RUPTURE, DEFRAGMENTATION & RECONCILIATION: 
RE-VISIONING THE HEALTH OF URBAN INDIGENOUS WOMEN IN TORONTO

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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ABSTRACT

This doctoral research seeks to advance understanding about what impacts the health and well-being of urban Indigenous women in Toronto, Ontario, Canada. It is grounded in the goal of centering Indigenous women’s knowledge and revitalizing recognition of Indigenous women as leaders in the care of health knowledge, who continue to carry roles and responsibilities as knowledge and vision keepers, healers, helpers and caregivers despite the mass devastation caused by colonization.

Utilizing an Indigenous research method, research circles and interviews were used to gather knowledge with twenty-three Indigenous women asking the following questions: 1) What helps you to be healthy and well here in the city? 2) What gets in the way of your health and well-being? and 3) What do you envision as needed to support your health and well-being and that of Indigenous women generally here in Toronto? The findings of the research highlight the ways in which women seek wholeness and (w)holistic health care and services in attending to their health and well-being. The stories shared speak to the rupture and fragmentation caused by colonization as experienced by the participants, specifically the disconnection and dislocation that they
faced due to child welfare apprehension, adoption or violence, while emphasizing the ways in which they have or are presently navigating these challenges in relation to their health and well-being – a process of defragmentation.

This thesis is also, in part, the story of how I am learning my role as a caretaker of knowledge (as I would describe the role of researcher), learning how to gather it, care for it and share it back in a good way. It is the story of what I know now, a knowledge that will continue to grow over time, with more experience to better understand the full beauty and depth of what has been shared. This thesis is a knowledge bundle of stories gathered with urban Indigenous women in the city of Toronto to help better understand what impacts their health and well-being, and what they see as needed moving forward. It is woven together with my own story of who I am, where I come from and why I came looking for this knowledge.
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DEFINITIONS AND USE OF LANGUAGE

**Indigenous**
Indigenous is used here as an umbrella term to refer to First Nations, Métis and Inuit peoples.

**First Nations**
First Nations refers to the Indigenous peoples of Canada who are not Métis or Inuit. In the context of legislation, First Nations peoples are referred to as “Indians”. The term First Nations includes both status and non-status Indians.

**Inuit**
Inuit peoples are the Indigenous peoples of the North. The traditional lands of the Inuit, referred to collectively as Inuit Nunangat, stretch across the Northwest Territories (Inuvialuit), Nunavut, northern Labrador (Nunatsiavut) and Quebec (Nunavik), and Inuit cultural practices and traditions vary across regions and communities (Inuit Tapiriit Kanatami, n.d.; Pauktuutit, 2006a). While the vast majority of Inuit peoples continue to reside in the North, a small but growing number of Inuit peoples are opting to live in urban centres in southern Canada (Pauktuutit, 2006a). The introduction of trade posts, Christian missions (including residential schooling) and RCMP authority in the North, contributed to rapid changes in Inuit cultures. Additionally, agendas of national defence and access to natural resources (e.g. mining) also led to forced relocation for several Inuit groups (Bjerregaard & Young, 1998). Similar to First Nations peoples, disconnection from traditional lands, foods and practices, as well as in the introduction of European diseases, cultures, religions and authority have caused dramatic damage to the health and well-being of Inuit peoples (Bjerregaard & Young, 1998). Although Inuit peoples constitute the smallest portion of urban populations across Canada, the urban Inuit population in the south is rapidly growing. Between 1996 and 2006, the southern urban Inuit population increased by 60% (Canada Council for Aboriginal Business, n.d.).

**Métis**
According to the Métis National Council (n.d.), the Métis peoples originate from relations between Indian women and European men, resulting in distinct cultural and linguistic traditions, and traditional settlements primarily based in western Canada. Métis peoples have historically been disparagingly referred to as “half-breeds”, and have long struggled for recognition as a unique cultural group in Canada. In the Powley decision, the Supreme Court of Canada upheld the traditional hunting rights of the Métis, which has substantially served to affirm the
distinct histories, traditions and practices of the Métis peoples. Approximately 60% of Métis people reside in urban centres (Métis National Council, n.d.).

**Indigenous versus Aboriginal**

Like Absolon (2011) and Baskin (2011), I am using the term “Indigenous” within my writing to refer to First Nations, Inuit and Métis peoples. While the term has typically (and in my own previous writings) been to refer to original peoples in the global context, and the term “Aboriginal” to refer to the original peoples in the Canadian context, I am following the movement towards the favoured use of “Indigenous” as demonstrated in the work of Absolon (2011), Baskin (2011) and Hart (2009). It is used, at some points, interchangeably with “Aboriginal” and “Native”, however, I have tried to my best to emphasize the use of Indigenous in favour of the standard term of Aboriginal in response to feedback from a research participant who objected to the use of the official legal but government imposed term “Aboriginal” and instead asserted a preference for the use of Indigenous.

In speaking about Indigenous ways of knowing and being, or Indigenous worldviews, values and practices, I am speaking from what I know in my own knowledge and experience as an Anishinaabekwe. I try locate where my teachings and understandings have come from as clearly as possible as part of my intention of diligently respected the diversity of Indigenous histories, knowledge(s) and practices on Turtle Island and not erasing this diversity through pan-Indigenous or pan-Aboriginal approaches. To this extent, I also make efforts to identify Indigenous scholars with their Nation throughout the text as a way of demonstrating the range of identities and perspectives, and the increasing presence of Indigenous scholars in the areas of social work and health.

**“We” and “Our”**

I use the terms “we” and “our” to demonstrate that I am not separate from other Indigenous peoples and certainly not from other Indigenous women here in Toronto. At the same time, I use this kind of language with great consciousness to not pretending or inferring that my experiences are the same as or that I can speak for every other Indigenous person. I am responding to the writing of Maori scholar Linda Tuhiwai Smith (1999) who offers warnings of the dangers of writing for Indigenous scholars and the challenges to not “write about ourselves as indigenous peoples as if we really were ‘out there’, the ‘Other’, with all the baggage that this entails.” (p. 36).
(Self) Location, location, location

Who are you and where do you come from? These are common greeting questions asked among Indigenous peoples when we meet each other. It locates us to the places, people, Ancestors and traditions we come from; it often includes conversations about our clans, traditional names and roles in our communities. It can bring forward stories of cultural dislocation, familial disruptions forced by colonization, disconnection from land base and language, and at the same time, the stories of journeys back to self, to memory, history, family, community and culture. Stories of the paths to knowing and being, to healing, health and well-being.

This thesis carries forth stories of Indigenous women in the city of Toronto speaking to what impacts their health and well-being and what they envision as needed to support the health and well-being of Indigenous girls and women here in the city. I locate myself – who I am, where I come from – in the context of the story of how I arrived at this research. This is a way of grounding myself and the knowledge I am sharing, and of providing a context for my intentions, motivations and relationship to the research. It follows Indigenous practices in research and the care of knowledge by acknowledging that what I know is shaped by and continuously interwoven with my identity, my history, my Ancestors, my relations and by what I have experienced in this life so far (Absolon & Willett, 2004; Kovach, 2010). It inherently prioritizes relationality in recognizing my respect for and responsibility to be visible and accountable to the Ancestors, to community and to those who are yet to come.
Who we are matters to how we know and what we do. Situating who we are and where we come from provides a context for people to understand us, our words and our actions more fully. It extends beyond our individual selves to bring forward our relations (those who walk with us, those who came before us, those who will come after us) and at the same time locates us in the broader realm of temporality (the past, the present and the future). In research, locating oneself in this way is a necessary act of transparency, setting out how you relate yourself to the research question and to the research participants, and making clear your intentions and motivations (Kowalsky, Verhoef, Thurston & Rutherford, 1996; Weber-Pillwax, 1999). Given the significant and prolonged history of colonizing and exploitative research in Indigenous communities, the importance of centering and re-centering transparency, respect, responsibility and accountability in research with Indigenous peoples cannot be overstated. This is true for both non-Indigenous and Indigenous researchers alike, as the colonial history of research has left a legacy of suspicion and distrust for all researchers whether they belong to an Indigenous community or not (Absolon & Willett, 2004). Speaking about who I am, where I come from and why I came to this research is my responsibility as a researcher, or as I would describe my role: caretaker of knowledge, to make myself, my intentions and motivations visible to those around me. My research is not separate from me, my family or my community, and the seed of its existence is held close to my heart. Chickasaw scholar Eber Hampton’s (1995) writing implored me to recognize, value and care for the role of my heart and my emotions in research:

“One thing I want to say about research is that there is a motive. I believe the reason is emotional because we feel. We feel because we are hungry, cold, afraid, brave, loving, or hateful. We do what we do for reasons, emotional reasons. […] Emotionless, passionless, abstract, intellectual, academic research is a goddam
lie, it does not exist. It is a lie to ourselves and a lie to other people. Humans – feeling, living, breathing, thinking humans – do research. When we try to cut ourselves off at the neck and pretend an objectivity that does not exist in the human world, we become dangerous, to ourselves first, and then to people around us.” (p.52)

My name is Billie and the traditional name I was given means Sun Comes Up Woman. It was given with a job of gathering old knowledge and bringing it forward. I am a mixed race (Anishinaabe – Chippewa/Algonquin, white – German, Dutch), Two-Spirit Anishinaabe-kwe, Turtle clan from Sharbot Lake, Ontario. Sharbot Lake is named after Francis (Kanien’kehá:ka) and Mary Sharbot (Algonquin), who came from Lake of Two Mountains (Quebec) and settled in the area in the early 1800s. My own family, the Antoines (Anishinaabe Chippewa/Algonquin), has similarly been in the area since at least the early 1800s and before that, Lake of Two Mountains. I am the daughter of Sue Jackson (nee Strack, nee Ladouceur, nee Vinkle) and Bill Hollywood (nee Strack). I walk with my grandmothers, Donna (Sally) Ladouceur (nee Badour) and Fay Stevenson, my Papa, Cecil Hollywood, and my great-grandmothers Mary Ada Badour and Ethel Antoine, all of whom watch over me from the spirit world. I am the niece of Donna, Sandra, Jo-Anne, Mary-Lou, Ronnie, Wayne and Christine, and the incredibly proud mother of Emma and Larkin. My family also includes many adopted along the way who have loved and shared their knowledge with me and with my daughters. I write with all of these loved ones in mind and heart, and with all of my Ancestors looking over my shoulder. I write with the intention of honouring the knowledge and lived experiences of the phenomenal women who so generously shared their stories with me, and with the

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1 I was raised to know the Sharbots as Kanien’kehá:ka, though this is contentious among descendants – some identify as Kanien’kehá:ka, while others identify as Algonquin and are registered through the Algonquins of Pikwakanagan (Golden Lake)
aim of lifting up their voices and visions to advance the health and well-being of our girls and women here in Toronto.

