed down through grandmothers: "keepers of the next generation in every sense of that word—physically, intellectually, and spiritually" (Armstrong, 1989, p. xi). Connections between spirituality and health, balance and well-being, honor and healing, the old and the young, were important themes identified throughout the literature which were explored in this research study.

Roles of Grandmothers

Roles of grandmothers have been outlined by the Aboriginal Peoples Family Accord (<http://apfabc.org/grandmothers.htm>). These roles include:

- building and strengthening communities
- stabilizing the future of children and grandchildren
- giving strength to children and their families
- providing cultural identity and historical values
- understanding the community best
- assuming responsibility for children within their communities.

In this section, some research involving roles of grandmothers in non-First Nations families has been included to reinforce the importance of grandmother's roles.

Building and Strengthening Communities

Grandmothers provide their children with a framework of how women's health is viewed in their families. Caring, nurturing, and supporting are all involved in this model of grandmothers:

Our grandmothers were aware of their own marginalization possibility because of their illiteracy and because of their own oppression and power simultaneously. They were empowered and they empowered others by creating continuity for themselves and their families by combining the biomedical model with many alternative ways of healing. (Meleis, & Im, 2002, p. 217)

This empowerment strengthened families and communities. A qualitative ethnography (Meadows, Thurston, & Lagendyk, 2004) included more than 40 Aboriginal grandmothers and great grandmothers aged 40-65 and found becoming a grandmother increased thought regarding their well-being as well as the well-being of their families and communities. Becoming a grandmother also offered women opportunities to explore and pass on traditional knowledge. Future potential was embraced as difficult past experiences were let go:

These women saw that they had a second chance to be parents of a healthy Aboriginal community. They turned their primary attention to their

grandchildren, but they continued to love and teach their own children, as well as pursue opportunities that enhanced their own health and wellbeing. Somehow the effects of discrimination and loss of traditional roots and values, personal or family experiences with residential schools, substance abuse, violence or death have become an impetus to focus on a healthier approach to life, and/or a decision to move beyond the past and into the future. (Meadows, et al., 2004, p. 163)

Stabilizing the Future of Children and Grandchildren

Huber and Breedlove (2007) provided a quantitative analysis on a probability sample from the human relations area files (HRAF) in a cross-cultural study about grandmothers and reported they invest the most direct care (differing from grandfathers and uncles) for mothers in prenatal, delivery, and postnatal periods. This demonstrates only one of many investments of grandmothers in the future of children and grandchildren. Kemp (2004) explored 37 life histories through interviews about the meanings and experiences of being grandparents. Behavioral expectations for grandparents included maintaining “good” or “grand” identities, with grandparents exerting positive influences on lives of each family generation. Further research was suggested, in order to understand the full range of both positive and negative experiences of grandparenthood ties with their families. Using data from ten multigenerational families (86 participants), to assess continuity and change in grandparent-grandchild ties across 3 generations, Kemp (2007) concluded, “grandparents can be key sources of support for younger generations in the face of social, economic, and emotional challenges” (p. 877). Further research was suggested regarding the mechanisms of intergenerational transmission in grand cultures, confirming the complex relationships and ties between grandparent and grandchild, and examining them in their cultural context.

Giving Strength to Children and Their Families

Brown (1982) performed a cross cultural anthropological study with middle age women and found that with ageing, exerting authority over kinsmen is possible, with opportunity for recognition and achievement beyond the household. First Nations grandmothers are recognized as a source of strength for their children and families, but others would argue they are powerless. Green (2001) stated “In Canada, to be female and Aboriginal is to be disempowered by the state” (p. 725). Canada is described as a masculinist culture which devalues women, despite their historical value. The title of this article, “Canaries in the mines of citizenship: Indian women in Canada” was powerful, and thought-provoking, but was not explained in its content. Canaries were used for the protection of miners, taken into mines in cages, and would be the first to die if noxious fumes were present, resulting in the miners leaving the mine. The author implied that First Nations women are powerless, controlled and used by others, trapped, with no way of escape. Green (2001) also described how women can use tradition to resist these colonialist trappings and regain their historical positions of power.

“Prior to the sexist specification of the Indian Act Aboriginal women were matriarchal in their families. Families thrived with their Aboriginal women’s strength and support” (Bourassa, et al., 2004, p. 28). Traditions and historical values were passed down orally (Struthers, 2001), valuing historical methods of healing as encompassing the whole person and their environment (Struthers, 2003). First Nations grandmothers can strengthen families and empower themselves by passing down historical and traditional values.

Providing Cultural Identity and Historical Values

A descriptive analysis of more than thirty years of anthropological immersion in field work focused on urban American Indian communities in the United States and First Nations communities in Canada. “Urban clan mothers” were identified: middle-aged and older women who offer homes which welcome and care for many, providing for basic needs and “act as teachers and counselors, or carry out spiritual responsibilities. In some ways, these women are fulfilling culturally-based traditional roles that have been adapted to urban environments” (Lobo, 2003, p. 519). These “urban clan mothers” ensure the well-being of their communities by sharing their knowledge and resources, thereby providing a source of cultural identity for others. These clan mothers were similar to “gravitational grandmothers” mentioned previously (Chamberlain, 2002). A study by Drywater-Whitekiller (2006) used snowball sampling to locate a group of 19 Native American students in their last year of undergraduate studies, from 19 different tribal affiliations and performed structured interviews using open-ended questions with a purpose to gain insight into intergenerational relationships of enculturation through the teaching of Elders. Four themes emerged from the study: biculturalism (walking in two worlds); respect; grandparents teaching traditional ways; passing on the traditions and culture to others. Students identified the influence and necessity of Elders’ teachings in all four themes: to find balance in biculturalism; to have respect for wisdom of the Elders as integral; to have grandparents to teach traditional ways was critical: “one student’s experience entailed her maternal great-aunt serving in the role of her grandmother when her maternal grandmother deceased [*sic*].” (Drywater-Whitekiller, 2006, p. 81); and to learn cultural traditions in order to pass them on to younger generations when the Elders are gone. Drywater-Whitekiller suggested further research to explore how Native

American families instill these teachings in younger generations, as well as to examine kinship roles of grandparents and their motivation to pass cultural beliefs to their families and communities.

Understanding the Community Best

Horowitz, Ladden, and Moriarty (2002) discussed “informants” in family-related research, and the importance of qualitative designs without statistical control being able to “elicit enough data about the participants to describe their important characteristics and understand their relationship to the study’s focus” (p. 318). As grandmothers have been illustrated as gatekeepers in other studies, this study’s view of the importance and reliability of gatekeepers will provide recognition of grandmothers as very capable in speaking for their families and communities. In a follow-up evaluation of a participatory nutrition education strategy focusing on grandmothers, they were described as untapped community resources: “in households in traditional societies around the world, older women or grandmothers have played—and in most cases continue to play—important roles in maternal and child health” (Aubel, et al., 2001, p. 62). A qualitative study by Long and Curry (1998) with 52 women, 17 female Elders, and 10 young women, explored traditional beliefs and practices regarding pregnancy through focus groups. A central theme was a breakdown in women passing on traditional cultural wisdom, with a recommendation “for health care practitioners to empower Native American communities to transmit traditional health beliefs by providing education, support, and services that will address the social issues that Native American women identify as most important to them” (Long, & Curry, 1998, p. 214). Grandmothers have been identified as understanding relevant cultural components to

child safety and welfare. Bunting (2004) emphasized the importance of placing Aboriginal children within their own communities when they are removed from their biological parents.

Assuming Responsibility for Children in Their Communities

A qualitative study (Standing, et al., 2007) with 26 grandmothers who were in roles as transitional care givers used semistructured telephone interviews and identified the following themes: mixed feelings; changes in personal freedom (increased and decreased); commitment to their grandchildren; flexibility with unexpected change (fluid nature of relationships); and spirituality as strength. Though this was not a study with First Nations grandmothers, times of transitioning in care giving were portrayed as times of vulnerability for the care givers which may have applicability to the current topic under study. A cross-sectional study (Fuller-Thomson, & Minkler, 2005) analyzed data from the 2000 American community survey/census and compared the experiences of 319 American Indian and Alaskan Native grandparents 45 or older, raising grandchildren, with 5,956 respondents 45 years of age or older who were not caregivers (and may have not been grandparents as the 5,956 respondents were not asked to provide this information). One in three caregivers had functional limitations, one in five had a severe vision or hearing problem, and were “raising grandchildren in the context of extreme poverty, activity limitations, and limited access to resources and services” (Fuller-Thomson, & Minkler, 2005, p. 136).

Poverty was also identified as a concern in a study by Goodman and Silverstein (2002), who sampled 1,058 African American, Latino, and White grandmothers raising grandchildren. Support groups were suggested as an effective way to provide positive

influences for these grandmothers. Support groups were also identified as helpful in a study by Leder, et al. (2007) using telephone interviews with a convenience sample of 42 predominantly Caucasian, as well as African American grandparent caregivers. This study used Likert-type scales such as a parental distress scale and reported increased stress in grandparents raising grandchildren related to physical and mental health. Increased stress with caregiving was found in a sample of 486 white and non-white grandmothers in a mixed methods study by Musil, et al. (2006). This study suggested that the vital role grandmothers occupy in their families warrants further research.

A critical review of research on the health status of grandparents raising grandchildren (Grinstead, et al., 2003) examined 46 studies, with samples including primarily African American and Caucasian grandmothers. As First Nations grandmothers have been identified as frequently care giving for their grandchildren, parts of this review (such as the strains and benefits of care giving) may be applicable to First Nations grandmothers. Negative aspects of health identified in the review completed by Grinstead et al. (2003) included:

- physical and mental health problems
- increased chronic diseases and exhaustion
- exacerbation of health problems and delay in seeking care because of care giving role or financial constraints
- mental health issues such as being emotionally drained
- psychological distress including anxiety and depression, and stress

The grandparents also experienced:

- excellent mental health

- increased self-esteem
- less worry when grandchildren in their care instead of their children's care
- increased purpose for living
- health improvement with more active lifestyle, weight loss, and smoking cessation

Common sources of alterations by care giving in grandparents' lives included:

- changing plans, personal sacrifice
- decreased time for recreational activities and friends
- social isolation
- not being able to continue education
- delay in marital satisfaction (husbands' jealousy of time with grandchild)
- poverty and lack of access to financial and other resources such as health insurance
- decreased income if they stop working in order to care for grandchildren
- leaving senior housing
- no legal guardianship
- increased stress because of behavioral problems in the children (could be due to addiction in mothers)
- caring for multiple grandchildren also increased stress

Grandparents identified prayer and social support networks as resources for coping.

First Nations Grandmothers and Health

Young (2003) conducted a medline review of journal research articles from 1992 to 2001 on Aboriginal populations in Canada and their health needs. Of 352 articles that

were found, 254 were selected for the detailed review. Of note, this review indicated that considerable research has been conducted on Aboriginal health issues, but there remains a lack of information about the health needs of women and children. The exceptions in the literature that have explored health issues among Aboriginal peoples from alternative viewpoints are as follows.

A post-colonial analysis of healthcare discourses affecting Aboriginal women identified how social issues influence involvement in health care (Browne, & Smye, 2002). They recommended switching the focus from what Aboriginal women “need” to an analysis of “why” they are not participating fully in health care. They suggested value in questioning and then bringing about change in the present health care system; “to interrogate those contradictions in health care that mistakenly reduce social inequities to lifestyle choices, racism to ethnocentrism, and lack of participation in health care as stemming from cultural differences” (Browne, & Smye, 2002, p. 38). Explanations for these contradictions: why First Nations women live with social inequities, why racism still exists in our society, why First Nations women are not fully participating in health care; are not easily discovered in the current literature. These contradictions are related to multiple and complex phenomena and provide a context for some of the grandmother’s discussions in this study.

A qualitative study was conducted with 10 women from a rural reserve area in northwestern Canada to gain an understanding of their encounters with mainstream health care (Browne, & Fiske, 2001). These women reported many encounters of invalidation, negative stereotyping, feeling marginalized and vulnerable, and disregard for personal circumstances in the health care system. Being dismissed by health care

professionals and viewed as passive, waiting until symptoms became severe before accessing services, or transforming appearance or behavior in order to be accepted were common scenarios described. Yet, affirming encounters such as participation in health care decisions, receiving exceptional care, and the development of a positive, long-term relationship with a health provider including affirmation of personal and cultural identity, had deeper meanings than the demeaning encounters. How to achieve these positive encounters as normative experiences for First Nations women and their families within our health care system encompassed an area of exploration in this study.

One other research project was conducted to extend understanding of the positive impact of cultural identity of wellness for Aboriginal women in Manitoba, Canada (Wilson, 2004). Ways in which these women had drawn on cultural values, teaching, and knowledge in efforts to heal themselves, their families, and communities were emphasized in the data collection. The project was guided by a respectful acknowledgement of reciprocal knowledge, acknowledgement of spiritual connections, and accountability in use of the research results (must benefit the communities involved). Focus group discussions and individual interviews were used to discover answers to two primary research questions: (1) What contributes to the health and well-being of Aboriginal women? (2) What has influenced the identity of Aboriginal women? Key findings of the study included: responsibility for the community starts at home; relationships with family and friends is key as is raising whole and healthy children; taking responsibility for grandchildren is important; and personal well-being is linked with community well-being. In other words, “the women do not separate their own selves or well-being from the selves or well-being of the children, men, elders and communities

with whom they share their lives” (Wilson, 2004, p. 22). The concepts presented and the research questions asked in Wilson’s (2004) project, were applicable to this research project.

Another research study explored contradictions in Canadian health policy and identified a “doublespeak”—pretending Aboriginal women are empowered while discrediting them at the same time (Fiske, & Brown, 2006). Policies position Aboriginal women as a cultural “other” who lacks power, often providing liaison workers who embrace dominant views of health care, imposing them on Aboriginal women. How to bring about change within the present health care system that empowers First Nations women is an enormous undertaking, with no simple solution.

Summary

First Nations women are an under-researched population even though older First Nations women have been identified as resources for their families and communities: consequently, gaining an understanding of how First Nations grandmothers promote health in their families and communities was central to this study.

The literature identified numerous integrated themes: (1) Urbanization has brought challenges for First Nations women, yet grandmothers create support networks for their families and communities with limited financial resources; (2) Complexities regarding the mechanisms of intergenerational transmission of knowledge have been identified; (3) Perceptions of being powerless within Canadian society, to affirmations of wisdom, strength and respect in traditional ways have been identified in the literature. Descriptions about the lack of participation in health care among First Nations women and their families requires respectful exploration.

Chapter 3

Research Methodology

In this chapter, the theoretical framework which guided the study is further discussed and the study design is described. Procedures for ethical approval are outlined, as well as data collection, management, analysis, and dissemination of results.

First Nations Women and Research

In a search for links between the history of colonialism, government interventions, and mental health of Canadian Aboriginals, Kirmayer, Simpson, and Cargo (2003) concluded: “the knowledge and values held by Aboriginal peoples can contribute an essential strand to the efforts of other peoples to find their way in a world threatened by environmental depredation, exhaustion and depletion from the ravages of consumer capitalism” (p. S21). This statement demonstrates the importance of the potential knowledge that First Nations women possess. Empowering, strength-based approaches are essential in research with First Nations women. Bastien (2004) described colonization as disconnecting people from their kinship alliances, while “research, understood as an inquiry using traditional protocols, is a journey of relating, participating, and understanding my relatives...decolonization is an essential prerequisite for the engagement with tribal alliances...we honour the strength of the ancestors and acknowledge their gifts to our present generation” (pp. 46-47).

Research about Indigenous people has been connected with colonization by Smith (1999), who emphasized that Indigenous communities agreeing to participate in research projects “tend to be persuaded not by the technical design, however, but by the open and ‘good’ intentions of the researchers. They also expect and appreciate honesty. Spelling

out the limitations of a project, the things that are not addressed, is most important” (p. 140).

Theoretical Framework

One theoretical framework guiding this study was that of “ways of knowing” in First Nations communities which the literature described as including beliefs about connectedness of health and well-being, community and family, respect and relationships (Bastien, 2004; Hungry Wolf, 1980; LaRocque, 2001). Colonialism has had genocidal effects on Indigenous people, according to Bastien (2004), and exploring traditional “ways of knowing” of First Nations people is an essential strand for healing and strengthening of individuals and communities.

Knowledge is generated for the purpose of maintaining the relationships that strengthen and protect the health and well being of individuals and of the collective in a cosmic universe. In this respect, seeking knowledge is a fundamental responsibility for contributing to the collective good. (Bastien, 2004, p. 2)

A case study in Nunavut with mostly Inuit women survivors of residential school by Fletcher and Denham (2008) described healing as:

...both an individual and a collective process that links the physical body, the mind, and capacity for clear thought with the social world of everyday life and the unseen and spiritual worlds. The healing process from within this broad perspective involves the proper ordering of one’s life experiences, living comfortably in the company of others, being within the proper place on both a social and a physical level, and being fully aware of, and moving in, the appropriate trajectory through the world. (p. 127)

These interconnections, ways of learning, and ways of living noted above blend well within the second theoretical framework used in this study; participatory action research. Participatory action research was described by Greenwood, Whyte, and Harkavy (1993) as a both a process and a goal involving: collaboration between the researcher and the

community being researched; incorporation of local knowledge; eclecticism and diversity which “mobilizes theories, methods, and information from whatever source the participants jointly believe to be relevant” (p. 178); learning lessons from specific cases; changing as the study proceeds; and linking research to social action. Participatory action research has been described as learning about “actual practices and not abstract practices. It involves learning about the real, material, concrete, and particular practices of particular people in particular places” (Kemmis, & McTaggart, 2005, p. 564). The Canadian Institutes of Health Research (2007) have described the usefulness of participatory action research:

Participatory research enables a range of levels and types of community participation while ensuring shared power and decision-making. Such partnerships will help to ensure that research proceeds in a manner that is culturally sensitive, relevant, respectful, responsive, equitable and reciprocal, with regard to the understandings and benefits shared between the research partner(s) and Aboriginal community(ies). (p. 3)

As I sought to learn from the grandmothers, I determined to use my position in society (white majority) to be of benefit for this study, rather than be a detriment during the process. Wilmot (2005) discussed taking responsibility for doing something to make change in our society: “since all white folks benefit—whether actively or passively, whether by doing something or failing to do something...since we are enrolled in the club, like it or not” (pp. 12-13). Being a white woman was not a disadvantage during the research project but I found ways that it could be used in a positive manner, such as taking responsibility by speaking appropriately about the study as opportunities presented themselves. As the grandmothers were sharing their knowledge and wisdom, often through personal stories, my respect for them grew, making it difficult at times to remain in simply a researcher role, or the “research instrument” (Loiselle, & Profetto-McGrath,

2007). As caring relationships developed with the grandmothers, it was imperative that I avoided coercing them into revealing more information than they wanted to for the study, as well as avoiding a role of counselor (Streubert, & Carpenter, 1999).

Connection with First Nations women involves a feminist ethic of care as illustrated by Gilligan (1995): “A feminist ethic of care begins with connection, theorized as primary and seen as fundamental in human life. People live in connection with one another; human lives are interwoven in a myriad of subtle and not so subtle ways” (p. 122). Fitzgerald (2004) described using feminist research with Indigenous women, outlining eight guiding principles:

1. Approval for the research, research methods and research outcomes rests with the Indigenous participants.
2. Research is a process of ongoing dialogue and collaboration between and among us.
3. Develop and share by looking and listening and find a place from which to speak.
4. Acknowledge and respect individual community, language and *whakapapa* [connection with past, present, and the environment] each person brings to the relationship.
5. Honour the knowledge that was imparted from the past, in the present and for the future.
6. Act in a respectful, trustful and responsible way and understand the principle of reciprocity.
7. Actively contribute to community through the research process and outcomes.
8. Ownership of the knowledge and the process rests with Indigenous women and their communities. (p. 239)

These principles align with those of ownership, control, access, and possession (OCAP)⁵ described by the Canadian Institutes of Health Research (2002). First Nations people must be recognized as owners of the knowledge gained through research. There

⁵ Cathryn George of the Association of Iroquois and Allied Indians is credited with the original acronym “OCA”. The “P” (Possession) was added to establish that RHS First Nations data should remain in the hands of First Nation authorities in order to respect First Nations’ principles and protect their collective information. http://www.naho.ca/firstnations/english/documents/FNC-OCAP_001.pdf

must be ongoing communication between the researcher and the people providing the knowledge for the research so that the knowledge is represented accurately. First Nations people should have access to the data, not only the study findings, and should be given copies of the data that they request. The perspectives of those participating in the study must be respected, even if they do not coincide with the perspectives of the researcher, as the research has been built on relationships of trust.

Principles of OCAP have not always been viewed positively by all in the research community. First Nations Centre (2007) has outlined some of OCAP's perceived limitations such as being an obstacle to doing research, and possibly blocking access to First Nations communities. Another difficulty is that of research being public knowledge, with no applicable limitations. The limitations imposed by OCAP can be challenging but result in more meaningful research projects.

Feminist perspectives may not always be viewed positively among First Nations women, as feminist agendas may be seen as not meeting their needs: "Feminism is sometimes seen as an extension of colonialism by Aboriginal women, meant now to further coerce Aboriginal women into white ideals...integrative feminisms can support a culturally-focused, male included, community-based approach which will benefit not only Aboriginal women but Aboriginal Peoples as entire communities" (Simpson, 2001, p. 137).

Study Design

Many streams of thought contributed to the development of participatory action research. Marxist theory, not to understand the world but to change it, was one of the early contributions (Reason, & Bradbury, 2006). In the 1970's, Habermas downplayed

Marxist ideals, and developed a theory of communicative action which emphasized mutual understanding between participants as more important than imparting knowledge (Hall, 1992; Rodgers, 2005). Paulo Freire (an educator and philosopher from Brazil) developed a theory of oppression, and linked social justice with education, placing the less powerful at the center of knowledge creation (Creswell, 2003; Rodgers, 2005). Lewin implemented social experiments and viewed action research as cyclical, dynamic, and collaborative, using participation to solve social problems (Corbett, 2007; Stringer, 2004) while Collier coined the term “research action” (Corbett, 2007; Stringer, 2004). In 1977, the first participatory research project in Toronto, Canada, became the Participatory Research Group, partnering with the International Participatory Research Network (Hall, 1992).

The importance of cultural sensitivity is utmost in research with First Nations communities, and the appropriateness of participatory action research has been confirmed in many studies. (Canadian Institutes of Health Research, 2007; Cochran, et al., 2008; Kelly, 2006; Meadows, et al., 2003; Purden, 2005; Smith, 1999). For example, the oppression of First Nations women in Canada was compared with oppression of racialized women in South Africa by McPhedran (2006), who recommended the use of participatory action research as it “can be a powerful tool for women’s rights, fought for by ordinary women who want to be able to live their rights, and, as is so often the primary driver for women, to build a place for their children and grandchildren to live their rights” (p. 12). Minore, Boone, Katt, Kinch, and Birch (2004) conducted a mixed methods, five year retrospective study of participatory action research in 3 Canadian First

Nations and Inuit communities and concluded it uses inclusion principles which allow communities to have control of research that will affect them.

Loppie (2007) incorporated Indigenous principles into her doctoral research of midlife health experiences of elder Indigenous women in Nova Scotia, Canada, and stated: “Participatory research is intimately linked to many Indigenous philosophies through the value of local participation, learning through action, collective decision making, and empowerment through group activity” (p. 278). The grandmothers in my study all reside locally, they assisted in choosing where and when to meet, what to eat, as well as assisting with preparation of their recipes while teaching me how to make them.

Dickson and Green (2001) used participatory action research as part of larger project recognizing that Aboriginal women had unmet health needs. Twelve older Aboriginal women were co-researchers with a total of approximately 40 grandmothers and offered the following definition of participatory action research: “It is inquiry by ordinary people acting as researchers to explore questions in their daily lives, to recognize their own resources, and to produce knowledge and take action to overcome inequities, often in solidarity with external supporters” (Dickson, & Green, 2001, p. 472). Grandmothers were portrayed as holding a perception of research as something done to them for the benefit of outsiders, and from which they themselves received no gain. Participatory action research changed this perception, making the grandmothers active partners in research, and fostered their empowerment. The grandmothers in my study actively participated in the group interviews, moved some of the discussions to their own interests and concerns, and suggested topics for further discussion. This participatory

action research (PAR) project was invaluable for my own experience as an external researcher (ER) as described by Dickson (1997):

An ER in PAR cannot be a detached scientist with a well-defined agenda and timetable but must be willing, indeed enjoy immersing her/himself in the lives of the participants. It helps to have a philosophical commitment to the people and their issues. (p. 280)

A study by Salmon (2007) with 6 young Aboriginal mothers in Vancouver's downtown Eastside utilized participatory interview methods. When given the choice, all the women in her study chose a group interview for support and encouragement as well as trust and safety: "Even limited use of group interviews, when they include a significant component of sharing analysis with participants, can reduce the risk of a researcher's appropriating the voices of marginalized women...issues of misrepresentation and appropriation of voice remain especially salient in Aboriginal health research because of the colonial legacies of Indigenous-White research relations." (p. 991). The grandmothers in my study all chose to participate in group interviews, with only one individual interview occurring.

Research about First Nations people can fail to include Indigenous perspectives (Bastien, 2004), continuing the colonization process (Smith, 1999), while "community action approaches assume that people know and can reflect on their own lives, have questions and priorities of their own, have skills and sensitivities which can enhance (or undermine) any community-based projects" (p. 127). Smith (1999) described community research as arising from within the community, or as working with development agencies toward the priorities set out by a community; both are action or emancipatory research. The essential part of research projects is to recognize that Indigenous communities have extensive knowledge and collaborative interests for which the "methodology and

method—is highly important. In many projects the process is far more important than the outcome. Processes are expected to be respectful, to enable people, to heal and to educate. They are expected to lead one small step further towards self-determination” (p. 128).

Before beginning this research proposal, I spoke with the community representative for Aboriginal seniors in Lethbridge, Alberta to ask her thoughts on whether a research project with seniors would be appropriate, and what kind of a project would be meaningful. She reviewed my proposal as I developed it, and thought it would be helpful for gathering together a group of seniors that had stopped meeting regularly due to a lack of available facilities. Reinforcement of their strengths and abilities as well as their knowledge was identified as an important goal for this project by their community representative. The grandmothers in the study also confirmed the importance of the study, voicing opinions such as: “I’ve missed our get-togethers; I think it’s important for people to know these things, to educate them about us”.

Following the completion of data collection, but before the grandmothers in my study began the data analysis process, they met together, under the direction of their community representative to participate in a community garden project; I had the privilege of joining them in their efforts, and learned from them once again. The grandmother who was absent for the two meetings when data analysis occurred, was present at the community garden events. I was also invited to a family wellness day where one of the grandmothers led an excellent session on personal health. Following the completion of the data analysis, and while writing the thesis, I was privileged to spend more time with the grandmothers at a cultural awareness event, assisting them with

serving food, and once again, learning from them. Spending time with a group out of the context of a study has been described by Long and Johnson (2000) as contributing to increased understanding.

In my study, I incorporated a number of principles and actions that acknowledged and honored the wisdom held by the First Nations grandmothers, and maintained an awareness of the privilege of entering into their circle. I chose to utilize participatory action research because of the way it included participants in the research process, as described by Hall (1992):

Participatory research is a social action process that is biased in favor of dominated, exploited, poor or otherwise ignored women and men and groups. It sees no contradiction between goals of collective empowerment and the deepening of social knowledge. The concern with power and democracy and their interactions are central to participatory research. (p. 16)

The importance of participatory action research in uncovering indigenous “ways of knowing” was identified by Cochran, et al. (2008): “The way researchers acquire knowledge in indigenous communities may be as critical for eliminating health disparities as the actual knowledge that is gained about a particular health problem” (p. 22). This concept was expanded by Bastien (2004) who described relationships as the ways in which Blackfoot people come to know:

Knowledge arises in a context of alliances and reciprocal relationships. Implicit is the notion of partnerships that entail obligations or responsibilities on behalf of both parties. In consequence, to seek knowledge is to take on grave responsibilities. Such a quest is founded upon the reciprocal relationship between knower and known. (p. 55)

A component of participatory action research involves look, think and act cycles which can be applied broadly: “when the process is internalized as a *modus operandi*, it can be sustained throughout one’s life as a strategy for building capacity or ‘moving on’.

‘Moving on’ or transition is the theoretical focus that holds these inquiries together” (Koch, Mann, Kralik, & van Loon, 2005, p. 276). These look, think, and act cycles were demonstrated in the grandmother’s determination to “turn it around” as described later in the study.

This participatory action research project was not without limitations as described by Etowa (2007), such as varying levels of participation (not all group members were able to attend every interview or meeting) and time constraints. Following the principles of participatory action research (PAR) does not guarantee momentous results, rather:

Belief in the principles of PAR is essential for the ER [external researcher] because there are many obstacles to surmount. Social and political change is neither popular in many quarters nor easy to achieve. Each PAR inquiry needs to be judged in terms of whether it contributes to participant’s well-being and thus to a better life, not whether it, in itself, transforms society. All of us are involved in community development and PAR must realise that although our initiatives will not ameliorate injustices on their own, what matters is that we are carrying out our work respectfully, in ways that increase, rather than diminish, equity. Most important, we are each part of a larger, collective movement to improve the well-being of all. Many small successes can build on one another to create the revolution. (Dickson, & Green, 2001, p. 257)

Grandmothers were invited to tell their stories and I listened. They decided what would be shared, and what would be done with the new knowledge they created. I attended each interview in an expectant manner, anticipating change in my knowledge and relationship-building with the grandmothers. I was not disappointed throughout the experience, as “in a truly empowering process, everyone changes. Empowerment always is mutual” (VanderPlaat, 1999, p. 777). The First Nations grandmothers in this research study considered the importance of personal and community health. They discovered new perspectives on their powerful status as untapped resources for health promotion within their families and communities. Within the safety of their group, reminders of the

importance of speaking up and speaking out for themselves, their families, and their communities were given to each other. I marveled at their strength and wisdom through adversity, and gained new perspectives and ideas applicable to my own life.

Ethical Approval Process

As this research project involved a special cultural group, it was conducted in such a way that local First Nations participation in decision-making was central. In the fall of 2008, the community representative for Aboriginal seniors in Lethbridge, Alberta provided verbal permission for me to undertake this project. She reviewed the proposed study, and suggested that I make a presentation to the First Nations Community Association (FNCA) in Lethbridge. I was invited to their December 1, 2008 meeting, where my plan for a brief explanation and invitation transformed into 90 minutes of informative and challenging discussion⁶. I distributed information sheets (see Appendix A), letters of invitation (see Appendix B), consent forms (see Appendix C), and questions for interviews (see Appendix D). The letters of invitation (see Appendix B) and consent forms (see Appendix C) have a reading level of grade 8. The community representative was available at the interviews to ensure informed consent was obtained.

A study proposal was submitted for ethical review to the University of Lethbridge, Research Services, Human Subject Research Committee. Guidelines from the Tri-council Policy Statement on Ethical Conduct for Research Involving Humans (CIHR, NSERC, & SSHRC, 1998) were followed and included:

⁶ Comments included: “You’ve bit off quite a bit; I wish you the best; would you like us to recruit?; I’ve lived in the community for 40 years and mixed with whites but still have prejudices daily; would rather use names than numbers, have been living with a treaty number all my life and don’t want to be another number; prepare to laugh; if you come with an open mind, you will learn and grow yourself, grow spiritually; we’ve been missing our group meetings as our space was taken because of politics, greed, misuse of grant money; food is important and containers to take it home in, we love to eat; better have lots of tape, we love to tell stories”.

- respect for human dignity
- respect for free and informed consent
- respect for vulnerable persons
- respect for privacy and confidentiality
- respect for justice and inclusiveness
- balancing harms and benefits
- minimizing harm
- maximizing benefit

According to the Tri-council Policy Statement on Ethical Conduct for Research Involving Humans (CIHR, NSERC, & SSHRC, 1998), research involving Aboriginal people must also follow “good practices” which include:

- respecting the culture, traditions and knowledge of the Aboriginal group
- conducting research with the Aboriginal group as a partnership
- consulting members of the group who have relevant expertise
- involving the group in the design of the project
- examining how the research may be shaped to address the needs and concerns of the group
- ensuring that the emphasis of the research, and the ways chosen to conduct it respect the many viewpoints of different segments of the group in question
- providing the group with information respecting the following: protection of the Aboriginal group’s cultural estate and other property; availability of a preliminary report for comment; potential employment by researchers of

members of the community appropriate and without prejudice;
 researchers' willingness to cooperate with community institutions;
 researchers' willingness to deposit data, working papers and related
 materials in an agreed-upon repository.

- acknowledging in the publication of the research results the various viewpoints of the community on the topics researched
- affording the community an opportunity to react and respond to the research findings before the completion of the final report, in the final report or even in all relevant publications

Ethical approval involved committee review and form completion, but ethics were encompassed and prioritized throughout this research study as trust, mutual respectfulness and collaboration (not coercion) were essential. I remained mindful of the position of power I as a white health professional (as noted by the participants during interviews) and novice researcher could portray.

Data Collection and Management

Having two reliable tape-recorders, tapes of appropriate length, and a ready supply of batteries was one practicality not to be overlooked. When one tape was not clear, or had to be turned over while a grandmother was speaking, the other tape caught the conversation. The batteries also included hearing aid batteries for a grandmother who attended regularly and needed them to participate fully. I used a coil-ringed notebook as an essential part of my data collection equipment. After completion of each meeting, such as with the First Nations Community Association, or informal meetings with the community representative, as well as following each interview, I made notes about what

had occurred. I jotted down ideas to ask the next time, issues to follow up on, my thoughts and impressions, as well as some of the conversations before and after the interviews. I carried this notebook around with me most of the data collection period, and would write down thoughts as they came to mind. These notes did not become “data” for the study, rather, refreshed my memory of meetings and interviews when writing the discussion section of this study.

The first group interview was scheduled for January 7, 2009, with a member of the FNCA deciding the time and place, and offering to recruit grandmothers, as well as participate in the interview. She called apologizing while I was waiting for everyone to arrive as she had become quite ill and was unable to attend or to encourage others to do so. We re-scheduled for January 14th at the same location with 6 grandmothers in attendance. After introductions around the table and signing of consent forms (see Appendix C) with direction from the community representative, who also chose to participate in the interviews, I began to ask the interview questions (see Appendix D). The conversation flowed without me having to interject many questions or comments. I served peppermint tea and coffee as well as lunch from a local bakery with all taking home leftovers. When I inquired as to the next lunch menu, one of the grandmothers laughingly suggested stew and bannock. I emailed transcripts to the community representative a week after each interview so the grandmothers could contribute their comments and ideas for the next interview.

A new group was suggested by Brigid (a pseudonym), who planned to recruit some more grandmothers she thought would be interested in contributing. I was unsure about this, but decided to go with her lead in sampling and discovered that flexibility was

imperative in this research process. Brigid planned for the new group to meet January 28, 2009. That day all the participants were sick except Brigid and this became the first and only individual interview of the project, with lots to eat and even more to learn. At times the interview became intense and the tape was shut off when I offered, or when Brigid requested it. I had planned for group interviews to be completed first, followed by more intensive individual interviews with those who wished to contribute further, but found that being open to opportunities as they presented themselves assisted the process more than sticking to a structured plan. This flexibility in sampling as well as process has been described by Whitehead, Taket, and Smith (2003).