I left home at sixteen. It was the earliest that I could leave and legally be on my own. I left to escape a childhood of abuse, repeated, unrelenting sexual abuse. This childhood of abuse was not separate from a childhood of love that I received from my grandmothers, my mother and my aunties, nor from the love that I experienced in being connected to the land – a childhood spent lingering among the trees, the reeds, the water…finding and following turtles and toads, fish, snakes, porcupines and baby birds. In terms of health, there has, since I was a baby, primarily been one longstanding physician in the community who I always experienced as curt and judgmental. It seemed apparent to me that if he did not like you, or your family, you would not be treated well. In my child and subsequently adolescent mind, healthcare was not something that I felt was characterized by kindness, care or choice.

When I left home, I moved to the nearest city and have lived in cities ever since. I came to Toronto in 2001, following my then partner who came for work. My first born daughter was not quite two when we came to Toronto and my second was born here, notably with the incredibly nurturing care of the Seventh Generations Midwives of Toronto (SGMT), an urban Indigenous midwifery practice. Despite my frequent pretending otherwise, my children are urban creatures…not raised in the woods and waters of Sharbot (though they are no strangers to it), but in the concrete, loud noise and sharp pace of downtown Toronto. And I, despite my protests, can no longer pretend that I am not fully urbanized or that I am only ‘visiting’ Toronto as I would often assert in conversation in some attempt to try to protect my sense of connection to home and my
remembering of something different than city life. As I have reconciled our lives as an urban Indigenous family, so too have I turned my mind to think about our health in the context of the city – but not by accident. It was in 2005 as I was received into the care of the SGMT midwives, welcomed without incident as a non-status First Nations woman, without incident as a survivor of trauma, and without incident as a woman afraid of medical care and, at times, of my own body. Moreover, I did not have to explain my cultural understandings of pregnancy and birth, or my desire for cultural practices in relation to my care and the care of my baby. In fact, my identity and culture were unquestionably placed at the centre of the care I received from SGMT. It was a remarkable, humbling and beautifully healing experience.

While I had been able to access midwives in my first pregnancy, I did not feel able to disclose my history of sexual abuse until nearly a week before my daughter was due to be born. I was young and scared. Terrified, in fact. I asked the midwife if she might be able to deliver my baby without touching me, or more specifically, touching my vagina. I think it was truly a stunning request and looking back now, I admire that she managed not to laugh at me. Instead, she handed me a book written by an Indigenous physician and traditional healer named Lewis Mehl-Madrona\(^2\). The book highlighted the differences he saw in approaches to health care between western biomedical and Indigenous approaches, and particularly relating to child birth, he outlined how western approaches almost acted as if the woman was an object or not even present during birth. Further, he noted the complex layers of challenges that impact Indigenous peoples’ well-being and how we engage with western medical systems. The book was

helpful to me, in beginning to realize how the trauma I had experienced had shaped my relationship to myself, my body, my sexuality, my pregnancy and to my sense of voice – or rather, to my voiceless-ness.

While I was busy reading, my daughter was busy turning herself about into a breech position. She managed to get one foot down and break her waters resulting in an emergency c-section. The midwife never received the emergency page and so my birthing experience was not only in hospital instead of home, but also led by a physician instead of a midwife. I was not allowed to have anyone support me in the room while the anesthesiologist taught his student, with many attempts, how to insert an epidural needle into my spine, and no one in the delivery room spoke to me while they were cutting a way to my baby and pulling her from my body. It was a difficult, disconnected and upsetting experience. I was once again finding myself telling a story of health care as a space without kindness, care or choice.

When the midwife finally reached the hospital, Emma was already making her peace with the work of breathing oxygen and nursing at my breast. The midwife laughed heartily and said “I knew you’d find a way to have that baby without anyone touching your vaginal!” I couldn’t really put together then how much my baby and my body had conspired to create the birth I had asked for, though not in the way I had imagined. As I prepared for the birth of my second daughter, I was required to attend an obstetrics consultation about my plan for a VBAC (vaginal birth after caesarean). The obstetrician, along with her student, informed me diligently of the risks of VBAC and stated several times that she wanted me to make the best choice for the safety of my baby. Having had the support of the SGMT midwives to really think about what I wanted for my birth, I
was able to respond with references from a stack of peer-reviewed medical journal articles about how the risks of VBAC are, at worse, over exaggerated, and at best, based on research with inconsistent measures that were not even necessarily validated. I could advocate for myself because the midwives had supported me in having a voice in my care, in really feeling and thinking about what would help me and my baby as we journeyed through pregnancy and birth, what would be healing for me. Weeks later as I laboured through a natural child birth with my midwife at Women’s College Hospital, I was again able to advocate for myself with the on-call obstetrician who came into the delivery room to express his concern about my plan for VBAC and remind me of the importance of thinking about what was best for my baby and not wanting to ‘hurt’ my baby. Larkin was born easily, though not painlessly, with no injury to herself or to me. As the midwives weighed the baby and prepared tea to celebrate the labour, I began to really feel the full beauty and relief of having experienced kindness, care and choice in a medical setting.

In the months that followed I worked with SGMT helping out postnatal programming. I started to think a lot about the experience of having that kind of care – the kind in which I felt I could have a voice and that it would be heard, in which I could be supported in ways that not only acknowledged or respected my culture, but supported my Indigenous ways of knowing and being. I could begin to think about the possibility of speaking up for myself with my family doctor, and of asking for things that I wanted or needed from her or other healthcare providers. I couldn’t immediately translate my experience from midwifery directly into some new magical way of being or some form of super confident self-advocate. In fact, I still have to work on using my
voice each and every time I begin to think about or act on my needs and concerns in relation to my health and well-being. I know that this struggle with voice is part of my walk through this life. Regardless, I wondered what it would mean if our girls and women could have that experience of meaningful, culturally relevant care that promoted self-determination; how would it impact not only our health and well-being, but our sense of our ability to navigate health systems in order to gather the knowledge, care and resources needed for our health and that of our families? This question was the seed of my research and it was fittingly birthed by midwives in the incredibly healing care they provided for me and the ways in which that care transformed how I thought about myself, my health and the experiences of Indigenous women in caring for our health and well-being.

I have storied myself in here so that you can see me, my thoughts, emotions and actions in the research within the context of my story. On one hand this is an act of ethics, as Kovach (2010) asserts that “[w]e need to know our own research story to be accountable to self and community” (p. 120). On the other hand it is a way of demonstrating rigour in Indigenous research by locating the knowledge I am sharing within a context of history, place, relationships and self. In this way, I am following Maori scholar Graham Smith (as cited in Kovach, 2009) who argues that subjectivity is in fact a more honest position:

“I wrote my personal story at the front of my thesis in order to lay bare my biases and cultural nuances, preferences, [and] prejudices. This is, all the things that make me up as a Maori academic, and that contribute to constructing my worldview and my perspective. In this way I am saying, ‘Well, this is me, I am trying to be neutral, but I can’t be because I am Maori. I am trying to be objective but I can’t be. So this is me, warts and all. The onus for issues of objectivity and neutrality are for you, the reader, to work out. You can read my text against
knowing my personal background and then make up your own mind about the validity and legitimacy of my arguments.” (p. 90).

This thesis is also, in part, the story of how I am learning my role as a caretaker of knowledge (as I would describe the role of researcher), learning how to gather it, care for it and share it back in a good way. It is the story of what I know now, a knowledge that will continue to grow over time, with more experience to better understand the full beauty and depth of what has been shared. I understand this thesis as a knowledge bundle of stories gathered with urban Indigenous women in the city of Toronto about what impacts their health and well-being, and what they envision as needed to support the health and well-being of Indigenous girls and women here in the city. It is woven together with my own story of who I am, where I come from and why I came looking for this knowledge.

This bundle belongs first to our women and through them, to their families and to our community. Part of it is shared here in this thesis as a means to demonstrate my accountability to and my application of learning from the doctoral program in social work at the University of Toronto. The bundle will continue to be shared back to the community long after the thesis process is finished, through community gatherings and access to agencies such as the Seventh Generation Midwives of Toronto (SGMT), the Native Women’s Resource Centre (NWRC) and the Native Youth Sexual Health Network (NYSHN). Further, I intend to explore and undertake creative means of sharing back the knowledge gathered with community including film-making and other arts-based community knowledge translation and mobilization (e.g. quilting, beading, photography, etc.). The bundle is also meant to be shared with those who serve or work alongside our women towards improving their health and well-being. This includes
but is not limited to health and social service providers, students, trainees, and educators in health and social service professions, policymakers and funders.