The community representative called January 30, 2009 asking if the venue could be changed to include a kitchen, and if the grandmothers could make stew for the next group interview which occurred February 11, 2009. Clara wrote out a recipe ahead of time, I brought the groceries, and had the privilege of being taught by Clara how to prepare the stew. Ida baked delicious bannock and brought it for our group. I gathered demographics about the grandmothers at the beginning of this second interview. At the conclusion of the afternoon, the group decided they would like to make stew again next time. The community representative and I had discussed the option of the grandmothers having access to copies of the tapes. I was given approval for a revised consent form from the University of Lethbridge Research Services, Human Subject Research Committee, and brought the alternate forms to the next group interview. The grandmothers declined as they did not want copies of the tapes with their names and discussion on them. The group decided they wished to avoid the tapes getting into the “wrong hands.” The grandmothers expressed a distaste for being identified by numbers,

as they had been “given enough numbers by the government”, therefore, pseudonyms with meanings resembling notable personality traits of the grandmothers were used in the study. Demographics were gathered at this second group interview as all the grandmothers were in attendance, and trust had begun to develop (see Table 1).

All the grandmothers agreed they would like copies of the transcripts once again, with a couple of them wanting summaries to avoid having to read the more lengthy documents. Summaries and documents were provided to the community representative a week after each interview for distribution to the grandmothers. Sibyl requested more specific questions for the group to think about before the next interview. I developed these questions building on topics the grandmothers discussed in the interviews (see Appendix E) and emailed them to the community representative along with summaries and transcripts.

The next group interview occurred March 10, 2009 with 6 grandmothers in attendance. Clara and Alice came early to make stew, graciously including me in the process, while Ida again baked and brought bannock. Transcripts, summaries and additional questions were emailed to the community representative ahead of the next interview, for which she suggested a change in menu. The community representative and I met before the next group interview and discussed working to identify strengths within the group, marveling at their positive outlook through numerous challenges.

April 9, 2009 was the last group interview, I baked cornbread and brought a bakery lunch. There were 5 grandmothers in attendance, it was with mixed feelings that we decided we would meet again just if there were more questions or clarification needed. The opportunity for individual interviews was presented. We discussed putting

actual names into the study, giving each the opportunity for recognition of their key roles in the research, but the response was unanimous: trusting others with knowledge is difficult, and too much information getting into the wrong hands is not a good thing.

April 28, 2009 I asked the community representative if she wanted to contact some of the quieter group members who might want to meet individually, again, there was no response from any of the members. This completed the data collection process. Transcripts, audio recordings, and completed analysis are stored appropriately as per my supervisor and University of Lethbridge requirements (see Appendix C).

The study followed standards of rigor during data collection and management, as well as analysis. “Rigour is the means by which we show integrity and competence: it is about ethics and politics, regardless of the paradigm” (Tobin, & Begley, 2004, p. 390). Lincoln and Guba (1985) described four standards to be considered when analyzing rigor in a qualitative research study: credibility (the findings of the study make sense to our participants and peers), transferability (the findings can be taken up in other contexts), dependability (the study fits the method and is consistent over time), and confirmability (the methods and procedures are clearly outlined in sufficient detail).

Credibility has been described as an assessment of the “truth” of the findings, “in terms of the researcher’s reflection on the research process and the participants’ ability to recognise their experience in the research account” (Ryan-Nicholls, & Will, 2009, p. 76). Providing the grandmothers with copies of the drafts of the thesis and asking for their assessment of accuracy has been essential.

Transferability has been described as the “fittingness” of the findings, “when study findings fit into the context external to the study situation, whereby the findings

are found to have meaning and can be applied to the audience's personal experiences" (Ryan-Nicholls, & Will, 2009, p. 77). The study must make sense to the grandmothers, as well as to the audience, their peers and family, my peers and my supervisory committee.

Dependability and confirmability have been described as the "auditability" of the findings, "when another researcher can clearly follow the audit trail used by the investigator during the study...could reach the same or similar conclusions with the use of the researcher's perspective, data and situation" (Ryan-Nicholls, & Will, 2009, p. 78). Though every thought process is individual, and another researcher may not have completed the study in the same manner, I must be able to account for my decisions during all phases of the project. Engagement with, and interaction between the researcher and the participants in the study rather than detachment from, and disengagement from what is being investigated has been described by Ryan-Nicholls and Will (2009) as essential in qualitative research. Frequent discussions with the community representative throughout the research process were necessary to confirm that the study was being completed in an acceptable and useful manner for the group. As the community representative was also one of the grandmothers participating in the study, this process was invaluable.

Data Analysis

Data analysis occurred as a process throughout the research project, using spirals of planning, acting on planning, observing, reflecting, and re-planning; look, think, and act cycles (Koch, et al., 2005). Analysis included checking transcripts with my supervisor, as well as using coding and theme development with assistance from the grandmothers.

Accurate transcriptions are a part of credibility and should include approximately 10 minutes of work for every minute of tape, according to Tilley (2003); in completing the transcribing myself, I discovered it took more time than suggested. As I listened and re-listened to the tapes, I recalled the grandmother's faces as they spoke, at times thoroughly enjoying the humor and at other times feeling drained when honest discussion regarding hurtful situations occurred. Performing the transcription process myself gave me an in-depth understanding of the interview content and meaning. Being familiar with the data and returning to it many times was essential, as outlined by Rose and Webb (1998).

Checking for accuracy involved reflexive processes with the grandmothers as they read the transcripts or summaries, and brought new ideas to each interview. The process of coding and theme development was done with assistance from the grandmothers. A paper by Bartlett, Iwasaki, Gottlieb, Hall, and Mannell (2007) documented an Aboriginal-guided research approach for First Nations persons with diabetes, describing in detail the methodological elements which contribute to decolonizing research. I completed the following steps using their method:

- paraphrases of all key statements from all the interviews were written in large letters on the front of cards
- the key statement itself was written on the back of the card
- each key statement was referenced by the interview number as well as the page number so it could be referred to in context

The community representative assisted in scheduling two meetings for data analysis, as not all the grandmothers could be at one common meeting. Over the course

of these meetings (with Chinese food), I met with the grandmothers and displayed all the cards on large tables. Those grandmothers who were unable to see the cards due to vision difficulties were assisted by other grandmothers who read the cards out loud. As well, those grandmothers who voiced not understanding a certain paraphrase of key statements were assisted by other grandmothers in the process, at times using their mother tongue instead of English. One grandmother was unable to participate in either meeting because of illness. The community representative kept her updated on the progress, asking for her ideas and input as appropriate. Reasons for absences during the interviews and meetings were sometimes for personal or family reasons, sometimes for illness. Participants dropping in or out of the research process were described by Koch, et al. (2005) with time for reflection important.

The grandmothers at the first meeting circulated throughout the room picking out the cards that were the most important to them as individuals. The grandmothers and I then identified 12 themes related to health and health promotion while I wrote each theme on a sticky paper, placing them on the walls. The grandmothers picked up cards that were most important to them and organized them under the themes. There was no limit placed on the number of cards or the number of themes. All the cards were laid out except the ones containing statements made about residential schools as the group decided that the residential schools affected every category and should be woven throughout the paper.

I prepared for the second meeting by placing each theme on the walls and laid out all the cards under each theme that the grandmothers from the first meeting had chosen. The remaining cards were laid out on a central table. Once again, no limit was placed on

how many cards the grandmothers could pick. This group requested to create another theme, that of dreams and intuition, therefore 13 themes were identified in total.

As the grandmothers assisted in developing themes and selecting key phrases most important to them, I thought about the unique ways the grandmothers placed them. As I was writing out all the key statements in the transcripts, some of the phrases that I considered important were not chosen by the grandmothers. Some examples of these were: “a lot of healing to be done, one person at a time; not having to take medications; learning is ongoing, I’m still learning; we’re the real people, the first people, the first real people; dilution, intermarriage”. I attempted to avoid interjecting my ideas, as to meet the standard of credibility, and to ensure that my research was believable to the grandmothers, my peers, and supervisory committee (Harrison, MacGibbon, & Morton, 2001), not just myself. Accurately reporting meanings the grandmothers described (Leitz, Langer, & Furman, 2006) was ascertained by asking consistently for their interpretations. This has involved the development of reciprocal relationships of trust, with the grandmothers, their community representative, and with my supervisory committee.

Transferability asks if the results can be taken up in other contexts. In order for this to occur, I obtained demographics about the grandmothers (Henderson, & Rheault, 2004), which were collected at the beginning of the second group interview, after trust was developing between myself and the group. The CIHR (<http://www.cihr-irsc.gc.ca/cgi-bin/print-imprimer.pl>) reported that identification of a group’s characteristics may be useful in knowledge-sharing activities. Even if this research study is not “fully transferable” to another group of First Nations grandmothers, it does have meaning for this group. The First Nations grandmothers will be able to access and use

this study, or the process of participating in it, for their own purposes. Other researchers may be able to use information contained in this study to gain an understanding of the meanings of health and means of health promotion of urban First Nations grandmothers.

It was essential for me to keep accurate field notes, using them for comparison when recalling events that had happened within a particular group setting, or to check an audio recording at a certain place in the transcript. Dependability must be demonstrable, I need to account for what has occurred during the research process, and field notes were an important part of this process. Confirmability occurred by presenting and reviewing copies of the study with the grandmothers, as well as my research committee and peers.

Dissemination of Results

Dissemination of results was and will continue to be performed under the direction of the grandmothers. As a copy of the transcripts and completed thesis has been provided for each of the grandmothers, they will be able to access them for future reference. One main idea that emerged during this research project was the lack of a space for regular group meetings. The community representative mentioned this study assisting her efforts in applying for grants to fund a building in which the grandmothers could meet regularly. Cooking facilities and space for grandchildren would be ideal. Jemima mentioned her wish to write a book about her life experiences, access to the transcripts may be a helpful addition to her efforts. The grandmothers spoke about supporting each other through their residential school hearings, and simply being able to meet and talk together was a strengthening experience for the group. The group discussed and planned field trips. Confirmation and recognition of the strength, knowledge, and

health promotion capabilities that the grandmothers possess will continue in cycles of support for each other, their families, and communities.

Participatory action research has been explained as seeking your voice and helping others to find theirs, with this mutual learning: “not providing an improved database for community health work, it *is* community health work” (Winter, 1998, p. 57). It will be my responsibility to discuss the findings of the study (knowledge transferred by the grandmothers to myself) with students and peers and with those I come in contact. This new knowledge will be my responsibility to share and is discussed further in Chapter 5. The grandmothers did not develop formal plans for change within this health care zone, but did resolve to speak up, “use your voice” when in situations their wisdom is needed. This may lead to increased understanding of health care providers, enabling them to provide more culturally sensitive health care than currently exists.

Knowledge translation⁶ is a research goal, and the grandmothers will perform it in their families and communities. I explained knowledge translation to the grandmothers by asking for their ideas on how they would like to use the information from the study, or how they would like me to use information from the study. I respect their decisions and thoughts, and have avoided imposing any plan of my own that has not been approved by the group.

Knowledge translation has also been described as knowledge transfer, or knowledge exchange. A study in British Columbia surveyed 52 community health nurses

⁶ Knowledge translation is described by the CIHR (<http://www.cihr-irsc.gc.ca/cgi-bin/print-imprimer.pl>) as the “exchange, synthesis and ethically sound application of knowledge in a complex set of interactions among health jurisdictions, Indigenous groups, researchers, policy makers, program developers and health care service providers”

working in First Nations communities and described the process of knowledge transfer as learning from the community, keeping in mind the principles of “building trusting relationships, building capacity, developing mutual understanding, centering care around clients and developing practice to be inclusive of elders and nuclear and extended family members” (Smith, & Davies, 2006, p. 38). Knowledge transfer was performed by the grandmothers, and the knowledge received will be my responsibility to share appropriately with others. The importance of building trust and understanding, while emphasizing the strengths of the grandmothers, has been essential in learning from them. Inclusion of families and communities contributes to the process of knowledge transfer.

Limitations

Significant vision and hearing impairment experienced by some of the grandmothers meant that it was difficult for them to write out key statements from the transcripts themselves. I picked out what I thought were key statements writing each on a card, therefore the possibility exists that the grandmothers may have chosen different statements than were available to them on the cards. As well, the grandmothers participated in the data analysis over the course of two meetings, with a part of the group at each one, and one grandmother unable to be at either meeting. Results may have been different if all the grandmothers had been available for both meetings.

There were 106 key statements regarding residential schools and secrets which I wrote out from the transcripts. As the grandmothers decided not to choose from them, I may have placed them under different themes than the grandmothers would have chosen. I felt strongly not to coerce the grandmothers into reviewing all the residential school statements. There was significant discussion both during and following the interviews

regarding the schools and the need to not dwell on it, rather, acknowledge it and move on. Therefore, the grandmothers decided not review the key statements about the residential schools.

This study was performed using the English language, while a more thorough understanding of the meanings of health and effective health promotion may have been gained using the mother tongue of the grandmothers. One of the grandmothers only spoke English, two spoke Cree and English, and four spoke Blackfoot and English.

The study involved a small sample of urban grandmothers who expressed personal views, feelings, and opinions. Rural or on-reserve grandmothers may possess differing beliefs about health and health promotion. However, many similar beliefs and ideas expressed by this group of grandmothers were discovered throughout the literature, reinforcing their strengths as educators.

Summary

Multigenerational bonds were described by Bengston (2001) as valuable resources, more important than those in the nuclear family, and including biological or kin-like ties. I would concur but add that these bonds have been valued in First Nations societies for centuries; “the stern, beautiful power that flows from all the Grandmothers, as it flows from our mountains themselves. It says, ‘Dry your tears. Get up. Do for yourself or do without. Work for the day to come. Be joyful.’” (Awiakta, 1988, p. 127). Urban First Nations grandmothers hold the key to the discovery of these bonds.

Using concepts and techniques of participatory action research, this study explored health promotion roles which urban First Nations grandmothers occupy in their families and communities. Meanings of health for the grandmothers was sought,

emphasizing their unique positions in society as essential for empowerment and change. Multigenerational bonds between grandmothers, their families, and communities were identified as irreplaceable sources of strength. Traditional roles in health promotion were identified and fortification of these bonds occurred through the grandmothers' descriptions. The grandmothers reinforced their unique positions of opportunity in health promotion. In the next chapter I review the findings and discuss the results of the study.

Chapter 4

Findings

The purpose of this participatory action research was to develop an understanding of the meanings of health for urban First Nations grandmothers and how they promote it in their families and communities. In this chapter, the findings of the study are identified and the results discussed. The grandmothers participated in 4 group interviews, with 1 individual interview occurring. Demographics were gathered during the second group interview, and are noted below.

TABLE 1: *Demographics of the Grandmothers*

Pseudonym and Age	Affiliation	Number of grandchildren	Number of great grandchildren	Number of great great grandchildren	Attended residential school	Raised in foster home
Joan 48	Blackfoot	1				
Clara 57	Cree	8			X	
Alice 60	Blackfoot	2			X	
Sibyl 60	Cree	6				X
Ida 79	Blackfoot	26	20	1	X	
Jemima 80	Blackfoot	2	4		X	
Brigid Age not revealed	Blackfoot	6			X	

The grandmothers helped to clarify 13 themes related to health and health promotion from their interview transcripts during two group meetings. Despite tribal background, age, and status as grandmothers, the group agreed on these themes. As one grandmother was unable to attend either meeting, the community representative kept her updated on our progress. The grandmothers chose key statements from their transcripts that were significant to them, relating their ideas to each theme.

One grandmother, with the pseudonym of Brigid, was the only grandmother who participated in an individual interview, therefore, she had a greater number of key statements, and many of them were chosen by other grandmothers as having significance for them. The grandmothers created a theme of staying healthy, which encompassed all the other themes, and included balancing physical, mental, emotional, and spiritual health. The research questions did not include any residential school topics, but the grandmothers decided that residential schools have affected every part of their lives, including health and health promotion, therefore, two threads, residential schools and no more secrets were woven throughout the findings.

The themes were as follows:

Staying Healthy

Physical Health

- role-modeling
- educating
- reserves

Mental Health

- trust/distrust

- problem-solving
- enjoying life

Emotional Health

- resiliency/surviving
- staying positive
- encountering racism

Spiritual Health

- spirituality
- culture
- dreams and intuition

Each theme is now discussed in turn with quotes (utilizing pseudonyms) from the interviews to illustrate them.

Staying Healthy (making your own choices)

The grandmothers described residential schools enforcing strict standards of cleanliness, hard work, and rules and regulations as ways to maintain health. Another way of “maintaining health” involved the demolishing of First Nations cultural practices; (the grandmothers were forced to keep their traditional beliefs and practices secret) while imposing the religious beliefs of leaders in the residential schools.

The grandmothers have gained freedom in choosing ways to stay healthy. Joan by being aware of her body, how she’s feeling, recognizing signs of stress, and “I start thinking about it and then I have to make changes in my life.” Brigid by managing a chronic health condition and making choices to be healthy:

My sons see this obstacle and they see that I’m managing, they follow my example like my being strong mentally, emotionally, physically, and lately,

spiritually...my personal resolve to not let this get the best of me...and yet it's because of them that I keep trying, how that cycle of support coming to me, from me, to my children, my family, it keeps us stronger, it keeps us healthier...My sons are my pillars.

Choices to be healthier included walking with grandchildren if they choose to participate, but role-modeling it alone if they do not. Cooking well and eating moderately was also a way to stay healthy, though that has changed with trips to the grocery store instead of the garden. Being responsible for health included making good choices: "How you see yourself has a lot to do with the choices that you make to improve or delete something, so body image is important" (Sibyl).

Brigid illustrated passing on physical strength to her sons as well as daughters through working and playing with them. Keeping active in order to have fun wrestling with her grandchildren was essential: "I really wouldn't want them to treat me like I'm a china doll, I want their hard loving. Because to me, that's their way of loving" (Brigid). Alice portrayed arm-wrestling and giving piggy-back rides. Ida and Jemima identified hard work, chores, and cleaning as well as doing things for others as a way of keeping healthy.