**Situating my entrance into urban Indigenous women’s health research: Making peace with myself, making peace with research**

**The stories we tell**

*I am in a room full of Indigenous women gathered to share knowledge and generate strategies and actions towards ending the pervasive Canadian silence on the mass deaths and disappearance of our girls and women. As Grandmother Lee Maracle says, we are here with the intention that our granddaughters and great granddaughters will not have to gather here to have this same conversation. There are family members here who have lost mothers, daughters, nieces, cousins. Some who they know have made their journey to the Spirit world and some who they still hold wrapped in the light of hope that they will come home. It is a deep, throbbing heartache that crosses generations and geography. This ache is here today but it is not alone. The room is also filled with laughter, respect, love and kindness, courage, memory, determination, honesty, wisdom and truth. We are connected to each other, to those who have journeyed on and those who are yet to come, to land and to water…to All Our Relations. In this room I know a beauty and a strength that is incredibly powerful and healing and it’s in our women.*

Beauty and strength, this is how I know our women and the power of their knowledge. Thomas King (2003) writes that “[t]he truth about stories is that that’s all we are” (p.153). He further cites the words of Nigerian storyteller Ben Okri who explains that:

“…we live by stories, we also live in them. One way or another we are living the stories planted in us early or along the way, or we are also living the stories we planted – knowingly or unknowingly – in ourselves. We live stories that either give
our lives meaning or negate it with meaninglessness. If we change the stories we live by, quite possibly we change our lives.” (as cited in King, p.153)

I have held the words of both of these writers close to my heart and mind as I have moved through the doctoral program – as I read, as I wrote, as I taught and as I set out on the journey of this research. I carried these words as teachers and reminders of the power of the stories we tell, first to ourselves and then to others. These teachers are profoundly important to how I situate and begin to speak about urban Indigenous women’s health, which is from a place rooted in beauty, knowledge, healing and power.

This was sharply reinforced while I was working for the Native Women’s Association of Canada (NWAC) on a project exploring abuse of senior Aboriginal women and was gifted with teachings from our project’s Community Advisory Committee. The project was meant to understand how Aboriginal women understood senior abuse, their experiences of it (personal or witnessed) and what they saw as needed to stop abuse of our seniors and Elders in our communities. I was seeking the guidance of the Committee in how to phrase questions about abuse to participants, given the extensive historical, intergenerational and structural trauma experienced within our communities and given the ill reputation of research with Indigenous peoples. One of the committee Elders, Grandfather Grafton Antone (Oneida), explained that across our diverse Indigenous traditions we do not simply stare at or focus on what is wrong, but move towards and embody what it is we wish to see or be. As such, he suggested that the questions focus on what helps keep the grandmothers safe and well and what else they thought was needed to improve safety and well-being for our grandmothers and grandfathers. This set forth a process of gathering knowledge that implicitly recognized the agency and knowledge of grandmothers and communities in
terms of what they were already doing to address senior abuse, as well as recognizing their roles as visionaries and leaders in identifying what was needed to address senior abuse moving forward, for this generation and generations to come. It was a foundational recognition of the power of our women and their knowledge.

I call forward that story as helper here in order to begin from a place in which urban Indigenous women’s health is located first within the context of our agency, knowledge, strength and beauty. This does not obscure or minimize the extraordinarily disproportionate burden of illness, disease or marginalization faced by Indigenous women in Canada, but it resists it as being more than one part of the story. It recognizes my realization that every grant proposal and policy document I had written in my work life was underpinned by a tacit understanding that in order to merit funding or policy attention I had to first situate just how bad things were for Indigenous women. Every document began with a single story of illness, disease, risk, harm and violence that Indigenous women in this country are more likely to face. It became evident to me that our ability to receive funding or support from policymakers was based heavily in our suffering and not in our humanity. With Grandfather Grafton’s words written on my heart, I chose to begin here by emphasizing the strength, beauty, wisdom and agency of our women.

Anishinaabe Grandfather Art Solomon (1990) wrote about the centrality of our women and the importance of our well-being to that of the collective: “[t]he woman is the foundation on which nations are built. She is the heart of her nation. If that heart is weak, the people are weak. If her heart is strong and her mind is clear, then the nation is strong and knows its purpose. The woman is the centre of everything.” (p. 14). This
research distinctly focuses on the health and wellbeing of urban Indigenous women with a recognition of the interconnectedness between our health and well-being that of our families and communities.

**Making peace with research**

“Aboriginal and non-Aboriginal researchers who tackle any facet of Indigenous study accordingly must have a critical analysis of colonialism and of research methodology as an instrument of colonization. In addition, we [as Aboriginal researchers] must learn, know and live our own Indigenous epistemologies, genealogies, traditions and cultures.” (Absolon & Willett, 2004, p. 12)

Deciding to do research felt like taking the deepest breath….a deep inhalation of knowing that the path would be long and require much courage. That being a researcher in the Indigenous context was like taking on an apprenticeship in the discipline of responsibility. It required gathering and care of multiple forms of knowledge long before coming near a single research participant: knowledge about myself, my own history and the broader histories of Indigenous peoples; knowledge about the history of research in, or rather “on”, Indigenous communities; knowledge about Indigenous research principles and practices; and knowledge about urban Indigenous women’s health. I understand from the teachings of my Grandma that this learning did not cease because my research began, but that it will continue throughout my entire life. This thesis is only a story of what I understand so far, a story that will continue to grow as I do.

Research has long been a dirty word in Indigenous communities, one associated with theft, deception and loss (Smith, 1999). Research was unethically and inaccurately used to establish the supposed inferiority of Indigenous peoples, providing a basis for or legitimizing legislation and enforcement mechanisms designed to entrench the rights of
settlers, and to extinguish Indigenous peoples or grossly limit their rights, movements and access to resources (Absolon & Willett, 2004; Smith, 1999; Wilson, 2008). Research has been used to establish “the truth” about colonial histories, institutionalizing western ways of knowing as the standard by which all other forms of knowledge are assessed (Absolon, 2011; Smith 1999). Western research not only governs notions of ‘discovery’ but also notions of ownership and control of knowledge and resources. For example, the ‘discovery’ by western researchers of Indigenous medicinal practices, that then become patented pharmaceutical formulas – legally enforceable means of capitalist advancement for western researchers and societies at the expense of Indigenous peoples (Battiste & Henderson, 2000).

In Canada, an explicit acknowledgement of the troubled role of research in Indigenous communities is written into the preamble of *Chapter 9: Research Involving the First Nations, Inuit and Métis Peoples of Canada* in the second edition of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS 2), which states:

“Research involving Aboriginal peoples in Canada has been defined and carried out primarily by non-Aboriginal researchers. The approaches used have not generally reflected Aboriginal world views, and the research has not necessarily benefited Aboriginal peoples or communities. As a result, Aboriginal peoples continue to regard research, particularly research originating outside their communities, with a certain apprehension or mistrust.” (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council Canada & Social Sciences and Humanities Research Council of Canada, 2010, p. 1)

The Chapter also more specifically references examples of the harmful impact of research in the Aboriginal communities in the Canadian context:

“In the case of Aboriginal peoples, abuses stemming from research have included: misappropriation of sacred songs, stories and artefacts; devaluing of Aboriginal
peoples’ knowledge as primitive or superstitious; violation of community norms regarding the use of human tissue and remains; failure to share data and resulting benefits; and dissemination of information that has misrepresented or stigmatized entire communities.” (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council Canada & Social Sciences and Humanities Research Council of Canada, 2010, p.2)

These acknowledgments are significant given that the TCPS 2 provides the ethical guidelines for all research funded by the Tri-Council representing the three major research funding sources in Canada: the Canadian Institutes of Health Research (CIHR), the Social Sciences and Humanities Research Council (SSHRC) and the Natural Sciences and Engineering Research Council of Canada (NSERC). I had, in the course of my previous work with the Native Women’s Association of Canada, the opportunity of witnessing and participating in the revisions to Chapter 9 in the second version of the TCPS, which were guided by the tremendous leadership and vision of Kanien’kehá:ka Grandmother Marlene Brant-Castellano (notably a social worker). The revisions to Chapter 9 were made with great attention to the protection of Aboriginal peoples from ill-intended or ill-informed researchers. They emphasize respectful, balanced relationships which prioritize, support and promote Aboriginal community engagement, control and decision-making in the research process. The chapter stresses the need for mutual benefit (reciprocity), including the responsibility to and importance of enhancing Aboriginal research capacity.

Awareness of and apprehensiveness about research certainly informs contemporary Indigenous researchers and research practices. However, Indigenous research is not merely a creature of reaction to historical and ongoing colonial research practices. Indigenous people have been gathering and applying knowledge for thousands of years, employing our own means and methods of documenting,
measuring, analyzing and carrying forward information (Absolon & Willett, 2004; Absolon, 2011; Deloria, 1995; Smith, 1999). I have emerged into the world of contemporary Indigenous research at an incredible time in which there are rapidly increasing writings, texts, conferences and even courses of study outlining Indigenous research methodologies, epistemologies and theoretical frameworks (see for example: Absolon & Willett, 2004; Absolon, 2011; Baskin, 2005; Battiste & Henderson, 2000; Ermine, 1995; Hampton, 1995; Kovach, 2009; Lavallee, 2009; Sinclair, 2003; Smith, 1999; Weber-Pillwax, 1999, 2001; Wilson, 2008). I am deeply aware of how much my path through academia has been made possible, easier, and passable by those who have come this way before me. I do not have to bear the task of explaining into existence Indigenous peoples or Indigenous ways of knowing and doing, including Indigenous research methods. I do not have to justify or demonstrate the worth of Indigenous ways of knowing, being and doing according to the standards of western rationalism and empiricism.

I can begin from who I am and where I come from, I can stand peacefully in the context of my Ancestors, of All My Relations. I can articulate with confidence my recognition of knowledge as coming not just from the head, but also from the realms of the heart, body, spirit and land. This is as it was, before colonization. Indigenous epistemologies and ontologies are increasingly being pulled forward, remembered, reclaimed, revitalized and renewed. This was the job given to me with my traditional name – to gather old knowledge and bring it forward and I am happily and spiritually employed.
“Social worker” and “researcher” are quite possibly two of the most despised occupations among Indigenous peoples, both replete with histories of deception and theft. I am trained as both. It was a long and difficult journey to make peace with how to identify as a social worker in community settings in which child welfare had ravaged so many of our families. When I placed social work in an Indigenous lens, I could understand it as the role of a helper – which provided an entirely different orientation to power, relationality, knowing and doing than what I had learned in social work school. It better reflected what I had learned in ceremony, through traditional teachings and through my own lived experience. I have made peace with myself as a social worker, and as I place “researcher” in that same Indigenous lens, I have made peace with myself as a helper whose job is to gather, care for and share knowledge in a good way. Chi miigwetch to all the Indigenous researchers who made a path for those who would follow behind them, chi miigwetch for remembering, resisting, insisting and transforming, chi miigwetch for dreaming forward space for Indigenous students to learn and be without having to be in pieces. Chi migwetch, chi miigwetch, chi miigwetch, chi miigwetch. All My Relations.
CHAPTER 2: LOOKING AT THE PAST IN THE PRESENT FOR THE FUTURE

The following chapter begins with a historical overview of the conditions, policies and practices that have contributed to the contemporary state of Indigenous women’s health in Canada, followed by a review of research literature addressing the health of urban Indigenous women.

I was taught by traditional teachers and Elders to look at the past, in the present, for the future. While this teaching is found in varying forms across Indigenous traditions, it is commonly talked about in the framework of the Seven Generations teaching which guides us to recognize that in making decisions within our lives, the lives of our families, communities and Nations, we must consider the challenges, lessons and wisdom of the seven generations who have come before us, as well as the implications of our choices for the seven generations to come. Who we are and how we are is always in active relation to our past and to our future, and we are tasked to honour both in our decisions and actions in the present. In imagining this research, I held on tightly to this teaching in thinking about where the story of urban Indigenous women’s health begins. This chapter examines the historical context of Indigenous women in understanding the contemporary state of our health and well-being.

At present, Indigenous women face severe and systemic marginalization in Canada. We are more likely to experience poverty, under or unemployment, marginal housing or homelessness, incarceration and violence (Adelson, 2005; CCPA, 2010; NWAC, 2007a; Smylie, 2001). We are also more likely to have lower levels of educational attainment and to contend with weaker community infrastructures than their non-Indigenous counterparts (Adelson, 2005; Benoit et al., 2003; CCPA, 2010; Smylie,
The marginalization of Indigenous women is further evinced by gross disparities in health and well-being. In addition to a shorter life expectancy and higher infant mortality rates, Indigenous women experience a disproportionate burden of illness and disease, with higher rates of diabetes, hypertension, heart disease, cervical and gallbladder cancer, HIV/AIDS, mental illness, substance abuse and suicide (Bourassa, McKay-McNabb & Hampton, 2005; Dion Stout et al., 2001; Gatali & Archibald, 2003; Grace, 2003, NWAC, 2007a). Indigenous women not only suffer poorer health than non-Indigenous women, we also endure higher rates of chronic disease than Indigenous men (Bourassa et al., 2005). However, all of this information can serve to further painful and damaging stereotypes of who we are as Indigenous women if they are not understood in the context of the history from which it has emerged.

The histories of Indigenous people on Turtle Island (North America) did not begin with the arrival of Europeans. To pretend that we were peoples without history and knowledge before settlers arrived is no less ridiculous than imagining that the land itself did not exist before it was “discovered”. Hubl (as cited in Kundera, 1980) states that “[t]he first step in liquidating a people is to erase its memory” (p. 159). Indeed, the histories and knowledge(s) of Indigenous people have been systematically and continuously minimized, denigrated or erased in the context of Canadian education systems (Kempf, 2006). Moreover, the government of Canada, in partnership with multiple churches, intentionally attempted to obliterate Indigenous ways of knowing and being through the program of cultural genocide known as residential schools that lasted more than one hundred years. These efforts to erase Indigenous knowledge(s) and
histories were and remain a fundamental practice of maintaining the Canadian nation state and obscuring the colonial lies and violence on which it is built.

While the colonial history of Canada is relatively ignored in public schools and public discourse, the effects of colonization are undeniable (Kempf, 2006). The intersectional relationship between gender and racialization has compounded the impact of colonization on Indigenous women. Mohanram (1999) describes the role of women in maintaining a nation – quite literally in that women embody the reproduction of the nation through childbirth, but notes that the patriarchal discourses of colonization constructs women as existing without agency. This idea of women without agency directly contradicts the status and roles of Indigenous women on Turtle Island prior to European contact. Indeed, many of First Nations were/are matriarchal, including the Haudenosaunee (Iroquoian) Nations within which women held all property rights, and Clan mothers selected and deposed of leaders (Larocque, 1994). Pre-contact, Indigenous women were understood as sacred and powerful in their multiple roles as “life givers, teachers, socializers of children, healers, doctors, seers and warriors” (Walters & Simoni, 2002, p. 520). These roles were ruptured by a colonial agenda that undermined the power of women, from treaty makers who refused to deal with women to the gendered oppression orchestrated through extensive colonial policies largely embodied in the Indian Act (Stevenson, 2011).

Policy as an instrument of colonization: Examining the impact of Canadian policy-making on the lives of Indigenous women

Indigenous women and the Indian Act

The colonial project of European settlers, aided by Christian missionaries, set about to “civilize” Indigenous peoples by upending traditional governance and cultural
practices and introducing and enforcing European values and norms, including the subordination of women. These efforts were eventually institutionalized in 1876 in the Indian Act, which along with many other human rights violations usurped the role of women in leading, selecting or impeaching leaders (i.e. the role of Clan mothers). This legislation instead installed Band Chief and Council structures in which only men could stand for election, and for which women held no right to vote (Blair, 2005). In fact, Indigenous women were excluded from any form of participation in local government until revisions regarding governance were made in 1951 (Stevenson, 2011).

The Indian Act was absolutely central to the denigration of women’s roles and status within Indigenous societies, as the legislation rooted Indian identity in male lineage: “[a]n Indian was defined as any male person of Indian blood reputed to belong to a particular band; any child of such a person; and any woman lawfully married to such a person” (Furi & Wherrett, 2003). The Indian Act removed the real property rights of Indigenous women and regulated their status such that women who married non-Indigenous men (or non-status Indigenous men) would lose their status, as would their children. In contrast, status Indigenous men who married non-Indigenous women conferred their status onto their wives and children.

The enactment of this legislation entrenched sexism towards Indigenous women and conferred upon them a lower class of citizenship. As Kanien’kaha:ke scholar Martin Cannon (2008) notes: “Indian policy made it so that women were divisible into either/or terms. Women could be either Indians (by marrying Indians) or women (by marrying non-Indians), but not both” (p.5). Cannon (2008) adds that this also positioned Indigenous women’s subsequent fight for rights in conflict with Indigenous peoples’
collective rights, trapping Indigenous women in their struggle to be recognized as both Indian and women. Grandmother Mary Two-Axe Earley, a Kanien'kehá:ka woman from Kahnawake (near Montreal), was a staunch activist in advocating for the rights of Indigenous women who had lost their status by “marrying out”. Not only did these women face eviction from reserves, resulting in separation from their families and communities, they could not even be buried on reserve with their ancestors (Brown, 2003). As Grandmother Mary once noted, her home community of Kahnawake had three graveyards, one for Protestants, one for Catholics and one for dogs (Brown, 2003). While dogs could be buried on-reserve, women who “married out” could not.

**Bill C-31**

In 1985, the federal government passed Bill C-31, rescinding the “enfranchisement” provisions of the *Indian Act* and reinstating those who had lost their status (Daniels, 1998). The purpose of Bill C-31 was to ensure that the Indian Act conformed to Canadian Charter of Rights and Freedoms, specifically section 15 – the equality rights section (Daniels, 1998). In removing the patrilineal line of eligibility, the gender neutral approach taken by Bill C-31 did not simply provide to Indigenous women the same right as Indigenous men to confer status onto their spouses and children. Instead, it placed status men in a position similar to that of status women under the old Indian Act, such that children of status women or men who married non-status or non-Indigenous individuals could not confer their status to their own children if they too married a non-status or non-Indigenous partner (also called the “second generation cut-off rule”) (Daniels, 1998; National Aboriginal Law Section - Canadian Bar Association, 2010).
At the same time, Bill C-31 provided Bands the power to determine their own membership and by-laws, such that those who re-gained status via Bill C-31 would not necessarily be recognized or “re-membered” by the Bands from which their families had originated. Band by-laws determine important issues including who can reside on-reserve (members and non-members), and benefits and protection accorded on reserve (for example, the decision to provide or deny benefits to non-member spouses and children of members living on reserve) (Furi & Wherrett, 2003), all of which can act as social determinants of health for Indigenous girls and women. While reserves are generally portrayed in the media as isolated, rural or remote in location, there are approximately 120 urban reserves in Canada (INAC, 2008), underlining the importance of analyzing the effects of Band-level policy issues in relation to urban Indigenous women’s health.