Socializing was noted as a way of staying healthy, with disappointment expressed throughout the group that regular meetings are no longer occurring related to the lack of an appropriate facility. Peer advice and support was crucial in maintenance of health, with good nutrition throughout pregnancy another essential. Brigid expressed health as being an intricate part of daily life as a child, not talked about, just lived: "It was always important, but I just never recognized it, or put it under that heading—health."

Four quadrants, physical—spiritual—mental—emotional need to stay in balance in order to stay healthy.

If one of those four quadrants are out of balance, say your emotional concept is, you're under stress, deadlines, what the world's throwing at you either from other people or your job or your immediate space regarding family, if that emotional part of you is—I'll use the term "at a low point", the other three are out of balance as well. Therefore you're not a healthy person, not a holistic, healthy person, cause one part of you is not in balance... Health applies to all of those, when you as one individual go out of kilter, when one part of you is not functioning completely, you become angry, which is not healthy, some people become self-destructive, which is not healthy, others become destructive to others, therefore family violence, that's not a healthy individual... It's good to have a good cry, it's good to scream, because that helps those four quadrants to stay in balance. But it's not good to turn around and beat another human being or pour alcohol or drugs into your system because you're not whole anymore. And your spiritual and your physical part tend to suffer because of those things, and the mental, emotional part will suffer when you are abusing your body through drugs, alcohol, not dealing with the stress that can be dealt with. You become mentally and emotionally unbalanced, "out of sync" to the point where you start feeling stressed out, guilty, because you're not being honest with yourself. On that medicine wheel circle you could add another quadrant, honesty, integrity, dignity, respect. You add to that a million, trillion, killion, zillion circles of four to each concept. All of them stem from the physical, mental, emotional, spiritual part of a human being. It's not just those four, you can break down the physical part too, you can do that as well with the emotional, mental and spiritual part. You can go on forever. That's an infinite circle. And all of it brings back the health of a human being. If you're dishonest to yourself, to others, you start kind of tipping, your footing, so to speak, and therefore you're not healthy in self-respect, your esteem, you're not healthy in the honesty part. When you start not looking at yourself honestly, truthfully, openly, respectfully, you become unhealthy in so many different ways. It leads to high blood pressure, low blood pressure, heart disease, respiratory problems, kidney, all of that. It's an infinite circle. Health applies to all of it, and the health of one human being, if you really stop and think about it, when a member of your family is not healthy, where are the rest of the members of that family? Because there's the grandparents, go back to that infinite circle, the parents, and there's the grand-grandfather, father, grandmother, mother, and then there's the children... And when one member's not healthy, or they start being less than human to themselves, they start going out of balance, and it throws everybody out too. (Brigid)

Regular checkups and screening were depicted as important in health

maintenance, physicals, cervical screening, screening for sexually transmitted infections as necessary, mammograms, x-rays, magnetic resonance imaging, and ultrasounds were all mentioned by the grandmothers. Experiences with physicians ranged from being left

by the physician without being able to tell what the visit was for, or the physician talking so much you give up. “You sit there for about a half hour sometimes, waiting for the doctor. By then he comes in and you’re just tongue-tied. Sometimes I think they don’t want to hear everything you have to say” (Joan). The grandmothers outlined the importance of finding a good physician and then asking him or her to address what you need, being brave and speaking up, and then being listened to. Jemima lamented, “Yeah, I go to my doctor, he doesn’t do anything for me, and I don’t know why.” Ida reinforced, “They talk so much you can’t get in edge-wise so you just give up, you leave without telling the main thing that’s bothering you.” Sibyl reported: “I am brave enough to say, ‘this is what I want’... it isn’t because he said so, it’s because I said, ‘it’s time to get this ticker checked.’” Ida added: “You just can’t be healthy, no matter what you do. Through the doctors you try to be healthy, but you bump up against the wall with these doctors.”

Praying was identified by the grandmothers as a way of maintaining health.

Things aren’t always medical, you need the strength inside, and you need a higher power to gain that strength, to keep trying hard, to keep working on something that needs to be fixed or made right and it can’t always be done mentally or medically, it might be a combination of all three. (Joan)

Gifts from the Creator were identified by the grandmothers such as sweetgrass and tobacco to ease suffering, sage for stomachs, colds, and sore knees. Berries help ease suffering, and crushing or drying them helps with cleaning out the digestive system. Mint aids with stomach ailments and colds, and cedar was also mentioned as important, whatever was available in the area they lived.

Physical Health

Role-modeling (changing myself first)

The grandmothers recalled gaps in role-modeling in residential schools. Matrons were described as mean, nuns as strict, and the cook as providing good food for the staff “they ate like kings” (Ida), while giving the children horrible food. Families were separated and there was a loss of brotherly/sisterly bonds as girls and boys couldn’t play together. Secrets about what was occurring at the schools were kept, children lost contact with parents, and when they did return home, “there’s nothing there...and we didn’t form a bond with our families, so a lot of times we fought” (Ida). These cycles were identified by Brigid as tough to break, overlapping “to my marital relationship, into the raising of my children, and I pray to God it doesn’t overlap where I’m involved with my grandchildren.” Alice added descriptions of working on trying to change herself and her present healthy relationships with her grandchildren. Relationships with grandchildren were noted to be stronger than with children among the grandmothers in this study.

Grandchildren are often catalysts for change with reciprocal relationships in many areas. Alice recounted how “everybody comes to me, on the phone, or to my house, to get some information or to see how they would handle this,” and Clara confirmed, “you’re a counselor now.” Ida explained learning from her kids as her formal education was “messed up” at residential school, and how she continues to encourage education for her children and grandchildren. Brigid explained how having taught her children, they have passed on to their children: “you see anybody having difficulty, offer your help.” Role-modeling was illustrated by Brigid in numerous situations in her immediate and extended family as well as in the community:

And their walks are all diversified. So when they come to me and I’m promoting mental, physical, spiritual, emotional health, I constantly have to see from their point of view because one way doesn’t work for everybody. In the community, I try to participate like I’m doing right now and interact with my neighbour, my

landlord, the people I meet in the street, the different organizations that I have contact with, I think just about every school in the whole city and surrounding area has had me pull at their ears, about being healthier in our societies, I'll use the words, "theirs" and "mine," those people and my people, trying to bridge the gap. You know for me that's absolutely healthy. Maybe some other person would say, "They'll never understand," but again, that role-modeling comes up... I try to promote health by bridging the gaps.

Joan described role-modeling in front of her children, especially when visiting a physician: "I wouldn't let myself be intimidated, I would ask the questions that needed to be asked because I always thought, 'my kids will have to learn from me how to do this'". Sibyl encouraged everyone in the group to "use your voice" and emphasized role-modeling for her children when they were young. She gave them money and made them stand in line for their own purchases, and taught them how to be polite in restaurants: "my kids have always seen when I voice myself and I'm not afraid to do it." The grandmothers' experiences demonstrated it was essential to speak up and stand up for one's own health and well-being.

I will never bend, I will keep trying to teach, to share. And the real cool part is, when members of the mainstream society come into our flow, you know what? They become whole. Have you ever noticed that? They become real people.
(Brigid)

Educating (increasing understanding)

The grandmothers described residential schools placing so much emphasis on chores such as cooking, cleaning, and ironing that there was not much time spent on formal education. "They got us so messed up with our education, supposedly education, I had such a hard time getting along in this world... I had such a hard time with my English" (Ida). Though some of the grandmothers viewed a lack of formal education as an impediment, some insisted that informal education through life experience, such as the

ability to speak and write your own language, is as important and necessary as formal education.

Education of others was identified as essential for increased understanding between those who are First Nations people and those who are not. Brigid described more movement by First Nations people toward mainstream society than the reverse process: “There’s so few that have progressed with us as we progressed with the mainstream society.” She maintained that as people “get educated” about First Nations people, they become healthier: “I’ve really not left Southern Alberta yet I’ve got contacts all over the world. People have heard my words. I’ve educated, I’ve made them healthier.” Sometimes this involved turning racist behavior into an opportunity for education.

I have gathered enough understanding, some knowledge, and the ability to smile as sweetly as I can and look the person in the eye and tell them, “Holy Moses, you really need to be educated. Because ignorance is not blissful anymore”...that person and I usually walk away with well wishes, gratitude, and a lighter, more spring to the step because we turned a bad situation into a good connection and I’d like to think of those people as my forever friends. And that’s how I try to promote health for all people, anywhere, within my community, anywhere I go.
(Brigid)

Brigid explained the results of her dad passing on things he had experienced and understood; she in turn adapting that knowledge, “so that I am stronger and I’m healthier in the four concepts, physical, mental, emotional, and spiritual...I adapt it to my era, my space, my grandchild, my sons, will adapt it to their space.” This wealth of knowledge has made her a “rich person, because I remember what my grandmother told me, it makes me a healthier, stronger, and I pray a wiser person” (Brigid). Joan identified the ability to pass on knowledge as strengths that the grandmothers each possessed. Sibyl emphasized the importance of all people becoming educated: about treaties and land claims, about

First Nations cultural practices. Secrets about what has occurred with First Nations people should not be kept. Those caring for First Nations people in the hospital, as well as those developing hospital policies, need to become educated about: extended visiting hours for those entering and leaving the world, more places to meet and have tea, more people allowed to “give love to this person.” Joan described speaking up during health zone meetings: “Your problem is your policies. We are not your problem.”

Reserves (splitting us up)

The grandmothers discussed reserves as part of a government plan to assimilate and exterminate, much like residential schools. The grandmothers noted tensions today between those friends and family living on-reserve and those who have chosen to live off-reserve. Joan viewed it as part of the government’s plan to eliminate: “They’ve got us fighting, the on-reserves think the off-reserves have it better. The off-reserves think the on-reserves have it better and they’re to me intentionally splitting us up.” As far as health being connected to families and community:

There is no community anymore, very little, you’re either on-reserve, off-reserve. Why are they so proud of that little chunk of land that the government gave them? Compared to us, to me, the off-reserves are living on our traditional lands. Those people, they’ve got their pride totally wrapped up in that little chunk of land that the government gave them, they were intending to keep all of us on there...the rest of us are exercising I guess our defiance, living on our tribal lands, our traditional lands. (Joan)

The grandmothers identified various reasons for living off-reserve: not being eligible for affordable housing; education not as readily available; health issues such as sanitation and access to clean water; to avoid seeing certain relatives and people; not one’s traditional land; not their home; and nepotism in the leadership. Living off-reserve was described as a way to maintain health, while living on-reserve was described as not

being healthy. Living on-reserve was discussed by the grandmothers as involving inadequate housing, advanced education is not readily available, sanitation is not as well-managed as it is in urban areas (often cisterns for water which results in rationing and questions about quality of water), ongoing abuse of power between relatives as well as those in leadership, and the reserves were a government idea, removing them from their traditional lands, they are not at home on reserves, rather, exercise their right to live on traditional lands by living off of the reserve.

They've really got an eloquent way of saying land base, they're actually prisoner of war land bases and then they call them reserves. And there's no health in that, there's nothing healthy about that. (Brigid)

Money and power were identified as affecting governance at the reserve level, a hierarchy the grandmothers described as based on money, not skill. The grandmothers maintained that long before contact with white people, their system was a true democracy. Questions they raised included: where are the revenues going from oil, gas, casinos; what about the selfish, mis-spending of money? Joan reported questioning some that sit in council chambers regarding a function they had attended using the tribe's money: "They need to be asked those things, 'How was the show?' They need to be asked, 'How does that make us healthy?' They need to be questioned about that, 'how does that make us healthy?'"

Joan questioned electing people versus natural leaders:

Sometimes they're not the healthiest people to be in that leadership, they still have a negative way of thinking and negative behaviors and I think that's something that the people need to start looking at and questioning when people are running for election, "How healthy are you, yourself?" And it's not just physical health, it's mental and spiritual health and all of those things.

Alice emphasized the need for leaders to be real. “There’s so many phoney people out there, you need to really look at yourself to become real...just be who you are and try and change things for the better, not to be so negative.” Joan clarified the importance of leaders “always coming back to the people and listening to them.”

Mental Health

Trust/Distrust (trust is difficult)

The grandmothers revealed feeling put down, small, hurt, and made fun of in residential schools. Ida offered details about a nickname that the staff and the children called her: “Even now I still feel like I’m just a little mouse, they called me ‘mouse’ at the school. That really hurt. Every day I’d hear that, they’d call me that and they can push you right into the ground.” Brigid provided details regarding a nickname she had been given but did not want to repeat it. The grandmothers found it difficult to trust either staff or peers in the schools.

Alice described talking about some of her life experiences with her children: “I told them about my past and what they could do for themselves, what they experience, they could turn it around to be positive.” Developing trust involved risk-taking and honesty which was not encouraged or tolerated at the schools. For Brigid, trust has developed with her grandchildren looking out for her as she loses her eyesight. Trust is difficult for the grandmothers, with a tendency to keep secrets about past experiences, but many times it is necessary in order to maintain and promote health.

The grandmothers identified layers of distrust between “their reality” and “our reality.”

The government, the authority, the powers that may be they don’t or won’t or can’t handle the truth [regarding reserves], their reality is theirs and if we come

out with ours, “you’re a dirty Indian, you’re a renegade, you’re a rebel, you’re a shit disturber.” (Brigid)

Joan shared her motto, “trust no-one except yourself...you try to do what you can on your own before you ask for help because you’re gonna owe somebody”.

You’re constantly on your toes, constantly thinking “who can I trust,” or “who can I look to, who can I ask, who can assist me,” stuff like that. “Who can I trust?” To the part where one First Nations is leery of their own kind. (Brigid)

In summary, difficulty with trust has infiltrated relationships with partners, siblings, children, and leaders.

Problem-solving (planning how to stay healthy)

The grandmothers reported residential schools contributed to making them naïve in some ways, being afraid to try new things, and finding it hard to ask and answer questions (i.e., from those in authority such as physicians or judges). Problem-solving was noted to be difficult by the grandmothers with the need to break old habits and develop acceptance of themselves.

“Being a healthy person doesn’t mean you have to be constantly angry at somebody...you can apply so much to health” (Brigid). There is a give and take process in staying healthy, “you give what you learn, you give and then you take what comes into you” (Brigid); and according to her Dad, “there’s more than one way to skin the cat.” Staying relaxed, taking what comes to you, giving it away, and doing things in your own way are strategies for problem-solving related to one’s health.

The grandmothers expressed staying healthy through plans to eat healthily, walk in groups or individually, and quit smoking. Ida provided an example of how disciplining yourself is hard if you are trying to stay healthy. She shared a recipe for home-made caramel which started out as a small treat but quickly got out of hand as it became an

almost daily occurrence, and her craving for sugary things got progressively stronger: “so I had to cut it out. I feel like making it right now! But I had to say ‘no’ to myself. ‘No more of this. It’s gonna hurt you’.” Sibyl reinforced Ida’s problem-solving abilities: “that’s an important discipline, deciding to discipline yourself and then maintaining a decision. That’s hard.”

Problem-solving often occurs in a group setting as Joan recalled a community cooking project:

They’d start socializing and talking about their grandkids and the problems, and one of them would say “Well, you know, this is who I talk to” or “Call so-and-so, they might know how to help you”, and so while they were cooking, that’s where they were solving their own problems and they really didn’t need that life skills class.

The grandmothers portrayed a positive resolve to resist being angry, despite residential schools, despite difficulties, and despite religious confusion, as it has made them stronger people. Using traditional stories with morals and lessons helped grandchildren learn to behave. Examples of these were the tipi ceremony⁷ or the one with the mask⁸. The importance of repeating these stories was emphasized by the grandmothers, and confirmed as a valuable means of promoting health (Dion Stout, & Kipling, 2003). The grandmothers explained that in every problem, the solution already exists, it just needs to be revealed by the individual. Problem-solving was one of the valuable skills possessed by the grandmothers, and available for maintenance of their own health as well as that of their families and communities.

⁷ Brigid described her dad being disciplined by his grandmother by putting him by the tipi poles.

⁸ When Brigid’s parents went to town, their grandmother would be there telling her not to look out the window in the dark, as “the one with the mask” would look back in on her. It was described by the group as a way to keep children from misbehaving. Some of the grandmothers discussed still not wanting to look out their windows at night, or keeping them covered as there were no windows in tipis. Not looking out the windows was described by Dion Stout, and Kipling (2003).

Enjoying Life (using humor)

The grandmothers portrayed residential schools as dreary places, but having a sense of humor and the ability to enjoy life making them somewhat bearable. Humor often had to be enjoyed in secret, away from the strict confines of the classroom. One memory Brigid shared was of humor being “one of the blessings, cause even if we had a really bad day in class, we’d all be in the rec room and there’d be nothing but laughter.” Ida recalls being told ““Get that smirk off our face or I’ll knock it off”. It’s embedded in us and you can’t ever forget it.”

Gratefulness for today and living day to day were concepts frequently referred to by the grandmothers. Using humor was talked about as a way of educating others, while also a way of surviving difficult situations. It was also a way of enjoying life, as Joan said, “that’s probably what gets a lot of them through is that humor.”

The grandmothers identified physical personal mobility as important for enjoying life and staying healthy. All the grandmothers were managing at least one chronic condition such as diabetes, heart disease, high blood pressure, platelet disorder, vision or hearing impairments. One of the grandmothers is a full time care giver, with most of the grandmothers assuming some responsibility for the care of their grandchildren. Being holistic, not judgmental, not angry, but using humor were mentioned as coping mechanisms for past and present difficulties.