The irony of Bill C-31, which was framed as a means to restore gender equity for Indigenous women, is that it actually serves to speed the extinction of status Indians – as hundreds of thousands of descendants of today’s status Indians will be disqualified from status rights over the coming decades (Daniels, 1998). Since the federal government has a fiduciary duty to provide for those with status, this effectively helps to decrease their costs and obligations by minimizing the population of status Indians (Daniels, 1998).

**McIvor v. Canada**

More recently, the British Columbia case of *McIvor v. Canada (Registrar of Indian and Northern Affairs)*, has illustrated that Bill C-31 in fact never truly addressed gender inequity. Sharon McIvor is a status Indian, whose husband was non-Indian. While Ms.
McIvor was able to transmit status to her son, her grandchildren would not be eligible for status unless their father married and bore children with a status Indian. The case utilized the example of a hypothetical brother of Ms. McIvor, who had married and bore children with a non-Indian woman (National Aboriginal Law Section - Canadian Bar Association, 2010). The grandchildren of this hypothetical union would automatically be eligible for status. Ms. McIvor was successful in her challenge to the Indian Act, resulting in the federal government agreeing to follow the order of the Court to make amendments to the Indian Act. On January 31, 2011, the Gender Equity in Indian Registration Act came into effect with an anticipated impact of returning status to approximately 45,000 descendants of Indigenous women (Aboriginal Affairs and Northern Development Canada, 2011b).

**Non-insured health benefits (NIHB)**

Status under the Indian Act has direct implications for health as only First Nations people with status and Inuit peoples recognized by an Inuit Land Claim organization are eligible for the Non-Insured Health Benefits (NIHB) program provided through the First Nations and Inuit Health Branch of Health Canada. While the provision of health services is generally the responsibility of the provinces and territories to “support First Nations people and Inuit in reaching an overall health status that is comparable with other Canadians” (Health Canada, n.d.), the roots of the NIHB and the First Nations and Inuit Health Branch lie largely in “medicine chest” clauses of historical treaty negotiations, for example, Treaty 6 references a “medicine chest” to be kept in the home of every Indian agent for the use and benefit of Indian peoples (Haworth-Brockman et al., 2009). Interpretation of the medicine chest clause has long been a
contentious issue between First Nations and the federal government. In application to the NIHB program, First Nations assert this as a right based in the federal government’s fiduciary duty to status First Nations and Inuit peoples, while the federal government frames the program and their provision of health services (for example, Home and Community Care Programs) as voluntary and reflective of federal policy commitments (Haworth-Brockman et al., 2009).

The NIHB program provides coverage for a range of medical goods and services, including specified medical supplies, equipment and transportation, dental and vision care, prescriptions medications, short-term crisis intervention and mental health programming (Health Canada, n.d.). Accessing NIHB, however, presents numerous challenges: the listing of approved services and medications is constantly changing, and some services require on-reserve residency in order to either access the service or program, or receive the funding necessary to access a service or program (Haworth-Brockman et al., 2009; Mother of Red Nations, 2006). The research of Haworth-Brockman et al. (2009) exploring health research, entitlements and services for First Nations and Métis women (focused particularly on the Prairie region), utilizes qualitative interviews with service providers in order to explore the challenges of accessing NIHB. The authors provide several poignant examples, including one in which a service user, unable to afford a costly medication, is asked to provide a letter to the NIHB justifying coverage of the cost. Paradoxically, the medication was for dementia, leaving the service provider to question exactly how someone with dementia could provide a letter to justify their medication needs (Haworth-Brockman et al., 2009). As a matter of policy, the NIHB program outright excludes non-status and Métis women, whose health risks
and access to care are already shaped by historical and ongoing marginalization (Haworth-Brockman et al., 2009; Mother of Red Nations, 2006).

The process of accessing NIHB entitlements is additionally layered with the policies and practices of each individual Band (Haworth-Brockman et al., 2009). For example, the impact of Band level politics on Indigenous women who were re-instated by Bill C-31 has been well documented, as Bands did not necessarily welcome their (re)membership, or provide equitable access to services and resources for re-instated women and their children (Canadian Feminist Alliance for International Change, 2003; Haworth-Brockman et al., 2009; Mother of Red Nations, 2006). Band decisions regarding the allocation of funding occur within a context in which federal funding to the Bands did not increase with the Bill C-31 re-instatements, or with inflation (Furi & Wherrett, 2003). However, a lack of communal resources, or the presence of already strained social conditions such as overcrowding, have certainly not informed all decisions to deny membership or access to resources for Indigenous women. In fact, some rather wealthy Bands have sought extreme measures to deny membership to re-instatees, including the Sawridge Band of Alberta. Activist Susan Huskey (as cited in Vazquez Garcia, 1995, p. 162) described this as motivated by a desire to protect existing members’ respective share of the wealth and to avoid any disruption of leadership subsequent to the increase of “new” members.

**Matrimonial Real Property Law**

The removal of property rights through the Indian Act continues to affect Indigenous women today. Provincial matrimonial property law (also known as matrimonial real property or “MRP” law) does not apply to Indigenous women living on
reserve, as reserve land is a matter of federal jurisdiction and the use of reserve lands, including housing, can only be decided by Band Councils (Blair, 2005). This is particularly problematic for women experiencing violence, which is estimated to be approximately one in three Indigenous women (Blair, 2005). Paired with severe on-reserve housing shortages, the lack of matrimonial property rights means that women choosing to flee violence may do so at the cost of their housing, or alternatively continue to live in violence in order to maintain housing (Blair, 2005; Varcoe & Dick, 2008).

In 1999, the First Nations Land Management Act (hereinafter referred to as the “FNLMA”) came into effect allowing First Nations to opt out of lands provisions under the Indian Act and to adopt their own land codes. The FNLMA stipulates that within twelve months of the ratification of their land codes, signatory First Nations must develop policy and measures to address “cases of breakdown of marriage, respecting the use, occupation and possession of First Nation land and the division of interests in First Nation land” (Aboriginal Affairs and Northern Development Canada, 2011). In response, the issue of MRP on reserve has received the attention of multiple federally appointed special representatives, advisors and consultants, and been the subject of numerous focus groups, presentations, information sessions, and parliamentary committees since 2000. Four bills addressing MRP have been introduced in Parliament since 2008, three of which died on the Order Paper due to the dissolution and prorogation of Parliament. Presently, Bill S-2 Family Homes on Reserves and Matrimonial Interests or Rights Act is before the House of Commons for a second reading. This means that thirteen years later a significant legislative gap impacting the lives of Indigenous women remains with little agreement between the federal
government, members of the parliament, and national Indigenous organizations on how to proceed forward. The issue of MRP interlocks with issues of housing shortages and violence in the lives of Indigenous women, both of which have and continue to be a powerful force in the urban migration of Indigenous women (Harper, 2009; NWAC, 2010b; RCAP, 1996).

**Violence as a vehicle of colonization**

*The naturalization of violence against Indigenous women*

“…Aboriginal women are significantly more likely than non-Aboriginal women to report the most severe and potentially life-threatening forms of violence, including being beaten or choked, having had a gun or knife used against them, or being sexually assaulted. According to Statistics Canada, Aboriginal women are also seven times more likely to be murdered than non-Aboriginal women in Canada. Research conducted by the Native Women’s Association of Canada (NWAC) demonstrates that Aboriginal women and girls are as likely to be killed by a stranger or an acquaintance as they are by an intimate partner—very different from the experiences of non-Aboriginal women in Canada, whose homicide rates are often attributed to intimate partner violence.” (Matthysen, 2011)

The racialized, sexualized violence levelled at Indigenous women is rooted in the colonial agenda of dehumanizing Indigenous women (and men) as savage, inferior and inhuman in order to justify the murder, exclusion and marginalization required to dominate both Indigenous peoples and our homelands. Sikka (2009) also links the history of enslavement of Indigenous peoples and the literal ownership of Indigenous women to the continuing sense of white male settlers of being able to “determine the appropriate “use” and value of Aboriginal women” (p. 8). Colonial images of the savage Indian woman imbued in the derogatory term “squaw”, underpin the severe violence Indigenous women continue to face in Canadian society today. In examining the roots of the notion of the “squaw”, Kim Anderson (2004) notes that:
“[t]he dirty, easy squaw was invented long before poverty, abuse, and oppression beset our peoples. She was invented then reinforced because she proved useful to the colonizer. The “uncivilized” squaw justified taking over Indian land. She eased the conscience of those who wished to sexually abuse without consequences.” (p. 269)

Larocque (1994, as cited in NWAC, 2007a) further describes the use and impact of the term:

“The portrayal of the squaw is one of the most degraded, most despised and most dehumanized anywhere in the world. The “squaw” is the female counterpart to the Indian male “savage” and as such she has no human face, she is lustful, immoral, unfeeling and dirty. Such a grotesque dehumanization has rendered all Native women and girls vulnerable to gross physical, psychological and sexual violence…I believe that there is a direct relationship between these horrible racist/sexist stereotypes and violence against women and girls….“ (p. 4)

Larocque links the brutal beating, sexual assault and murder of Helen Betty Osborne, a Cree woman from Norway House, Manitoba, by four young white men to having been raised with a notion of Indigenous girls and women as “squaws”, such that Osborne’s attempts to fight off their sexual advances contradicted the expectation of subservience to whites causing a rage that resulted in her death. The discourse of the squaw also contributes to a conflation of the Indigenous female body with prostitution, serving to somehow naturalize and justify the sexual violence levelled at Indigenous women (Razack, 2002; Gibson, 2003). The extremely violent murder of Helen Betty Osborne in 1971 is neither an isolated or unique case, but shares much commonality with that of Pamela Jean George who was sexually assaulted and killed by two white male university students in 1995 who were subsequently convicted of manslaughter (Amnesty International, 2007; NWAC, 2010b). The stories of the stolen lives of Helen Betty Osbourne and Pamela Jean George are held among the excruciating number of missing and murdered Indigenous girls and women in Canada.
For Indigenous peoples, these missing and murdered girls and women are our mothers, daughters, sisters, aunties, nieces, grandmothers, granddaughters, and friends. The theft of these women from our families and communities is deeply painful, reflecting and furthering intergenerational trauma as many are survived by children and grandchildren (NWAC, 2010b). NWAC, through its Sisters in Spirit (SIS) initiative, developed a database in 2005 to track the number and demographics of missing and murdered Indigenous women in Canada. While the SIS database has identified nearly 600 missing and murdered Indigenous women, others suggest that the actual number may approach 3000 (Kraus, 2011; Talaga, 2012).