A situation about how control from the residential schools filtered into relationships and how Alice resisted that control by sticking up for her right to enjoy her own life was described:

I have a habit, I don’t even know it sometimes, that I’m smiling. And I do it at home and I don’t see it. Even my ex one time was telling me, “I’ll take that smirk

off your face” and I was looking at him, “What smirk?” He said “You’re sitting there,” I said, “I don’t know why,” he said, “You must be thinking about something.” I said, “I don’t know, cause I can’t answer it. I don’t see my own face, if I’m smiling or if I have a long face”. And I said, “Well you drag your face through the carpet and out the door if you want to have a long face, with me, I’m going to sit here if I want to smile”...So maybe it all has to do with the boarding school because it was control there and it was control here again.

Emotional Health

Resiliency/Surviving (we’re still here)

The grandmothers described residential schools instilling fear: of going to sleep, of staff, of being locked up, of causing friction, of taking food and getting caught, of not cleaning well enough, of lights off. These fears manifested themselves in physical symptoms such as sleep disturbances and palpitations, “people were just totally raised in fear” (Joan). Developing a fear of their own parents was another result of residential school and it “just keeps overflowing, overflowing, overlapping into every concept” (Brigid).

Resiliency and survival are essential to health, and the grandmothers offered their perspectives regarding both concepts. Disconnection has occurred through the colonization process, “at one time we as a tribe thought of ourselves as one and if you have a healthy tribe, if the people in the tribe are healthy, then the whole tribe is healthy” (Joan). Living off-reserve has been one way of maintaining resiliency:

I’m going to stand up for what I know to be truth and fact, I won’t be pushed around. And I tell my reservation relatives: “Stand up for what you know is right, what is fact, base your life on fact, do the right thing, don’t be pushed around, not even by our chief or council”. That’s why I’ve been off-reserve for 40 years.
(Brigid)

The grandmothers talked about not being pushed around by others and how that requires the ability to speak up for yourself, as well as to get things out in the open, to not keep

things to yourself, don't keep secrets. They also stated that it is hard to break learned habits, but it is possible to persevere, to change, to speak out, "without being embarrassed to say what I need to say, so they'll [my kids] be open about what they have to say. Because I was always told, 'you can't—keep your mouth shut'" (Alice). Not having a formal education has made it difficult to communicate for some, but "my kids and grandchildren went to school, they know how to take care of themselves" (Ida).

Links between education and resiliency were identified by the grandmothers. The importance of a good education was shared by Brigid with her children and grandchildren:

Never, ever think of yourself (I don't tell them this part—as I was made to think of myself) this is who and what you are and this is what you have, and you are a very important person. Get a good education.

She also passed on to her children, and now her grandchildren, the idea that: "The world is your oyster! You can do anything" (Brigid).

Perseverance was related to feeling positive by Clara, "when I started something I wanted to finish, for me personally, I felt good about it." An evolving sense of self-worth since leaving residential school was described by Brigid:

It didn't dawn on me while I was at residential school that I would eventually begin to see myself as less than other people... "I'm not as good, I'm not as capable, I'm not as smart"... I began to realize, because of the different environments I got into that "hey, you're an okay human being. You're not less than, you're not more than" and I find myself to be in a comfort zone now at this stage of my life, knowing I've never been less than and I've never been more than any other human being... I am of value to whomever I meet because I see the value in other people.

Brigid also expressed her value in coming from "the best of both worlds... I am a very rich person... I remember what my grandmother told me and it makes me a healthier,

stronger, and I pray, a wiser person.” Finally, Clara said: “I think in all of us, we’re all survivors. No matter what we’ve experienced in our past and the future yet to come.”

Staying Positive (turn things from negative to positive, from dark to light)

The grandmothers related how residential schools made them feel controlled, as they were told what to do, how to dress, what to eat, how to clean and complete tasks such as ironing. Strict schedules contributed to not being able to initiate their own lives: they had to be perfect and do what they were instructed.

Keeping positive involved many factors such as making a conscious decision:

Trying to turn everything from a negative to a positive. Like I could wake up in a real miserable mood but I could turn it around, so I don’t live in that darkness anymore. I want it to be light. Even if it’s gloomy like this, I’ll try to make something happier. (Alice)

Watching eating habits and exercising was described as part of managing diabetes and other chronic disease, and also as a method for staying positive: “I think I’m pretty healthy, I try to take care, eat good” (Jemima). Being positive was not only impacted by physical actions but by psychological sense. Clara simply stated, “think positive.” Brigid expressed it more fully in the following quote:

The more healthy I am in these four basic concepts, physical, mental, emotional, and spiritual, the more I understand, the more my attitude changes to the healthier individual and it brings out, a lot of times I pray, the best in who I am. That’s how I work with the community and my family and myself to stay healthy...there are some days when I walk around with a big deep dark cloud over my head and a “stay out of my road” kind of attitude, but I work with me, I come upstairs from my basement bedroom and I look to the east, look at the day that’s been gifted to me, and I’m grateful for that...I keep a very open mind. I keep a real bright sun in my day, whether the sun is actually shining or not. I try to see the light about a lot of things...the attitude of many, many people could get a whole lot healthier if they would just open themselves up.

“If you can hold onto your health, that’s a major strength, to stay physically healthy” (Joan). Part of staying positive is enjoying life which includes occasionally

indulging in bingos, casinos, restaurants, eating food that is not always the healthiest and trying to hide it. Joan reported bringing “contraband” McDonald’s into her office down the hall from a dietician’s office: “I have to get past her and then I close the door and open the window and I gotta get a bottle of Febreze so I can air it out.” Sibyl (who has diabetes) mischevously recalled the sneaking of nachos and cheese at bingo:

Then I thought I should just check my cheese, check my blood sugar, I should just check my cheese and I did and it was 17.1 and I just couldn’t believe it and then I quickly put it away because my partner says “How much is your cheese?”, “What was your blood?” and if it was 17 I’ll lie and say it’s kind of high, it’s 12 because I don’t want him to know and then he’ll ask and I’ll have to tell I ate the nachos.

Discussion about secrets was woven throughout the interviews, secrets about residential school, about the ability to be honest with yourself and others around you, even your own children. “Kids do listen even if we think they don’t” (Joan). How letting go of secrets can contribute to staying positive: “I don’t want to keep secrets anymore because it, I used to feel terrible in here, keeping all that, once you’re going to start talking about it you feel lighter” (Alice). Letting go of secrets can also help turn your life around to the good, as noted by Alice: “It’s amazing how you can turn your life around...sometimes it just shocks me, ‘whoah, I came a long way.’” It is not easy to reveal things to those around you “there are times when I can talk and there are times that I just absolutely can’t talk” (Ida).

Encountering Racism (being treated differently)

The grandmothers revealed residential schools resulting in abuse from staff, as well as between peers, feeling dirty and embarrassed. “You’d be amazed if I could tell you all of the things that happened to us at residential school...you were made fun of and oh, you could just kill yourself. Get it over with” (Ida). Clarifying Ida’s suicidal

reference, Joan commented: “Well some of those people that actually did must have just not have been able to get over that pain in any way.” Alice added her thoughts about the abuse encountered at the residential schools: “Like they say you had to have proof, but how can I prove it when it’s not recorded?” Secrets about residential schools have been kept for years. Describing dread about going to the residential school hearings⁹ was a topic of discussion uppermost in one of the interviews.

I used to wonder, “when is this nightmare going to be over.” You’re re-living it now that everything is coming out, and you just put it where you thought it was safe, and you felt safe for so long and now...I used to say, “when is it gonna end, they said, “till death, till you die, that’s when it will end.” I used to say, “its no big deal,” but it is a big deal and I have to admit it. (Alice)

As some of the grandmothers described being afraid of the hearings, Clara commented: “Well my day in court, how I’m gonna handle it, I’m not showing that they broke me, they didn’t break me...I’ll tell it as it is.”

Joan identified the dilemma for some:

If you don’t go along with the lawsuits it’s probably like giving them the okay that what they did to you is okay, even though the money is so little. You have to do it because that’s where it hurts those people, that’s where it hurts the churches, in their pocket and if you don’t go along with the lawsuit they think, “well it must have not been bad enough for her, she probably liked it”...so you do have to at least take the opportunity to have to suffer through those hearings.

Explaining why her work with seniors is so rewarding, Joan emphasized opportunities to reinforce their value and essential roles they occupy in their families:

Sometimes they don’t find that worth in themselves because of residential school, they’ve been so beaten down and they need to have somebody build them back

⁹ The federal government announced settlements of \$10,000 each for former residential school students, plus \$3,000 for each year in school. Proof of physical or sexual abuse increases the amount of eligibility. As of July 19, 2009, 11,972 claims have been received by the Canadian government with a compensation of \$174,493,789 paid to survivors <http://www.classactionservices.ca/irs/updates.htm>. It is estimated that there are approximately 80,000 residential school survivors alive today according to the Native Counseling Services of Alberta <http://1000conversations.ca>

up...when their kids are being raised in that kind of attitude where their caregiver feels like they're nothing, how can their kid feel like anything?

Brigid shared her feelings of not measuring up and having to maintain a "low profile:"

When I left the reserve, that's when I realized, "Hey, I'm an okay person, I'm not what I've been led to believe without any doubt." After I left, walked away from that reservation mentality or residential school mentality, whichever it is or a combination of both, that's when I realized the value I had as a member of the human race. Prior to that it was not very evident.

Sometimes residual feelings remain:

I think sometimes you're conditioned into who you became, but it's such a big thing to turn it around. Like with me it took a lot to turn me around, but it's still there, it's just like a fester, it just doesn't go away. (Alice)

Experiences were discussed about the wrongs done to First Nations people: "If you knew what road we've been on, you know why we're so, radicals, and renegades, and shit disturbers" (Brigid). The grandmothers described feelings of being treated differently than mainstream society members in encounters with health care providers. Though mainstream society members may also experience frustration with how they are treated by health care providers, those who have experienced residential schools may have a heightened awareness of mistreatment due to historical trauma (Dion Stout, & Kipling, 2003). The lack of sensitivity by health care providers in certain instances was viewed by the grandmothers as racism against First Nations people. For example, embarrassing and hurtful events in physicians' offices demonstrated a lack of sensitivity and understanding for Ida which was perceived by her as overt racism. For Joan, mis-handled situations in an emergency department were understood by her as being due to her identity as a First Nations person; the result was two years of hospitalization. Sibyl shared having to demand proper follow-up care from her physician following heart surgery, and related this as racism due to her First Nations identity. Unpleasant hospital

experiences were recalled by Joan, “it makes you not ever want to be sick and have to be in the hospital cause you feel like you won’t get cared for, that you’ll just be kind of left on your own. Kind of scary.”

Positive experiences occurred as well, a physician following up at home on Brigid after she left his office when he informed her, “I’m not God, I can’t do everything.” Clara had a good doctor who also told her he was not God, which was confirmed when he died, as she joked with the group: “there goes one doc!” Pleasant experiences were shared about another doctor and also a pharmacist by Joan and Ida, those who took the time to listen and act on what they were being told.

Spiritual Health

Spirituality (everyday experiences)

The grandmothers revealed residential schools causing confusion regarding: guilt, forgiveness, punishment, cultural beliefs, religion, and the “natural” (i.e., close relationships with siblings; celebrating menstruation) way of life made “dirty” (i.e., separated from physical and social contact with siblings; not allowed to talk about menstruation). Keeping secrets about their own spiritual beliefs was not a healthy way to live. As spirituality is intimately connected with health, among this group of grandmothers, coming out of the confusion and speaking up about their beliefs was a freeing experience for some of them as well as for their children and grandchildren. Joan clarified that any religion can be abused, “even ours, (i.e., traditional) to hear somebody say it one way and then see it happen another way, but I’ve always had respect for religion.” The effects of the punishment and control imposed by residential school was described by Alice:

I remained in that area for a long time, being controlled, and I didn't know how to function. Then you start attending programs and finding out who you are. And the people who have control, they become threatened, so it even came to the point where I separated from my spouse because of that, and even then he asked me who was telling me how to talk, "who told you to say those things" and I say, "I finally came out of my shell, no more control" so he didn't know how to respond, so he left. So it's always been like that in school you do what you're told and that's how I lived my life was being punished but now I turn it all around and I became stronger because of that. And the people that are around me don't know how to handle me, "there's a different person here", so those people that controlled me, they don't know how to talk, how to approach me now. So that's one of the strong things about me now is the control. I never knew that I was being controlled, and if I didn't do what somebody else wanted, I used to beg for forgiveness for what I did, sometimes I don't even know what I did, and it's just like in school you're forced to make a confession. We don't even know what sin is, so we make up stories, like "we'll tell them this and then the priest will give us penance".

Spirituality has been described as "mind, body and soul, it has a lot to do with well-being and your health" (Clara). Ida explained it as a daily occurrence, with Sibyl adding:

Spirituality is like an everyday thing for me, that I know that I'm just a person here on earth, I have an existence, and I do live. That's what makes my existence important and meaningful, is *how* I live. So if I'm too much this way, or I'm with too many people that are talking negatively all the time, I need to go back here. And I'm very aware of it, if I go this way, and then I start meeting all kinds of people that help me with my plans, but also help me to be a part of a bigger plan, then I know that I'm living daily in a spiritual way. It's not going to the church once a week, it's just like a daily thing and that's how [Ida] is, I can see that.

Brigid depicted her life as not being perfect as far as being the most beautiful, being the best-dressed, or financially stable, but those are just "earthly things... thanking the Creator for the gift of this day... you just start thinking different and you become a better human being, more holistic and a whole lot healthier." She explained using "visual aids" to help her grandchildren stay healthy such as sharing ceremonies, gatherings, and the protocol of the Blackfoot people. The healthfulness of looking at the concept of two sides to everything, was shared by Brigid, with the medical concept of human beings as

well as the knowledge that her people have. Recalling her dad's words when out fishing and hunting, and gathering plants, Brigid repeated: "if you use what the Creator has given to us as gifts through creation, your body will stay good long."

Staying healthy in a spiritual way also included "fixing myself first, because being in this area (i.e., the control imposed by residential school) for so long I have to fix myself before I can walk my talk" (Alice). Another perspective was added by Brigid, "walking my talk is helping me heal." Clara illustrated how she has stayed healthy and positive: "For me it's faith, and being able to have, to hang on to someone, a higher power, knowing that I'm not walking alone with this problem that I have." Alice and Ida described prayer as helping conquer fear of being alone at night, of not wanting to stay alone.

Culture (is two-sided)

The grandmothers reported residential schools as separating them from their families as well as their cultural beliefs; they were not allowed to speak their language, wear traditional clothing, or practice traditional ceremonies. Their cultural beliefs were secrets to be kept. They described feeling no love, having no caring given to them, they weren't allowed to play, the nuns and matrons made their braids too tight, sometimes they had to wear sackcloth dresses, had no friends and in general, experienced a horrible life in residential schools. Brigid mentioned her inability to give "positive strokes" to others as a result of the mistreatment. Difficulty accepting loving relationships was also described:

We lost everything, love, everything. You tell me what love is. I don't know. And somebody's telling me, "I love you" and I'll say, "You're full of it"...I love my children and I love my grandchildren. I know that much, just the way I feel about them. Through a male, forget it. (Alice)

Assimilation and extermination were mentioned frequently, with comparisons made by the grandmothers to the Japanese internment¹⁰, as well as the holocaust¹¹.

Culture for the grandmothers was portrayed as two-sided: “I’ve lived away from the reserve for so long, that I’ve developed my way. It’s based on knowledge from both cultures that I live within. Mine and the mainstream” (Brigid). She also described how she uses knowledge to adapt to and stay healthy in both cultures, as well as sharing knowledge of her culture with others to improve their health.

The grandmothers placed the changing roles of men under the theme of “culture” and attributed the changing roles of men to attempts at assimilation. The grandmothers described a lack of strong male role-models accompanied by feelings of emasculation resulting in “making babies” and not providing for them. Sibyl lamented, “Women are strong, they are the backbone, but finding place and belonging for the man so he can express and become more responsible, I think it’s high time that this be done.” A physical space for men to meet was discussed as necessary to provide opportunities for men to expand and understand their roles in the community, resulting in healthier communities.

Dreams and Intuition (things we can’t explain)

The grandmothers described an “invisible” part of them that remains because of the effect of residential schools and the secrets kept. No-one can see this “invisible” part of the grandmothers, but their children and grandchildren have felt its effects. Some of

¹⁰ During WWII, thousands of Japanese Canadians were removed from their homes, losing possessions and land, and placed in internment camps to prevent spying for the Japanese government. In 1988, Prime Minister Brian Mulroney provided a government apology and compensation package for the survivors.

¹¹ During WWII, approximately 6 million Jews were placed into concentration camps and exterminated by Nazi Germany. Millions of other non-Jewish people viewed as inferior were also exterminated. Germany has since provided an apology and compensation for survivors.

the grandmothers who attended residential schools have become the severe cook, matron, or nun with their own children whereas some have become lax. The grandmothers described extremes as common with some punishing their children severely and some not disciplining at all.

Though some of the grandmothers have depicted breaking the cycle and changing things, “turn it around” (Alice); others say this “feeling is forever” (Ida). Even though attempting to change and move on, the grandmothers revealed re-living the experiences of residential schools recently, believing it is unnecessarily re-occurring, through the stressfulness of the hearings. Accusations of lying were described, along with experiences of interrogation, having to prove yourself, then “digging at something...you’re put back in there” (Alice). “They don’t believe us because we’re First Nations” (Brigid).

Attempts to make up for the cause of these effects have not been viewed as successful by the grandmothers. Settlements have been described as “blood money” and purchases made with it as unpleasant reminders of what happened. As for the apology from Steven Harper, Clara stated, “he didn’t mean it,” Brigid added, “there was nothing human about those words, there was nothing positive from that, cause the very next time I walked out of my home into a mainstream society gathering, I was still the ‘Indian’.”

This feeling of being the “Indian” has profoundly affected how grandmothers view their health and the health of their families and communities. Though the word “Indian” has been described as having negative connotations, a discussion during the grandmother’s last meeting revolved around cause and effect, dreams and intuition, and causal events (willing or causing events to occur) as part of their own spiritual and

cultural beliefs. These add new dimensions of wealth and strength which the grandmothers' possess in health promotion in their families and communities. Brigid chose a statement from her individual interview to describe it:

And I hang onto that like almost in a physical state of my mind, which is coupled by that emotional part of me. It's every breath I take, every thought I have, it comes from that spiritual point of what I was taught when my dad was alive, my grandmothers. And as I get older, I think its called wisdom, to understand and to know these things and to be able to, I pray someday I'll be, I'll get to a point where, so unconscientiously, I'll just live my life in total benevolent, peaceful giving of love, of human being.

Summary

The grandmothers possess a wealth of knowledge regarding health and health promotion. Though the topic of residential schools was not included in the interview questions, the grandmothers decided the effects were pervasive and should be combined with the topic of "no more secrets" included throughout the themes. Staying healthy was described as difficult in the residential schools with ideas of health maintenance imposed by the school leaders not in agreement with what they had been taught at home. The grandmothers described maintaining physical, mental, emotional, and spiritual health through now making their own choices rather than being forced. Strategies for living in a healthy way included keeping physically active, socializing, regular physician visits, and using sweetgrass, tobacco, sage, berries, mint, and cedar as available.

Maintaining physical health involved role-modeling, educating, and living off-reserve. Role-modeling was described as poor in residential schools, yet as an essential part of maintaining and promoting health. The grandmothers described "fixing myself first" as helping them heal as well as providing an example for their children and grandchildren. Reciprocal relationships (with grandchildren as catalysts for change) were

identified as contributing to improved health. The grandmothers described their education (or lack of education) at the residential schools and how educating others now helps to build bridges between two cultures. They discussed both formal and informal education as having benefits for their families and communities, as well as the “mainstream” society. Reserves were described by the grandmothers as: dividing families and communities, a government plan, a chunk of land that’s not home. The grandmothers in this study have all chosen to live off-reserve and have expressed that this has contributed to their health.

Maintaining mental health involved developing trust, problem-solving, and enjoying life. Layers of trust and distrust were deposited in the residential schools, between staff and the grandmothers, as well as between peers in the schools. These layers have emerged in relationships the grandmothers have attempted to maintain in their present lives. Difficulty with trust between individuals, families, and community leaders has made health promotion complicated. The grandmothers reported being pleased with their abilities to trust their grandchildren. Problem-solving was described as a necessary yet difficult part of staying healthy, as the control enforced by those in authority at residential schools contributed to fear of trying new things. The grandmothers described the importance of their personal plans for keeping themselves healthy, as well as participating in group activities as ways of maintaining and promoting health. Utilizing humor was described by the grandmothers as one way of coping with the residential schools. Enjoying life and using humor was described as part of staying healthy now, helping the grandmothers take control of negative situations.

Maintaining emotional health involved resiliency and surviving, staying positive,

and managing encounters the grandmothers view as racism. The grandmothers' lives are rich with experiences of resiliency and survival: they described conquering fear, not letting themselves be pushed around by others, speaking up for themselves, and perseverance. The grandmothers described their strategies for staying positive which included overcoming feelings of being controlled, turning situations from negative to positive, and letting go of secrets when they choose to do so. The grandmothers described situations of racism in their lives, beginning with the residential schools and being brought up again by the residential school hearings. Experiences of wrongs done to them were related, as well as ways of "turning it around" by making choices to value themselves.

Maintaining spiritual health involved spirituality, culture, dreams, and intuition. Spirituality for the grandmothers was confusing when at residential schools, abuse of power and religion was described by the grandmothers; coming out from under this control was a freeing experience, and has positively affected the well-being of the grandmothers. The grandmothers described using traditional knowledge and ceremonies, as well as prayer and faith in a higher power as contributing to their health as well as the health of their families and communities. Maintaining cultural beliefs and practices now assists them with staying healthy in both cultures. Beliefs in dreams and intuition, all things having a cause and effect, and the belief that causal events occur reinforces the grandmother's views of the Creator's central place in their health.

Chapter 5

Discussion

This chapter discusses themes the grandmothers co-created, situating them within existing literature. The grandmothers in this group have broad understandings of health and health promotion, which have all been affected by the scourge of residential schools. The stories the grandmothers told illustrate their strength and wealth of knowledge, and revealed profound insights on many topics. Following discussion of the themes, dissemination of the findings are outlined. Limitations of the study are discussed, with suggestions for further research followed by the conclusion.

The first research question, what does health mean to urban First Nations grandmothers, was described by the grandmothers as maintaining balance in 4 quadrants: physical, mental, emotional, and spiritual. The grandmothers linked personal health with family and community health, and identified cycles of support between themselves, their families, and communities as they educated and passed on knowledge.

Physical health encompassed areas of physical mobility and strength and managing chronic health conditions through exercising and eating well. Living off-reserve was also described as contributing to health, as well as care giving and role-modeling for grandchildren.

Mental health encompassed the possession of well-being, which included socializing, peer support, and enjoying life. Maintaining healthy relationships, employing humor, and living without anger were all part of living healthily. The grandmothers described “fixing myself,” as well as “walking my talk,” and problem-solving as ways to stay healthy. Trust developed as they gained healing and worked through difficulties.

Emotional health involved resiliency as well as being aware of their value, at times necessitating rejection of controlling and punishing relationships, and turning things around from negative to positive. Staying positive was described as essential for health, as well as surviving, resisting, and persevering. Standing up for themselves among mainstream society and within their own communities was also described as crucial for living in a healthy way. The importance of strong relationships with grandchildren promoted health maintenance as they described working through ongoing personal difficulties to change things for their families.

Spiritual health was described as living daily in a spiritual way, being part of a bigger plan. Having faith, employing prayer, maintaining gratefulness, as well as belief in cause and effect, in dreams and intuition, and in the ability in certain circumstances to bring about events. The grandmothers described practicing traditional knowledge and ceremonies as visual aids for health promotion in their families and communities, as well as for maintaining their own spiritual health. These practices were emphasized by Dion Stout and Kipling (2003) as “important sources of pride and self-esteem, serving to support individuals in their struggles against adversity” (p. 23).

The second research question, how do they promote it (health) in their families and communities, was answered through the 13 themes the grandmothers co-created.

Staying Healthy

The grandmothers described the enforcement of strict regulations at the residential schools, with work and cleanliness defining health. Avoiding their own cultural practices, or keeping them secretive, while practicing the enforced religion was the correct way to “stay healthy” as defined by the residential school staff.

Choices the grandmothers have now made to stay healthy included: managing chronic health conditions, walking, cooking and eating well, socializing, peer support, and maintaining physical strength as well as passing it on to their children. Obtaining support from family and friends, maintaining good nutrition, and following traditional beliefs during pregnancy was identified by the grandmothers as contributing to health for their children and grandchildren. The importance of this prenatal care was described in a study by Long and Curry (1998). A cycle of support was identified between grandparents, children, grandchildren, and all family, keeping everyone stronger and healthier. Negative cycles were also described, where unhealthy behaviors in one individual could affect other family and community members. Links between well-being and intergenerational family relationships were found in a quantitative study by Reitzes and Mutran (2004). The importance of a healthy body image was also expressed by the grandmothers, and confirmed in the literature (Poudrier, & Kennedy, 2008; Marchessault, 2004). Health was illustrated as balancing four quadrants, physical, spiritual, mental, and emotional; an infinite circle.

Regular physician visits and health screening tests were recommended as a way to stay healthy, with an emphasis on finding a good physician who listens. Although most of the discussion focused on physicians, the grandmothers also related difficulties as well as positive encounters with other health care providers. A community-based participatory study with urban Aboriginal women was performed by Kurtz, Nyberg, Van Den Tillaart, and Mills (2008) which confirmed many of the grandmother's descriptions of difficulties in experiences with health care providers: racism, discrimination, communication barriers such as not being listened to or not having a chance to tell about

what they came for. Descriptions of difficulties and misunderstandings in encounters with health care providers were prevalent throughout the literature (Browne, & Fiske, 2001; Browne, & Smye, 2002; Dodgson, & Struthers, 2005; Fiske, & Browne, 2006). Though difficulties were encountered, the grandmothers described the importance of role-modeling attempts at positive interactions with health care providers.

Role-modeling

Gaps in role-modeling existed in residential schools, which the grandmothers described as affecting relationships with their children and families. The grandmothers explained their resistance to allowing these cycles to move into their relationships with grandchildren. Concepts of working on changing themselves with grandchildren providing the catalyst, and descriptions of stronger relationships with grandchildren than with children were outlined. Role-modeling was described as an important tool for teaching their children and grandchildren as well as maintaining healthy relationships. The literature confirms the existence and importance of these strong ties with grandchildren (Kemp, 2004; Kemp, 2007; Meadows, et al., 2004).

Role-modeling occurred with extended family, as well as friends, and others in the community. One of the grandmothers talked about everyone coming to her for help or information, with another confirming her role as a counselor. This invaluable role, was identified by Lobo (2003), that of an “urban clan mother,” as well as in a cross-cultural study by Chamberlain (2002), a “gravitational grandmother”. Valaskakis (2005) also referred to First Nations women as having always been “clan mothers, care-givers, educators, and energizers in Native communities” (p. 143).

The grandmothers emphasized the importance of education for their children and

grandchildren. Drywater-Whitekiller (2006) maintained that the recommendation of education by grandparents is about contributing to the well-being of the community, not just for personal benefit. Community well-being encompassed immediate and extended family, as well as friends and neighbors, and people in the street, with role-modeling an essential component of health promotion. Sometimes this educational role-modeling involved revealing stories or secrets gained from people in their past, in order to pass on traditional knowledge, to keep the knowledge going.

“Bridging the gaps” was a method of health promotion outlined by the grandmothers, between two societies, “theirs” and “mine.” Living within two cultures was a challenge identified in the literature (Long & Curry, 1998; Loppie, 2005). For those from the “mainstream” able to learn from First Nations people, able to “come into our flow,” the results are significant, “they become real people.” This phenomena was illustrated in a cross-cultural study by Delgado-Gaitan (1993), the shifting of “values, beliefs, and practices as a result of new knowledge and new contexts...to counter our own ignorance and biases as researchers, we must integrate into our research rigorous and systematic joint analysis with our participants” (p. 409). Spending time with the grandmothers has changed the way I view those around me, and has reminded me of the pleasure in simple things, taking time for others, listening, and expressing gratefulness for each day. The education I have received from them is invaluable.

Educating

Formal education was described as almost non-existent in the residential schools, but the grandmothers identified the importance of informal education through life experiences and knowledge gained from their parents and grandparents. This was

confirmed in the literature, by LaFrance (2003) as well as Standing, et al. (2007) who quoted one of the grandmothers in their study, “we are educated all because of life, not stacks of books, but from our own failures and success stories” (p. 630).

Educating others was explained as essential in health promotion, as an increased understanding about First Nations people can make other people in society healthier. A quantitative study assessing black grandmothers’ fulfillment of family roles by Strom, Heeder, and Strom (2005) reported teaching as their greatest strength. Coy (2006) discussed ethical dilemmas using feminist participatory action research with a group of women, noting: “women were visibly empowered by being in the apposite position of educating me” (p. 426). The grandmothers educated me through the telling of their stories as well as through cooking together, fulfilling one of the comments made at the FNCA meeting before the study began: “if you come with an open mind, you will learn and grow yourself.”

The grandmothers depicted racist behaviors of others as opportunities for education, with one incident recalled demonstrating the gentle strength which Mayer (2007) described:

There are still many strong, fierce mothers who display gentleness and respect, not because they are oppressed but because they are strong, powerful women with a deep sense of their own personal worth. Today, as yesterday, most Native people have tremendous respect for gentleness and they respect the mothers who provide such gentleness, especially in the face of so much pain and suffering in our communities. (p. 34)

This wealth of knowledge and strength is adaptable from one generation to the next, an affluence not found in material things, yet making the grandmothers, their families, and communities richer, healthier, and stronger. In order to be beneficial, this knowledge must be passed on. One of the grandmothers identified that a strength each of them in

the group possessed was having the knowledge as well as the ability to pass it on.

Education of all people is important in order to understand the perspectives of First Nations people, and is essential for health care providers. In a policy statement by the Society of Obstetricians and Gynecologists of Canada (SOGC, 2000) it was recommended that health professionals have an understanding of the effects of colonization:

It has had a major, ongoing impact on the physical, mental, emotional, and spiritual health and well-being of Aboriginal peoples in Canada. It impacts on current relationships of Aboriginal peoples with their health care providers and with the mainstream health care system (which grew out of the colonial system). Policies and attitudes which perpetuate this history still exist today. (p. 5)

Though 9 years have passed since this recommendation has been made, the grandmothers are describing situations within hospitals, such as prohibitive visiting policies for family and friends, and uncomfortable encounters with health care providers, that do not demonstrate an awareness or understanding of the effects of colonization. We must move on, become educated, become aware, even if it is uncomfortable. Many hospital policies, procedures, and attitudes of health care providers need adjustment. “A postcolonial framing rests on an overarching mindfulness of how domination and resistance mark intercultural health care encounters at individual, institutional, and societal levels” (Reimer Kirkham, & Anderson, 2002, p. 10). Care of those entering and leaving the world was mentioned by the grandmothers with the importance of places to meet and have tea together; these findings were confirmed in a qualitative study (Kelly, et al., 2009). Birth and death were noted to be times when First Nations people may seem to be in conflict with “mainstream” policies and procedures (SOGC, 2001).

Browne (2007) emphasized that encounters between nurses and First Nations

people are not simply between two individuals, rather, “they reflect the history of relations between Aboriginal people and the Canadian state, and the positioning of individuals within those relations” (p. 2174). An awareness of the history of colonization is essential, as one of the effects has been marginalization for First Nations people. Health policies for marginalized populations must demonstrate awareness of the principles of cultural safety¹² as “cultural safety reminds us that it is incumbent on all of us in health care to reflect upon the ways in which our policies, research and practices may recreate the traumas inflicted upon aboriginal people” (Smye, & Browne, 2002, p. 47). One of the traumas inflicted on First Nations people the grandmothers identified was that of the government placing them on reserves.

Reserves

Comparisons were made between reserves and residential schools, with tensions between those who choose to live off-reserve and those who choose to live on “that little chunk of land that the government gave them.” Reserves were viewed as splitting up communities; part of the assimilation and extermination agenda of the government. The grandmothers expressed the feeling of “no community anymore, very little;” while Morrisseau (1998) described the importance of communities in surviving the losses of residential school as “much of our self-worth and identity comes to us through our identification with our communities” (p.79). Reserves were described as not traditional, not home; these decreased connections to the land were described by Wilson (2005).

¹² Smye and Browne (2002) reported that cultural safety was developed by Ramsden, a Maori nurse in New Zealand, who wrote: “cultural safety was designed to focus attention on ‘life chances—ie, [sic] access to health services, education, and decent housing within an environment which it is safe to be born brown—rather than lifestyles, i.e., ethnography’. Cultural safety is, therefore, not about ‘cultural practices’; rather, it involves the recognition of the social, economic and political position of certain groups within society, such as the Maori people in New Zealand or aboriginal people in Canada” (p. 46).

Valaskakis (2005) described the importance of “‘living in a good way’—in physical, social, and spiritual health and harmony; a mixture of meanings that is intertwined with land” (p. 103). Barrios and Egan (2002) discussed older women living off-reserve and feelings of isolation that may ensue. This group of grandmothers described living off-reserve as a healthy choice, they had supports of family and friends in the urban area, and felt that their traditional lands were not the on-reserve lands the government historically forced them to live on.

The grandmothers questioned the wisdom and processes of the present election system, and identified a “disconnection” because of corruption occurring in the leadership. Descriptions of intergenerational individual, family, as well as community trauma for American Indian and Native Alaskan communities were reported by Evans-Campbell (2008) who identified past stressors as negatively affecting functioning of today’s societies. Disillusionment of American Indian people with their leadership has also been documented (Jervis, & American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project Team, 2009). Being healthy, positive, real, and listening to the people were described by the grandmothers as important traits for their leaders. Bourassa, et al. (2004) has outlined some of the difficulties:

Band governing bodies are not working according to the traditional Aboriginal way, instead using legislation to exclude women and protect male privilege. After fighting for the recognition of Aboriginal rights, Aboriginal women have found themselves at odds with some of their own community leaders. Indian women and their children have not been welcomed back to their communities. Since the 1980’s, when the federal government began the process of devolution of control to Indian bands, band governments have been able to refuse band membership. (p. 26)

Avoiding relatives or certain people living on-reserve who had harmed them in some way was discussed by the grandmothers and also found in the literature (Balfour,

2008; Browne, et al., 2005). A lack of eligibility for affordable housing was also noted by the grandmothers, as well as a decreased availability of clean drinking water and adequate sanitation on-reserves, confirmed in a study by Bharadwaj, et al. (2006). The grandmothers viewed living off-reserve as freeing them from the confinement of living on-reserve, contributing to keeping them healthier; physically, mentally, spiritually, and emotionally.

Trust/Distrust

Issues of trust and distrust were brought up by the grandmothers as stemming from residential schools. Lafrance (2003), documented one community's descriptions of the results of residential schools which included:

- the pain of abandonment
- the loss of culture and language
- lack of parenting
- lack of love experienced as children
- inward pain
- sickness of mind
- imbalance of mind and spirit
- emotional, physical, and sexual abuse
- family breakdown
- difficulty in creating and maintaining relationships
- walls of distrust and dishonesty between people
- a sense of hopelessness among many
- a loss of self-identity

- a fear of the police
- a loss of traditional sense of sharing

As secrets about residential schools were revealed, layers of distrust emerged throughout the grandmother's discussions, between "their reality" and "our reality," between the government, between authorities, with other First Nations people, with partners, siblings, and children, to culminate in: "trust no-one except yourself." This distrust has also been linked to residential schools in research by Dion Stout and Kipling (2003). A study of social capital using participatory action research with urban Aboriginal and Torres Strait Islander communities (Brough, et al., 2006) outlined the lack of a social environment that builds trust between Aboriginal and non-Aboriginal Australians. Struthers and Lowe (2003) described nursing care with Native Americans, and documented that if trust is violated at an early age, it may continue with negative consequences later in life such as poor relationships, "it is imperative to recognize historical trauma as an existing factor that affects the way the world and aspects of health are viewed" (p. 265). It is essential for health care providers to allow time for trust to build before attempting to provide health care services for First Nations people.