The pervasive and persistent hatred and violence experienced by Indigenous women in this country is most painfully embodied in the vast numbers of missing and murdered daughters, mothers, sisters, aunties, grandmothers and nieces. Amnesty International (2004) has described Indigenous women as over-policed and under-protected in the Canadian state, in which police are more likely to arrest Indigenous peoples for crimes in which white people would likely not receive the same treatment, while at the same time demonstrating limited support in response to the safety concerns and needs of Indigenous women. This is readily apparent in the slow, low or no response by police to reports of missing Indigenous girls and women, an issue long raised by families and communities of missing girls and women and now becoming an area of inquiry for the United Nations Committee on the Elimination of Discrimination Against Women (Canadian Feminist Alliance for International Action & Canadian Labour Congress, 2012; Talaga, 2012).
In addition to a lack of attention to or action towards protecting the safety of Indigenous women, members of the Canada’s justice system have been implicated in violence against our women. In 2004, Justice David William Ramsey was sentenced to seven years for purchasing sex from and sexually assaulting four Indigenous girls aged 12-16 years old who had appeared before him in court, abuses that took place over nearly a ten year period (Amnesty International, 2004). More recently there has been an increasing recognition of police brutality against Indigenous women, including reports of sexual and physical assault (Human Rights Watch, 2013).

**Disconnection, dislocation and distress: Denigration of the role of Indigenous women as mothers**

**Attack on the body: “Medicalization” of childbirth and sterilization**

The denigration of Indigenous women was an essential centrepiece in destabilizing First Nations and asserting colonial control (Anderson, 2004; Walters & Simoni, 2002). This has been accomplished through multiple methods, including legislated and institutional oppression, acts of physical and sexual violence, and ultimately undermining the role of Indigenous women to have and care for their children. The medicalization of maternal health has had significantly damaging effects for Indigenous women and their families, particularly for those who hail from remote and far North communities. The invasion of the western medical model destroyed, or in some cases drove underground, traditional practices of midwifery and maternal/child care. Subsequently, pregnant women in remote and far North communities face mandatory medical evacuation (typically at 34 weeks gestation) to southern urban centres (for example Winnipeg, Thunder Bay, Ottawa, Montreal, etc.) to birth their babies. This removes a pregnant woman from her family and community, and from traditional lands.
and medicines, to an alien environment in which she is likely to experience isolation and encounter racism.

Stonier (1990) provides an overview of some of the detrimental health effects of mandatory medical evacuation of women from the far North including anxiety, loneliness, increased smoking and loss of appetite. She also notes the collateral impact on other children and family left behind, including an increase in school difficulties and reported illness for children of evacuated mothers, and a loss of connection to and understanding of the birthing process for fathers (Stonier, 1990). Significant efforts are being made by Indigenous women, their communities and the National Aboriginal Council of Midwives (NACM) to bring birth “home” both in rural and urban contexts, to support women to be able to birth in the safety, comfort and support of their families and support systems and in the context of culturally safe care.

Here in Toronto, tremendous work has brought forward an Indigenous midwifery practice – the Seventh Generation Midwives of Toronto (SGMT), which opened in 2005 with the aim of improving access to prenatal and maternal healthcare for Indigenous women and their families. SGMT was notably successful in its proposal to lead the development of Toronto’s first birth centre slotted to open this year. In developing their proposal, SGMT hosted a three day event gathering entitled For Seven Generations: Visioning for a Toronto Aboriginal Birth Centre to seek community input and direction from midwifery clients (past, present and future), Elders and community members, traditional and registered midwives, Indigenous community organizational stakeholders, broader health systems and political stakeholders and allies. The event emphasized the importance of restoring traditional sexual and maternal health knowledge(s) and
practices and providing safe space and culturally grounded care as a means of healing in the face of the damage caused to Indigenous women’s health and well-being by colonial policies and practices.

Beyond birthing, there is a very dark history of direct assault on the childbearing capacity of Indigenous women. Across the imposed colonial border, 40% of Indigenous women of childbearing age were subject to non-consensual sterilization by Indian Health Services in the United States during the 1970s (Walters & Simoni, 2002). This practice of “eugenics” was also exercised in Canada, primarily in Alberta and British Columbia (Grekul, Krahn & Odynak, 2004). In Alberta, approximately 2800 Indigenous women underwent forced sterilization between 1928 and 1972 (The Truth Commission into Genocide in Canada, 2001). Testimony provided to the Truth Commission into Genocide in Canada (2001), indicated that sterilization of Indigenous women was in some places (i.e. provincial training schools) standard practice. Moreover, there is evidence to indicate that the Department of Indian Affairs financially rewarded physicians for each Indigenous woman sterilized, “especially if they weren’t churchgoers” (The Truth Commission into Genocide in Canada, 2001, p. 13).

**Attack the family: Residential schools, the sixties scoop & contemporary child welfare**

Where Indigenous women could not be prevented from procreating, the goals of cultural annihilation were enacted by removing Indigenous children from their mother’s care, their families, homes and communities, first to residential schools and then by means of child welfare agents, to foster care and cross-cultural adoption. Notably, social workers were active in these efforts, participating in the removal of children from their homes to residential schools, as well as in the subsequent apprehension and
placement of children into long-term foster care and trans-racial adoption (Blackstock, 2008; Sinclair, 2004).

Residential schools were designed to assist in the assimilation policy of the colonial government, through which Indigenous children would be “civilized” through instruction in European language, cultural and religious practices. Survivors have shared in depth their stories of culture and language loss, and of physical, sexual, emotional and psychological abuse at the hands of priests and nuns; abuse used to enforce their assimilation (Blondine-Perrin, 2009; Haig-Brown, 1988; Knockwood, 1992; McLaren, 2007; Miller, 1996). The agenda of residential schools is often bluntly referred to as intending to “kill the Indian in the child”; indeed these schools manifested a comprehensive attempt at cultural genocide:

“[Assimilation could not] be achieved, however, unless the children were first released from the shackles that tied them to their parents, communities and cultures. The civilizers in the churches and the department understood this and, moreover, that it would not be accomplished simply by bringing the children into the school. Rather it required a concerted attack on the ontology, on the basic cultural patterning of the children and on their world view. They had to be taught to see and understand the world as a European place within which only European values and beliefs had meaning; thus the wisdom of their cultures would seem to them only savage superstition. A wedge had to be driven not only physically between parent and child but also culturally and spiritually. Such children would then be separated forever from their communities, for even if they went home they would, in the words of George Manuel, bring "the generation gap with them". Only in such a profound fashion could the separation from savagery and the re-orientation as civilized be assured." (RCAP, 1996b, Volume 1, Part 2, Chapter 10)

For those who lost their children, for those who were taken, for their children, grandchildren and great-grandchildren and for our communities, this history lives within us and through us. The collective memories of residential schools continue to ripple
into the contemporary context, contributing to distrust of religious and non-Indigenous institutions and authorities, including social workers. The distrust of social workers was intensified by their role in the mass apprehension of Indigenous children into foster care and adoption into white families, starting in the 1960’s (Sinclair, 2007). This is referred to as the “Sixties Scoop”, since the initial spike of the number of Indigenous children taken into foster care or into adoption began in the 1960’s, and since many of these apprehensions occurred without the knowledge or consent of families or communities (Sinclair, 2007). The effects of the scoop were devastating, resulting in one third of Indigenous children being separated from their families by the 1970’s, through both adoption and foster care (Fournier & Crey, 1997, as cited in Sinclair, 2007).

Despite system changes in response to the Sixties Scoop, including the development of Indigenous-run child welfare authorities (still only existent in pockets across Canada), Indigenous children continue to be grossly overrepresented in child welfare involvement. Accounting for less than 5% of the country’s child population, Indigenous children represented, in 2005, an estimated 30-40% of children in care across Canada (Gough, Trocme, Brown, Knoke & Blackstock, 2005). First Nations children with status specifically experience disproportionate representation, with a 71.5% increase in the number children taken into care between 1997 and 2001 (McKenzie, 2002), and an appalling 1 and 10 status children in care by 2005 (vs. 1 in 200 for non-Indigenous children) (Wien, Blackstock, Prakash & Loxley, 2005). More recent numbers from the National Household Survey suggest that the numbers of Indigenous children in care have increased even further such that 14,225 of the approximate 30,000 children in care in Canada are Indigenous, meaning that 4% of all
Indigenous children are in care as opposed 0.3% of non-Indigenous children (Woods & Kirkey, 2013).

The First Nations Child and Family Care Society of Canada (FNCFCSC) initiated a human rights complaint in 2007 in an attempt to hold the Canadian government accountable for discriminatory treatment of First Nations children involved in the child welfare system. This includes disparities in funding provided for First Nations children involved in the child welfare system, which is only a portion of that allocated for non-Indigenous children (FNCFCSC, 2013). Despite efforts by the federal government to prevent the matter from proceeding to a hearing, the Canadian Human Rights Tribunal finally began hearings on the matter in February of 2013; these hearings will continue through August of 2013.