Problem-solving

Developing self-confidence and the ability to try new things, asking and answering questions, breaking old habits, letting go of secrets, and developing self-acceptance were all revealed as difficult for the grandmothers. Though letting go of secrets was not possible for some of the grandmothers, for others it was a freeing experience. Many of them explained moving toward value and acceptance of themselves, after feeling de-valued and rejected through experiences at the residential schools. The

grandmothers demonstrated creative problem-solving in their paths to health and healing.

DeGagné (2007) outlined key themes from the Aboriginal Healing Foundation in Canada, and maintained that healing from the effects of the residential schools is circular. Progress is made and then may circle back if challenges occur. Those who have made progress in healing can assist others in their communities:

Community healing is a necessary complement to individual healing. Restoring networks of family and community support is essential to stabilize the healing of individuals who continue to carry the burden of childhood trauma and family disruption. Reservoirs of resilience in individuals and communities can be tapped. (DeGagné, 2007, p. S53)

The grandmothers in this study have progressed and were continually progressing in healing as they described working on themselves, and could be considered these “reservoirs of resilience” within their families and communities as DeGagné (2007) described. Valaskakis (2005) reported, “in the narratives of traditional knowledge that express Indian identity and community, women have always represented empowerment” (p. 146). A give and take cycle in healthy living was identified by the grandmothers; an ethnographic research study of a four generation American Indian family echoed this belief:

In an effort to “bring things into balance,” the Si John family recognizes the importance of teaching, as opposed to learning, taking and never giving back. The cycle of learning must be completed by giving something back to that circle. “Take what knowledge you have gained in your life, use it somewhere else, and return it back to the circle”. (Denham, 2008, p. 410)

Determining to stay healthy involved planning to eat well, exercise, and quit smoking, as well as saying “no” to yourself. The group acknowledged the difficulty of these decisions, as well as the difficulty of living without anger. Strength was found in traditional beliefs and practices, with the description that in every problem, is also the

solution. The grandmother's abilities to enjoy their children, grandchildren, and their lives despite a large number of obstacles and difficulties was commendable, an example to be followed.

Enjoying Life

Humor was "one of the blessings" at residential schools, a way of surviving difficult situations, of avoiding the control of others. Humor has become a way for the grandmothers to educate others about health. The ability to enjoy life while living day to day with gratefulness were explained as important tools for coping with past and present difficulties. The grandmothers identified the importance of maintaining mobility as it allowed them to enjoy life and stay healthy even though managing chronic diseases. The grandmothers' abilities to employ humor and enjoy life are remarkable.

Resiliency/Surviving

The grandmothers expressed feeling the effects of residential schools in all parts of their lives; other studies have described similar results (Dion Stout, & Kipling, 2003; Smith, Varcoe, & Edwards, 2005). Furniss (1992) has identified the potential for powerful and long-term psychological and social consequences: "For many Native people the residential school experience not only serves to explain many of the difficulties they have faced in their personal lives since leaving the schools, but also epitomizes on a small scale the deep-seated historical problems that have permeated Indian-white relations in Canada for centuries" (p. 31). Keeping quiet and keeping secrets about residential schools has not been an effective way of healing; speaking up and speaking out has been an important part of a progression toward healing for the grandmothers, their families, and communities.

In a collection of biographies of women who experienced residential schools, Starr (2004) explained: “There is a feeling that the inevitable must be endured, but it must not be accepted” (p. ix). The grandmothers depicted themselves as survivors, with abilities to stand up for themselves, to resist, to not be pushed around, to persevere, and to change. The concept of “survivance” was coined by Gerald Vizenor and illustrated by Kuokkanen (2003) as not a “response or reaction but rather a proactive stance; a willingness to take a stand by drawing upon one’s culture and tradition...a strategy that is constantly modified according to the needs and possibilities of both resistance and survival” (p. 699).

Four resources have been described by Dion Stout, and Kipling (2003) as essential in the resilience of residential school survivors: support, of spouses, friends, and family; sharing, of stories with others, often with humor; learning, both formal and informal, with emphasis on original languages; and spirituality, described as a lens, “through which to make sense of one’s suffering, as well as the strength to overcome its destructive power, these beliefs foster a sense of peace in individuals arising from their feelings of connectedness with a force more powerful than themselves” (p. 50). The grandmothers in this study identified these resources in their own lives, possibly without realizing the significance of how they have contributed to their resiliency and survival.

The grandmothers linked concepts of their own resiliency with an emphasis on the importance of education for their children and grandchildren as described by Cheah and Chirkov (2008). Explanations the grandmothers offered of their value and well-being as not dependent on material sources were also reported in a study by Cooke, Guimond, and McWhirter (2008).

Staying Positive

The controlling by residential schools the grandmothers revealed has been confirmed in various articles and reports (De Leeuw, 2007; Kirmayer, et al., 2003; Millon, 2000; Robertson, 2006; Royal Commission on Aboriginal Peoples, 1996c). The control reached far beyond the schools and resulted in many children being placed in foster care, with beliefs that parents could not raise them properly. “The large-scale apprehension of Aboriginal children from the family, community, and cultural context via the residential school system and the ‘Sixties Scoop’ has had damaging consequences for individuals and communities.” (Kirmayer, et al., p. S17). Speaking up about the misdeeds done to them involved letting go of secrets, and acknowledging that this treatment was unacceptable to them as human beings.

The legacy of colonialism has been trauma. The residential schools and other forms of institutional and substitute care are, for many Aboriginal people, the most harrowing of traumatic experiences. For others, the deepest traumas lie in the dysfunctional relations of family and community. (Fiske, 2008, p. 89)

The grandmothers have persevered in their determination to “turn it around” as they described their methods of changing things for the better, from negative to positive, for their communities, families, and themselves. Smith, et al. (2005) identified this phrase as the central concept of the participants in their study, as a way to combat the effects of intergenerational impacts of residential schools. The importance of maintaining balance in the four quadrants of health: physical, mental, emotional, and spiritual, was identified by the grandmothers and confirmed in the literature (Dion Stout, & Kipling, 2003; Labun, & Emblen, 2007; Lavallée, 2008; Goudreau, Weber-Pillwax, Cote-Meek, Madill, & Wilson, 2008; Wilson, 2004). The grandmothers explained that staying

physically healthy was a strength, which was also confirmed in a study of a program for urban Aboriginal women in Vancouver, British Columbia (Nadeau, & Young, 2006).

Enjoying life was emphasized as significant by the grandmothers, and included attending bingos and casinos. Traditionally, gambling in First Nations cultures was a group pursuit rather than an individual activity, with both sacred and secular purposes:

European and British philosophies about gambling saw the practice as ill-advised and a waste of time. The puritan ideal of succeeding through hard work was antithetical to the gambler's hope of obtaining a livelihood by participating in games of chance. The gambler was, by definition, lazy and unable to accept societal norms. (Belanger, 2006, p. 30)

Gambling was used as a method of renewing social relationships, community building, cultural interaction, healing sickness, dividing possessions after death, and to gain power (Belanger, 2006). Today, gambling among First Nations people may be used as a method of escape, or as part of living day-to-day with limited resources (McGowan, & Nixon, 2004).

In a review of multicultural models of women's health by Meleis and Im (2002), women who were marginalized "tend to have secrets and share information only with those with whom they have developed human bonds. They are voiceless, but they tend to be more reflexive about their behavior and the behavior of others and consequently share profound insights" (p. 219). This was demonstrated in the grandmothers' discussions about numerous secrets they hold and the difficulty with which they reveal those secrets. Sharing of secrets with others and affirming each other through this process, the grandmothers displayed another strength, that of staying positive through adverse circumstances. The grandmothers described adverse encounters they experienced and viewed as racism.

Encountering Racism

Residential schools were reported as a nightmare; there remain for the grandmothers things that have been and have not yet been revealed, even within their families. The keeping of secrets has been a difficult obstacle for the grandmothers to fully overcome. Suicidal thoughts and achievements referred to by the grandmothers are not uncommon occurrences (Dion Stout, & Kipling, 2003). For the survivors of the schools, the process of being forced to reveal, of providing proof, of attending the hearings, has not been without resistance and dread. Admitting being afraid, not feeling safe, that residential schooling was a life-changing experience, and though it affected them, it did not break their spirits were all expressed.

The grandmothers repeatedly discussed feelings of self-worth and value developing after being negatively conditioned by residential schools, and how again, to “turn it around.”

The ensuing nightmare of the effect of residential schooling on our communities has been what those “Indian problem” statistics are all about. The placement of our children in residential schools has been the single most devastating factor in the breakdown of our society. It is at the core of the damage, beyond all the other mechanisms cleverly fashioned to subjugate, assimilate, and annihilate. (Armstrong, 1989, p. x)

The strength and perseverance of the grandmothers was evident as they expressed working through difficulties to change things for their families. Sunseri (2008) emphasized finding strength in families:

Indigenous women like my aunt and grandma have offered us the opportunity to grow and develop in a positive way by giving us a space—our family—of resistance against racism and colonialism. Home and family are spaces where our identity is affirmed and valued, and where healthy lives are constructed... It is within our families that we come to learn and appreciate our Indigenous histories and cultures, and where we acquire the tools needed to fight against the negative images of Indigenous peoples that bombard mainstream Canadian society. (p. 23)

The grandmothers outlined many negative experiences that they viewed as forms of racism; and a few positive experiences with health care providers. Anderson (2004) disclosed that “the process of racialization is omnipresent. So with any client, complex intersectionalities will organize their experiences” (p. 243). Other clients who are not First Nations may also have encountered difficulty with health care provider interactions, but may not possess a history of the colonized and the colonizer. Browne, Smye, and Varcoe (2005) emphasized the need for a post-colonial theory in research “for understanding the ‘burden of history’ and how this shapes present-day experiences and new forms of inequities” (p. 22). The concept of cultural safety uses a post-colonial framework to “examine not only current unequal health care outcomes and experiences, but also the long histories of economic, social, and political subordination that contribute to current health and social conditions” (Reimer Kirkham, et al., 2002, p. 227). An awareness of cultural safety is vital for all health care providers working with First Nations people.

Spirituality

Descriptions of confusion regarding guilt, forgiveness, punishment, and the religion of the residential schools were woven throughout the grandmothers’ interviews. Secrets about their own religious beliefs and ceremonies were kept, and sometimes forgotten. This confusion was also established in Dickson’s (2000) case study of older Aboriginal women involved in participatory action research; a lack of familiarity with traditional culture was one result of churches and governments forming their beliefs as children. Being unsure, and ashamed, of their traditional beliefs had negative effects, one of which was the development of dysfunctional relationships. “Too commonly, the

contemporary experience of many Aboriginal people shows little relationship to the harmonious, respectful, proud, and wise aspects of their ancestors' lives" (Dickson, 2000, p. 199).

The grandmothers again emphasized "turning it around" by rejecting relationships which control and punish, and finding strength in being with those who provide a positive influence, "help me to be a part of a bigger plan." Spirituality was explained as having a lot to do with well-being and health: including mind, body, and soul; an everyday way of living; prayer and gratefulness; belief in a higher power; living in a spiritual way; fixing myself; walking my talk; having faith. Using visual aids such as attending ceremonies, and practicing traditional knowledge was emphasized as a way of helping themselves and their grandchildren stay healthy, which was also confirmed throughout the literature (Dion Stout, & Kipling, 2003; Iwasaki, Bartlett, & O'Neil, 2005; Redbird, 1995; Robbins, et al., 2005).

Culture

Effects of residential schools for the grandmothers included separation from their culture as well as their families, with myriad losses, including love, also described by Dion Stout and Kipling (2003). In a study of homelessness in young First Nations women, their grandmother's experiences in residential schools have trickled down, affecting their own ability to maintain healthy relationships, similar to descriptions of the grandmothers (Ruttan, LaBoucane-Benson, & Munro, 2008). Goals of assimilation and extermination the grandmothers described still occur, though in more subtle ways:

Just as "healthy" and Christian were equated, so were "traditional" and diseased. As medical authorities examined Aboriginal health in the twentieth century, they created the perception that Aboriginal people were inherently unhealthy so long as they lived lives that were not fully assimilated. (Kelm, 1998, p. 62)

The grandmothers expressed the complexities and misunderstandings, as well as strengths of living with two sides to culture, as they described how assimilation for them has not been fully achieved. Francis (1992) described common beliefs in the mid-1900s “Canadians did not expect Indians to adapt to the modern world. Their only hope was to assimilate, to become White, to cease to be Indians” (p. 59). The grandmothers have not assimilated, nor been exterminated, nor have they become white. They have utilized knowledge from both cultures as well as shared their knowledge with both cultures to promote health. Brough, et al. (2006) depicted the concept of “being caught between two worlds” (p. 401) as a common source of stress, though possession of an Aboriginal identity is also a strength.

The grandmothers described men’s roles having changed with assimilation attempts by the government, resulting in emasculation. Though the grandmothers viewed women as “strong, they are the backbone;” a resolve to help men find their rightful place in families and communities was voiced. The importance of men establishing their place can be found throughout the literature (Dion Stout, 2005; Wilson, 2004; York, 1990).

Dreams and Intuition

The grandmothers revealed many lingering effects and secrets from residential schools; some have been able to move on, others have been unable to forget. Feelings of being different than others, as being “the Indian” affected their views of health and health promotion both negatively as well as positively. Finding strength through their cultural beliefs because of their experiences in life included access to dreams and intuition, belief in cause and effect, as well as belief in causal events.

“Events and knowledge that occur in dreams break down the barriers between

realities—physical and spiritual, past and present—and the information they provide is integrated into the lived experience of everyday life” (Valaskakis, 2005, p. 186). As the grandmothers described some of their experiences, Garro’s (2003) article similarly related narrative accounts of individuals from First Nations communities in Manitoba, Canada:

The possibility that the root of misfortune may be in one’s own inappropriate actions or in the covert ill will of another...someone that seems outwardly affable may have secretly taken steps to cause misfortune or affliction in another...to accept that other-than-human persons can communicate through dreams and visions is to be open to the possibility that private sensory experiences may represent true knowledge of the world as it currently is or as it may become. (p. 35)

The strengths of the grandmothers in health promotion are complex and not easily understood.

Health promotion activities engaged in by the grandmothers include:

- Maintaining positive cycles of support between grandparents, grandchildren, and families, keeping everyone stronger and healthier
- Role-modeling positive interactions with health care providers and others
- Promoting formal and informal educational opportunities
- Bridging the gaps between two societies
- Passing on knowledge and traditional teaching from one generation to the next
- Living off-reserve
- Expecting integrity in band leadership
- Sharing secrets; speaking up and speaking out
- Progressing in healing of self while “reservoirs of resilience” for others
- Demonstrating “survivance”; resisting, persevering, changing, and taking a stand

- Determination to “turn it around”, changing things for the better for their communities, families, and themselves
- Working through residual effects of past difficulties to change things for their families
- Living daily in a spiritual way and practicing traditional knowledge.

Promotion of health can occur through positive role-modeling (Barrios, & Egan, 2002) as well as the construction, sharing, and transfer of knowledge (Smylie, Williams, & Cooper, 2006; Smylie, Kaplan-Myrth, McShane, & Métis Nation of Ontario-Ottawa Council, Pikwakanagan First Nation, & Tungasuvvingat Inuit Family Resource Centre, 2009). Involvement of the grandmothers in the research process has contributed to reinforcement of their strengths and abilities as health promotion specialists as described by Pyett, Waples-Crowe, and van der Sterren (2008). Spiritual beliefs and connections are essential in maintaining health of individuals and communities (Arnold, & Bruce, 2005).

Dissemination of Findings

Some of the grandmothers have expressed an interest in, and provided verbal consent to participate in digital storytelling¹³. A visual aid will be produced, which will assist them in passing on traditional knowledge and educating their families and communities for years to come. Videotaping the stories of the grandmothers was not a part of this research study, but was introduced as an idea for transferring knowledge contained with this group to their families and communities. These digital stories will be useful in providing educational opportunities if the grandmothers provide permission for

¹³ Digital storytelling involves a combination of video, narration, and exhibition of personal artifacts. It can be used as a means of education for others, as well as for personal use.
<http://digitalstorytelling.coe.uh.edu/>

me to share them with groups of nursing students or health professionals. Production of these visual aids will begin in January of 2010 with the grandmothers who wish to participate.

The grandmothers discussed the importance of nursing students gaining an understanding of their culture, as well as nurses and other health care professionals who are presently working with or who may work with First Nations people in the future. As opportunities to present the findings of this study arise, ideas for further research may evolve. Since completion of this study, three of the grandmothers from the group have met with a group of nursing students from the University of Lethbridge to increase their awareness of First Nations culture. These students are participating in a community health project, examining ways to increase access for First Nations clients to the Building Healthy Lifestyles program in Lethbridge, Alberta. These meetings included one of the grandmothers who was a quieter member of this study, but who spoke up with the students. This project was presented to the local Building Healthy Lifestyles program, with the potential for province-wide use.

In a study using an Indigenous participatory action research approach, Smylie, et al. (2009), recommended utilization of five pertinent themes for effective dissemination of health knowledge following research studies: (1) Valuing of experiential knowledge – personal experiences and word of mouth are important in evaluating certain health care services or providers. The grandmothers demonstrated this in their discussion of physicians, who the “good ones” were, and will continue to disseminate this knowledge within their families and communities. Recommendations for certain pharmacists who were helpful were also made by the grandmothers within their group interviews, and will

be continued for friends and family. (2) Influence of community structure on health information dissemination – more cohesive communities spread knowledge faster than those whose populations are dispersed. Even though the grandmothers in this study were from an urban area, they have kept in contact with each other, as well as with their families on the reserve. News about the research study has been passed on to others, and I have been asked, “how is the study going?” by those in their community who are not involved in it. (3) Preference for “within the community” messages – health messages generated from within the community, using culturally appropriate pictures and words are preferred. The grandmothers may assist in further presentations to students, or to health care providers, or on health care boards as they are invited. As I share the findings of the study, I will actively seek opportunities for the grandmothers to share their knowledge publicly (i.e., nursing classes, conferences, and policy meetings), as well as ask for their direction on the appropriateness of resources I am developing, such as the prenatal curriculum for our health zone. (4) Dissemination through family and community networks – family and community networks are one of the most effective means of dissemination of information. The grandmothers are sharing information gained in their own families and communities, as I am sharing within mine. (5) Local effects of colonization – Indigenous knowledge has been negatively affected by colonization, which may continue to interfere with the uptake and dissemination of new information. The grandmothers expressed difficulty with trusting information given by those with whom they may not have a relationship or friendship with, as well as difficulty with trusting those in leadership positions within the First Nations community, especially those in leadership on the reserve.

In descriptions of lessons learned with Aboriginal grandmothers and participatory action research, Dickson and Green (2001) suggested the importance of fitting research into programming or projects in order to make it meaningful and manageable within time constraints of people's lives, as well as providing opportunities for research for those who would not normally have the chance. Perhaps the next proposal for funding for programs such as the continuation of the community garden, or for funding for a facility for programs, or for field trips such as berry-picking, will include partnering with a researcher from the local university.

When provided with the opportunity, tools, and support, ordinary people can indeed conduct research that is meaningful to them and contributes to personal and social change. Nonetheless, to transform the negative impression of research held by marginalized people, further similar experiences with respectful, participatory, and responsive inquiry will be needed. Moreover, for the research process and findings to be empowering and health promoting, participation and power-sharing must be increasingly emphasized in inquiry. (Dickson, & Green, 2001, p. 481)

An increased confidence in their own capabilities has developed in this group of grandmothers through participation in this study, and they have discussed speaking up and speaking out more as opportunities arise. An increased understanding about First Nations grandmothers and health promotion has developed through my participation in this study and I will take advantage of opportunities to present the findings, with peers as well as nursing students, at conferences or in journals as possibilities for these are found. As I continue in my nursing career, a mindfulness of the knowledge gained in this study will stay with me as I interact with others. Opportunities for dissemination of results will be ongoing, as described by Kemmis, and McTaggart (2005):

Participatory action researchers might consider, for example, how their acts of communication, production, and social organization are intertwined and interrelated in the real and particular practices that connect them to others in the

real situations in which they find themselves (e.g., communities, neighborhoods, families, schools, hospitals, other workplaces). They consider how, by collaboratively changing the ways in which they participate with others in these practices, they can change the *practices* themselves, their *understandings* of these practices, and the *situations* in which they live and work. (p. 565)

Change is not an easy or immediate process, but will continue to occur over time. I look forward to more opportunities to learn from this local group of grandmothers by continuing to participate in their activities as I am invited to do so. I anticipate change in my local community, neighborhood, family, school, hospital, and other workplaces as described by Kemmis, and McTaggart (2005) when knowledge gained about First Nations people is shared. As the grandmothers in this study continue to share the knowledge they possess, further change will occur through those fortunate enough to learn from them.

Suggestions for Further Research

Throughout this study, questions have been raised which may involve areas for further research. Future research that focuses on health and health promotion roles of First Nations grandmothers in different circumstances (i.e., on-reserve, off-reserve) and with different tribal affiliations (i.e., Blackfoot, Cree, Dene) could be undertaken. The findings of such studies could be used in the development of nursing curriculum and evaluated after the curriculum is implemented. A PAR study could be developed that links the First Nations grandmothers with existing health programs (i.e., Building Healthy Lifestyles) and nursing education programs (i.e., Support Program for Aboriginal Nursing Students {SPANS, <http://www.uleth.ca/healthsciences/spans>}) to assess their roles as resources, advocates and educators.

The community representative within this health zone may be able to work with

relevant local university researchers and a group of First Nations grandmothers to continue PAR studies that would address issues such as creating a First Nations grandmothers health promotion centre. Working on such a project is a task that this group of grandmothers is fully capable of and would be ideally completed in collaboration with nursing students (including SPANS students). Such a PAR project that results in the creation of a health promotion facility would be beneficial to the health of First Nations peoples as well as providing a practical setting for nursing students to learn about delivering care that is not only culturally appropriate but demonstrates commitment to cultural safety. This study could be replicated in an on-reserve community, with the group of grandmothers suggesting adaptations as applicable. Other studies that could be undertaken could examine the necessity of increasing the number of First Nations health care providers in this health zone.

The grandmothers in this study automatically talked about their residential school experiences and dreading the hearings that are ongoing. A relevant research question is: What are the experiences of First Nations grandmothers regarding the residential school hearings? This study would begin to generate answers about the need for adequate support and counseling.

A final research question that could be pursued is: have health care facility policies such as visiting hours affecting First Nations families been successfully changed in other zones across Alberta Health Services (<http://www.albertahealthservices.ca/252.asp>), or in other health regions across the country; and how could these be effectively implemented and measured in our health zone?

Conclusion

Residential schools have affected every area of the grandmother's lives, including those of health and health promotion. Through opportunities to meet and socialize gained during this study, discussion of struggles resulting from the schools and fear regarding the hearings resulted in peer support. Friendships between group members were renewed and strengthened, with plans to participate in future group outings and activities. The grandmothers developed more confidence in their knowledge regarding health, and in their abilities to promote it in their families and communities, therefore increasing their sense of well-being.

The knowledge owned by this group of grandmothers and their abilities to promote health encompass holistic views which are not always understood by "mainstream" health care providers (myself included). Expectations of the present health care system do not often fit the expectations of these grandmothers, as their definitions of health encompass their families and communities, not just individual health. If scheduled individual appointments interfere with caretaking or socializing within their community, the appointments may not be kept. Misunderstandings and conflict with health care providers has impacted this group of grandmothers deeply, reminiscent of the control imposed by residential schools. The grandmothers may not be able to communicate fully without adequate time to tell their stories, or for trust to develop. It is essential that health care providers respect their ideas and opinions and listen to their concerns, both spoken and unspoken. Hospital policies and procedures may interfere with the need for family support and nurturing, as well as the essential place traditional beliefs and practices occupy.

Collaboration in this research study with the grandmothers has been at times an overwhelming experience. My understanding of health and health promotion, of surviving through dreadful circumstances in which the grandmothers had no choice, has been humbling. As I have worked with and observed the grandmothers throughout this study, I have grown to value them as individuals, and as a community group, recognizing their abilities to maintain their health, while promoting health in their families and communities. The grandmothers have provided me with an invaluable education and I am indebted to them for the opportunity to have received it. Hungry Wolf (1980) described it best:

...Indian women have knowledge to contribute to world history. I wish more people would share the ways of their grandmothers. I think it would help the present world situation if we all learned to value and respect the ways of the grandmothers—our own as well as everyone else's. (p. 17)

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Appendix A

Information Sheet

Urban Aboriginal Grandmothers: Health Promotion Roles in Family and Community

Why is this study important?

- grandmothers have important health promotion roles in their families and communities
- the roles of aboriginal women in health are under-represented in research studies
- grandmothers are highly capable of speaking for their communities
- grandmothers are valuable resources in their communities, capable of empowering others

What will occur in the study?

- the community representative for aboriginal seniors will ensure that informed consent is obtained, and that the research proceeds in an appropriate manner
- participatory action research (which makes sure that the participants have a say in how the research is done, what information is shared, and how it is shared) will be the goal
- 4 to 6 group interviews will be completed (or as many as the grandmothers determine are appropriate), and individual interviews may be completed if any of the grandmothers wish
- grandmothers will be asked about areas of health important to them and how they promote it
- traditional roles of grandmothers may be explored

How will the information be used?

- the grandmothers will be encouraged to determine what will be done with the knowledge they produce
- the results may be shared in journal articles, conference presentations, or in classrooms for nursing students and/or other health professionals. It may help health professionals prepare and deliver health programs for aboriginal peoples
- the grandmothers and their community representative will have full access to the data and the finished study in a written format

Who is completing the study?

- grandmothers who will share their wisdom will be the main participants in this study
- the study will be completed by Carla Ginn (carla.ginn@uleth.ca), a master of science in nursing student at the University of Lethbridge. Her supervisor is Judith Kulig (kulig@uleth.ca) (403) 382-7119.

Appendix B

Letter of Invitation

(Insert Date)

Dear *(Insert Potential Research Participant's Name)*:

You are invited to be in a study about health in your family and community.

This study will occur during your regular meetings with other grandmothers. If you would like to be in an interview by yourself, you may do so. Your group leader will be there for all the group interviews.

During the interviews, you will be asked about health in your families and communities.

You will also be asked about areas of health that are important for you, your families, and communities.

By taking part in this research, your group may come up with new ideas about how to help your families and communities become healthier. Your group will help decide how these ideas will be used.

Thank you for thinking about being a part of this research study.

Sincerely,

Carla S. Ginn
University of Lethbridge
Master of Science in Nursing Student
(403) 382-7119

Appendix C

Consent Form

(Insert Date)

Dear *(Insert Potential Research Participant's Name)*:

You are invited to be in a study about health in your family and community.

The interviews will be done by myself, taped and then written down. How many times you want to be interviewed is up to you. You may stop coming to the interviews any time you want to.

There will be no danger related to this research and your privacy will be protected. The interviews will belong to your group (kept by your community representative) once they have been written down. The interviews will NOT have your name in them. Words from the interviews that you think would let others know who you are will be taken out, unless you would like your name to be in the study.

The typed interviews will be locked safely at the University of Lethbridge, and only I and my supervisor will be able to see them. Your community representative will be given a copy of the typed interviews so you can read them when you would like. All the information kept at the University of Lethbridge will be destroyed after 5 years time.

The results from this study may be shared in writing in journals read by nurses and other health workers, or in speaking at conferences or in classrooms. It will help them to know how to work toward health goals you have for your families and communities.

If you want to know more about this study, or would like to speak to me or my supervisor, please call Carla Ginn or Judith Kulig at 403-382-7119 at the University of Lethbridge. If you have any other questions regarding your rights as a volunteer in this research, you may also contact the Office of Research Services at the University of Lethbridge at 403-329-2747.

I have read (or have been read) the above and want to take part in this study.

_____ (Printed Name)

_____ (Signature)

(Date)

Adapted from:

<http://www.uleth.ca/rch/funding/forms/Human%20Subject%20Research%20Sample%20Letter%20of%20Consent.doc>

Appendix D

Questions for Interviews

Research Questions:

- (1) What does health mean to you as an urban First Nations grandmother?
- (2) How do you promote health in your families and communities?

Guiding Questions:

- (1) What are some ways that you try to be healthy?
- (2) How does your spirituality help you to stay healthy?
- (3) What are some things you do with your families to help them stay healthy?
- (4) What are some things you do in your communities to help them stay healthy?
- (5) Are there any changes that you think could be made within Chinook Health region to increase health for your selves, families, and communities?

If the grandmothers guide the study in a different direction, such as health for teens and youth, or diabetes, or menopause, or pregnancy; these questions may not be used, or may be altered to fit the topics the grandmothers identify as important to them.

Appendix E

Additional Questions for Interviews

These were emailed out a week before the March 10th interview:

Here's some more questions you might like to think about before the next group.

1. What are some things you do with your families to help them stay healthy?
2. Are there traditional ways or roles of healing you would like to pass on to your children?
3. How do you pass your knowledge on to your families?
4. How is your health connected with the health of your families and communities?
5. How have your own health challenges made you a stronger person?
6. How have your own health challenges helped your family stay healthier?
7. What are your strengths as a grandmother that you share with your families?

These were emailed out a week before the April 9th interview:

Here's some more questions you might like to think about before the next group.

1. How have your past experiences made you stronger? How do you pass this knowledge on to your families?
2. What are your thoughts on aging, on menopause?
3. What are some more experiences you have had with the medical system? In the hospital?
4. How do your families help you stay healthier?
5. How is your knowledge a strength? Do your families know all you have to share with them?
6. How do you maintain a positive attitude in your life?

Appendix F

Steps in the Research Process

Sept. 2007	Considering a topic	Literature review regarding identified important areas of further research in health as urban First Nations people, health needs of women and children, as well as the role of First Nations women in healthy living.
Sept. 2008		Investigating the possibility of a study with the community representative for Aboriginal seniors, asking her if it would be appropriate and helpful, who would be interested, what would be “good” questions.
Oct. 2008	Choosing a method	Qualitative approaches seemed most fitting, with participatory action research (PAR) demonstrated throughout the literature as an appropriate method involving a “marginalized” population.
Sept. 2008	Remaining flexible	Plans to complete the required classes the first year were achieved while plans to conduct interviews and write the second year stretched out over 18 months.
Nov. 2008		Plans to meet with the First Nations Community Association (FNCA) were delayed by a month as the first scheduled meeting the room was not available. This was somewhat stress-relieving as we stood in the hallway visiting informally, and met a month later.
Jan. through April 2009		Plans to complete group interviews followed by individual interviews were altered as participants’ availabilities changed due to illness and life circumstances.
June 24, 2008	Presenting the proposal	A power point presentation was e-mailed to and discussed with the community representative. It was then presented to my University of Lethbridge supervisory committee and interested attendees. The power point presentation was not presented to the FNCA, as the community representative recommended a more personal and informal style of presentation.
July 30, 2008	Obtaining ethical approval	An application was submitted to the University of Lethbridge, Research Services, Human Subject Research Committee. Following approval of the study, including information sheet, letter of invitation, consent form, and questions for interviews; these were presented to the FNCA. If the FNCA had not given their approval to the study, I would not have continued with it.

Feb.2009	Requesting a revision	Revised consent forms were developed and submitted to the University of Lethbridge, Research Services, Human Subject Research Committee in order to give the grandmothers copies of their tapes. After much discussion, the grandmothers decided they did not want to possess the tapes themselves, only the transcripts (which I transcribed without including their names), therefore these revised consent forms were not used.
Jan. through April 2009	Conducting the interviews	<p>Two tape recorders (with a good supply of batteries) were used in order to keep the flow of conversation intact when changing tapes.</p> <p>A comfortable place to conduct the interviews was essential and the suggestions of the grandmothers were followed.</p> <p>The community representative (and occasionally myself) provided transportation for the interviews. Food was ordered from local restaurants for the interviews, with extra ordered each time and containers brought for take-home portions as suggested by the FNCA members. The grandmothers suggested meeting to make stew for the interviews as they became more comfortable with the process. They wrote out a recipe and I brought the ingredients to our meeting place where we worked on it together. One of the grandmothers made and brought bannock for the interviews.</p> <p>The time and place of the first interview was decided by one of the FNCA members, who also had decided to be a participant in the study. The times and places changed according to the suggestions of the grandmothers and the community representative (and the need for a kitchen to prepare the stew).</p>
Jan. through April 2009	Transcribing the interviews	I performed the transcribing myself and found that the group interviews took longer to transcribe than the individual interview. Having 2 sets of tapes was invaluable, during one interview (as I was stirring the stew) one of the tapes was turned over and the machine's "play" rather than "record" button was pushed by one of the grandmothers. A whole blank side of tape in one set was recorded on the other set. There were 350 pages of single-spaced transcripts.
Jan. through April 2009	Summarizing and preparing further questions	Transcripts were provided to the community representative for distribution to the group after each interview. Requests were made for a summary to avoid the lengthy reading, and I provided these for each transcript after that point. At the beginning of each interview the grandmothers were encouraged to share comments or thoughts about the transcripts. One of the grandmothers asked for more questions

before each interview; these were provided to the community representative with the transcripts and summaries for distribution.

Jan. through June 2009	Reading the transcripts	I read the transcripts repeatedly, highlighting key statements and themes relating to health and health promotion in each transcript. I then noted similarities across the interviews. Re-reading the transcripts occurred often throughout the writing process.
June 2009	Checking the transcripts	My supervisor read the transcripts and we compared key statements and themes. These were also compared with the community representative.
June 2009	Developing key statement cards	Paraphrases of key statements were printed in large letters on the front of recipe cards with the entire key statement itself, including the interview and page number identified on the back of each card for cross-referencing. This cross-referencing was invaluable when determining the context of a key statement in the data analysis process with the grandmothers, and as I later wrote about key statements the grandmothers had chosen.
June 2009	Data analysis with the grandmothers	<p>Two meetings were held in order for all the grandmothers (one was unable to attend either due to illness) to assist in development of themes and choosing of key statements most meaningful to them.</p> <p>I had printed 556 key statements on recipe cards (106 of them about residential schools which I had in a separate pile). I laid the cards out on large tables, the grandmothers circulated throughout the room, picking out the cards most important to them. They organized these cards under sticky papers attached to the walls around the room naming themes connected to health and health promotion. The grandmothers called out some of the names for themes and I called out some of the names for themes. At the first meeting, 12 themes were created.</p> <p>I prepared for the second meeting by placing each theme on the walls and laid out all the cards under each theme that the grandmothers from the first meeting had chosen. The remaining cards were laid out on a central table, with each grandmother choosing the ones with most meaning to her. This group decided to create another theme, that of dreams and intuition; 13 themes were identified in total. The grandmothers decided not to look through the residential school statements, rather requested that I weave them throughout the paper as they have affected every aspect of health. There were then 450 possible key statements for the grandmothers to choose from, in total, they picked 129.</p>