The historical and ongoing over-surveillance and disproportionate apprehension of Indigenous children continues to shape how Indigenous families, and Indigenous women specifically, engage with a variety of systems and services including education, housing, social, health and mental health services (Bennett & Blackstock, 2007; Benoit et al., 2003; Denison, 2012; Dion Stout et al., 2001; Fiske & Browne, 2006; Su, 2009; Vazquez Garcia, 1995). Long denied by federal government and church officials, the effects of these acts are now clearly recognized as having devastating, intergenerational effects on the lives of Indigenous peoples. Movements towards reconciliation (see for example, Blackstock, Cross, George, Brown & Formsma, 2006; The Truth and Reconciliation Commission of Canada, n.d.) acknowledge the role of colonization in disrupting cultural knowledge and practices, dismantling gender equity, and rupturing family and community cohesion (Smith, 1999). Colonization crafted
circumstances that foster pain, dysfunction and disproportionate rates of ill health and violence (Kirmayer, Brass & Tait, 2000; Moffitt, 2004). Even still, our Nations, our women and our cultures have survived.

**Unsettled territory: The continued thrust of colonization in the lives of Indigenous women**

The complex issues facing Indigenous women in navigating the societies (mainstream and Indigenous) and systems that impact our lives are interconnected and complicated. The severe poverty created by colonization, entrenched in the Indian Act and reinforced through the sturdy mechanisms of racism effect access to housing, education, health and social services and food. For example, for many Indigenous peoples living in rural and remote reserves or territories, traveling into urban centres is mandatory in order to access specialized health and social services, employment and education (NWAC, 2010b). Indigenous youth in remote communities are frequently forced to leave their home communities in order to access education beyond grade eight, an isolating experience that can create tremendous vulnerability. In Thunder Bay, Ontario, there are seven documented deaths since 2000 of Indigenous youth who were attending school in the city away from their home communities, five of whom were pulled from local rivers. The loss of each of these precious lives reflects contemporary manifestations of colonialism in the inadequate funding and prioritization of Indigenous education and the isolation and marginalization faced by Indigenous youth who must choose between access to education or access to family and support systems.

Indigenous peoples are overrepresented by an estimated factor of ten in the homeless population of Canada (Hwang, 2001). The colonial determinants of Indigenous homelessness extend beyond poverty and inadequate or affordable
housing, to include child welfare. While Sinclair (2007) identifies the connections between homelessness and transracial adoption of Indigenous children, Baskin (2007) points to a history of having been in the care of CAS as tied to Indigenous youth homelessness in Toronto.

Poverty, homelessness, child welfare and racism are also linked to sex work and sexual trafficking of Indigenous girls and women (Sethi, 2007), which has multidirectional relationships with violence. This means that Indigenous girls and women who are trafficked or who are involved in sex work are at increased risk of violence, and that violence in the context of the family, home community or foster care can also cause Indigenous girls and women to flee to the city with increased vulnerability to being trafficked or entering sex work for survival (Sethi, 2007; Sikka, 2009). For example, in Winnipeg, it is estimated that two thirds of street sex workers had been apprehended into foster care as children (Sikka, 2009).

Indigenous women are egregiously overrepresented in incarceration: one in three women in federal incarceration is Indigenous (Wesley, 2012). Indigenous peoples as a whole represent the youngest and fastest growing population in Canada, and Indigenous women represent the fastest growing population in incarceration with an approximate 90% increase over the past ten years (Wesley, 2012). All of the forces of oppression discussed in this chapter contribute towards these rates of incarceration. For example, homeless is linked to greater risk of incarceration (Walsh, McDonald, Rutherford, Moore & Krieg, 2011), as is child welfare involvement and involvement in sex trade or sexual trafficking (Sikka, 2009). Incarceration and homelessness reflect to two of the most severe means of dislocating and marginalizing Indigenous girls and
women, while the theft and murder of our stolen sisters reflects the most extreme form of colonial violence in the lives our girls, women, families and communities.

**Looking back, moving forward**

In the context of decolonizing our communities and improving the health and well-being of Indigenous peoples, drawing on the wisdom and experience of Indigenous women and ensuring their health is integral. In urban environments Indigenous women are facing socioeconomic disparities and marginalization that undoubtedly impact health and well-being. Looking at the past in the present firmly roots urban Indigenous women’s health in the context of history (both pre- and post-contact), guiding action forward from a place of consciousness and responsibility to those who have come before me. It further resists a pathologizing of Indigenous women in the face of significant health and social challenges, and prevents these challenges from being framed within an individualized lens which views health and social issues as a result of personal choice with no attention to collective context or the life choices and chances available in the continuous fallout of colonization.

**Understanding the present: Review of research literature addressing the health of urban Indigenous women**

The following review of relevant literature focuses on research from the Canadian context addressing the health of Indigenous women in urban settings. It does not address literature from international contexts with similar colonial histories of oppression of Indigenous peoples (i.e. the United States, Australia and New Zealand) since, despite comparable colonial histories and contemporary health disparities, the response to the health needs of Indigenous peoples in each country is informed by unique health
systems. The review is organized by the extent to which the research either includes or excludes the voices, experiences, and/or the knowledge of urban Indigenous women. A main point of consideration here lies in discerning both what is known about the health and healthcare of urban Indigenous women, as well as how it is known – by critically analyzing the ways in which the knowledge was constructed. This approach is intended to assess the extent to which health knowledge production and subsequently health policy, programming and services are actually informed by the urban Indigenous women they serve.

Constructing the review of literature in this manner is also meant as a form of “talking back” (hooks, 1989; Smith, 1999) to the problematic and persistent requirement of justifying the need for and importance of Indigenous women’s health research (i.e. to funders and policymakers) by producing a litany of statistics regarding the ill-health, violence, poverty, pain and trauma, which can contribute towards pathologizing images of Indigenous women as chronically flawed, victims or lacking in agency (Bartlett, 2005; Su, 2009). Such negative discourses perpetuate uneven societal power relations in which Indigenous communities are imagined and suspended in images of sickness, disorganization and dependency, which somehow serve as evidence of ongoing need for paternalistic health intervention (O’Neil, Reading & Leader, 1998; Tang & Browne, 2008).

In situating this literature review, it is necessary to provide some constructive commentary on the use of statistics and other research data relating to Indigenous peoples generally, and Indigenous women specifically. Not only drawing focus on data collection (methods, sampling, generalizability, etc.), but also articulating the
responsibility to avoid inadvertently reinforcing stereotypes and systemic racism through the application of statistics and other research data. While this may seem self-evident to some, the deeply painful history of both research and social policy directed towards Indigenous peoples underlines the responsibility of researchers, educators, policymakers, health professionals, community workers and social workers to gather, share and apply research data in ways that disrupt stereotypical, one dimensional images about Indigenous women, and instead advance their health, well-being and self-determination. One means of responsibly utilizing research data is to ensure adequate discussion of the historical and ongoing colonial context faced by Indigenous women in Canada. Another is to ensure the data is framed within the perspectives and voices of Indigenous women. These are important considerations in assessing the literature, as set out below.

**Missing in action: The absence of urban Indigenous women**

Levin and Herbert (2004) discuss the results of an exploratory study that examined the experiences of urban Indigenous people as health care consumers, identifying practice implications for hospital social workers specifically, as well as other health professionals more broadly. Although the authors are not focused solely on the health of urban Indigenous women (but rather urban Indigenous peoples), they do identify barriers to service as well as social work practice considerations specific to urban Indigenous women.

This study employed a grounded theory methodology in which the authors interviewed seven key respondents, who were identified by informants with “professional and personal knowledge of Indigenous issues”. To be eligible for
participation, key respondents had to hold a position which required frequent and broad contact with urban Indigenous peoples, possess comprehensive knowledge of both Indigenous issues and the health care system, and be able to clearly articulate their views. The seven key respondents held various positions, primarily in healthcare, but also in social service settings. The majority of the respondents were Indigenous (5/7) and female (6/7). While the composition of the respondent sample certainly indicates that the study drew upon the voices of Indigenous women, it appears to be solely from their perspectives as service providers. In addition to the small sample size, the findings are presented in an academic article written by two non-Indigenous authors whose interpretation of the data is troubling.

For example, six of the seven key informants identified obstetrics and gynaecology as particularly problematic to program for urban Indigenous women. They reported that some young pregnant women do not attend for care until the day they deliver due to apprehension about male physicians, fear of judgment about their age or lifestyle, or fear of child welfare intervention. The authors, however, go on to describe the provision of healthcare to urban Indigenous women in a troubling manner:

“Groups that bring particular problems are young Aboriginal women, mothers of young children, and those Aboriginal women for whom seeking medical care from a male doctor is exceedingly difficult and traumatic due to the terrible legacy of authoritarianism and abuse that is so prominent in Aboriginal history.” (p176)

Why are Indigenous women constructed as ‘bringing problems’ as opposed to being subjected to (on an intergenerational basis) horrible acts of colonial violence and oppression that should, in fact, be viewed as a social determinant of their health? Certainly this view does not foster an understanding of Indigenous women as having agency, or even yet, wisdom to challenge and change the healthcare services they are
provided. In addition to lacking a gender-based analysis, the problematic language and lens of the authors does not adequately honour the voices of Indigenous women, but instead illustrates some of the dominant, racist discourses that underpin healthcare provision.

The authors conclude by noting that the role of addressing Indigenous issues would be an excellent means for hospital social workers to reinforce and advance their roles and utility in hospital settings (social workers are often in a tenuous position in hospital settings, in which they must constantly work to validate their role within the healthcare team). The authors’ conclusion underlines the paternalistic tone of the article as a whole, which uses problematic and blaming language in describing the “problems” of urban Indigenous peoples in accessing healthcare. The authors (as opposed to the key respondents) seem far more concerned with how the research results can contribute towards legitimizing and sustaining the role of hospital social workers, rather than actually improving the accessibility, availability and acceptability of health services for urban Indigenous peoples.

Another study focusing on urban Indigenous health generally, but offering some insight specific to urban Indigenous women, is that of Jacobs and Gill (2001) examining substance abuse in Montreal’s Indigenous population. The article identifies the researchers’ relationship to the subject matter – both are members of the Native Mental Health Research Team at McGill University, and Ms. Jacobs is a member of the Kanien’kehá:ka Nation (Kahnawake). They present the findings of their study which engaged a large sample (n=202) of urban Indigenous participants in structured surveys,
in order to explore the social, legal and psychological consequences of substance abuse.

The authors provide an overview of relevant literature that establishes disproportionate rates of alcohol and substance abuse among Indigenous peoples in Canada. They note that the literature largely constructs Indigenous peoples in a very homogenous manner, failing to account for the diversity of the Indigenous population. This refers to both the failure to examine and compare differences in patterns of use or prevalence in various regions (e.g. rural versus urban, on-reserve versus off-reserve) or among different Indigenous groups (e.g. Algonquin, Kanien’kehá:ka, Métis, Inuit, etc.). Since much of this existing body of research has been undertaken with reserve-based Indigenous populations, the authors easily establish the need for their urban-focused study.

The findings identify a number of social, legal and psychological consequences that are significantly more likely to be present for substance abusers (n=67, 33%) versus non-abusers (n=135, 67%). These include higher rates of suicide, attempted suicide, and experiences of physical abuse both over their lifetime and within the 30 days prior to being interviewed. Abusers were also more likely to have legal problems, to be on probation or parole, and to have more convictions and more time served in jail than non-abusers.

Women accounted for 65% of the sample, however, gender stratified data are not clearly or consistently presented throughout the article (for example, not tabled as was data stratified by abusers/non-abusers). The data presented for women participants did not identify or separate that of abusers from non-abusers, making it difficult to ascertain
what the differential issues might be for urban Indigenous women who abuse versus those who do not. Women in the study were more likely to report family and childhood histories of physical, emotional and sexual abuse. They reported more than twice the rate of lifetime sexual abuse than male participants. Unfortunately, the article does not speak to the relationship of the higher rates of family and childhood abuse and subsequent substance abuse for urban Indigenous women.

Despite the high proportion of women in this study, and the gendered experiences of violence/abuse, the voices and perspectives of the women themselves are glaringly absent. The value of the quantitative data presented in this article is in its capacity to establish the prevalence of substance abuse within an urban Indigenous population, as well as identifying the prevalence of associated factors (e.g. criminal involvement, family history of abuse, etc.). The value of statistics, however, is limited without ample contextual data (i.e. historical, social and economic intersections) and can serve to perpetuate negative stereotypes of Indigenous women, reinforcing colonial narratives and justifying paternalistic healthcare responses (Browne, Smye & Varcoe, 2007). It should be noted that the authors do conclude with a recommendation of further quantitative and qualitative research in order to better understand the experiences of Indigenous peoples in urban contexts, and the factors that contribute to their health and well-being within these contexts. While the absence of women’s voices/narratives within this article may be due in part to the use of a highly structured interview format, it nonetheless compounds the overall lack of contextual framing. Undertaking to situate Indigenous health statistics within a colonial context helps to disrupt the blaming discourses that contribute to the poor health and well-being of Indigenous peoples.
Using the words and wisdom of urban Indigenous women to frame statistical data would not only provide a context rooted in lived experience or embodied knowledge, but recognizes the agency of the women to make sense of their own experiences and to recommend priorities and pathways for change.

A similarly statistically-based study is that of Luo, Kierans, Wilkins, Liston, Uh and Kramer (2004), which analyzed British Columbia’s live birth records documented between 1981 and 2000, to determine whether disparities in infant mortality rates between First Nations and non-First Nations women changed over time in rural versus urban areas. The total number of records analyzed was vast (n= 877,925; First Nations sub-sample n= 56,771, non-First Nations sub-sample n= 821,154), and analysis included rates, relative risk and risk differences of neonatal, postnatal and total infant death. The authors found that while infant mortality rates for First Nations women had steadily declined in rural areas, rates for urban First Nations women illustrated a rise and fall pattern. As such, while there have been notable reductions in disparities of infant mortality rates between First Nations and non-First Nations, reductions for urban First Nations women were far less substantial and consistent over time than for their rural counterparts. The authors conclude that there is a need to direct further attention to matters of maternal and infant healthcare for further attention urban First Nations women.

This article is troubling in several ways, both in how the research has been constructed, as well as in the complete absence of Indigenous women voices. In terms of constructing the research, the authors define First Nations as the “current preferred term” for North American Indians, and note that First Nations is one of three groups
captured under the umbrella term “Aboriginal” in Canada (First Nations, Métis, and Inuit). This is no problem they assert, since virtually all Aboriginal people in British Columbia are First Nations, as such, they were able to identify all First Nations births via three different sources that track status Indians. This is highly problematic, as despite the authors’ assumption, not all First Nations people have status under the Indian Act. Moreover, not all Aboriginal peoples in British Columbia are First Nations, in fact Métis peoples presently account for 30% of the province’s population, which also includes a small but growing Inuit population (Statistics Canada, 2007).

The authors also provide little context for the disparities, for example, they note that poverty is important risk factor for consideration in First Nations births, citing statistics that indicate a First Nations individual is 80% less likely to have a university degree than their non-First Nations counterparts, and twice as likely to be unemployed. Acknowledging the challenges of population-based studies of birth in the Canadian context, the authors indicate that the records they drew upon did not provide them with such data as the mother’s occupation, level of educational attainment, or income; use of prenatal care; or use of drugs, alcohol or cigarettes. They suggest the latter data could help to explain the unaccounted for disparities in their statistical analysis, since smoking and drug and alcohol use are more common among First Nations peoples. In failing to situate lower educational levels, higher unemployment and higher rates of smoking, drug and alcohol use within the context of colonization, the authors reinforce discourses that infer inherent flaws or poor personal choices as the source of health disparities, as opposed to resulting from historical and ongoing structural oppression.
Not only does this article provide an essentially a-contextual presentation of a health disparity for urban First Nations women, it fails to in any way reflect or acknowledge the voices and knowledge of these women. This is not to say that one must be an urban Aboriginal woman to undertake research on the health issues of urban Aboriginal women. Rather, failure to solicit the perspectives of these women, to contextualize their experiences, or to actually employ them as a research team member, can enforce practices of ‘othering’ and objectification. These discourses encourage a dehumanized or limited view of Aboriginal women as existing without agency, thereby enabling and justifying paternalistic approaches to the provision of the healthcare.

**Present and accounted for: The inclusion of urban Aboriginal women’s voices**

Bent (2004) conducted exploratory research with Aboriginal women in Winnipeg, Manitoba, to advance understanding of how Aboriginal women conceptualize wellness, and how they prioritize their health and wellness concerns. Notably, Winnipeg has one the largest urban Aboriginal population in Canada, with Aboriginal peoples accounting for 10% of the city’s inhabitants (Statistics Canada, 2009b). The study employed a two-pronged approach, beginning with the distribution of a survey questionnaire (n=120), followed by a separate sample of in-depth interviews (n=10). Survey participants were recruited through six urban Aboriginal organizations in Winnipeg, where questionnaires were then distributed. Interview participants were selected via snowball sampling, but no further information is given in this regard.

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3 See page 106 for discussion of the problems of census population estimates for Indigenous peoples in Canada.
The author situates her research by identifying the ontological and epistemological gaps between western and Aboriginal understandings of health; the former generally defining health through the absence of illness and disease, and the latter through the presence and balance of spiritual, emotional, mental and physical well-being. She asserts that this gap constitutes one of the largest barriers for Aboriginal women in attempting to meet their health and wellness needs. In response, the author proposes to gather the views of Aboriginal women, to better understand how they understand wellness, and how they prioritize their health and wellness concerns.

While she does not overtly socially locate herself in relation to the research, the researcher is, in fact, herself an urban Aboriginal woman, which I am aware in having previously worked with her on projects at the Native Women’s Association of Canada. Some comment on her social location within her report would have served to clarify her intent and relationship to the research at hand. The author notes that this report is focused more specifically on the quantitative findings of her research, with minimal comment on qualitative data though she does stipulate that qualitative findings will reported upon in greater depth in future writings. The questionnaire was designed to include the four domains of health (spiritual, emotional, mental and physical). Further description of the development of the questionnaire (i.e. whether there was community or advisory committee input; how the survey was validated) and the approach to data analysis would be helpful. Such information would assist readers in appreciating how the author arrived at her conclusions and whether participants had any opportunity to engage in the process of analysis (or, for example, member-checking).
The survey findings are composed of descriptive statistics through which Bent reports the following key issues most frequently identified by participants: 1) top health concerns: fitness, depression and diabetes; 2) top health needs: balance (among emotional, spiritual, mental and physical health), treatment for depression, meeting their nutritional needs and improving access to services; 3) what constitutes wellness: balance (see above), good health, emotional/mental health and low stress/security; and 4) what constitutes good health: physical fitness, absence of pain, eating/drinking well, taking care of oneself and balance. As the author highlights, the recurrent theme of ‘balance’ reflects and affirms a foundational value of Aboriginal approaches to health and well-being. It would be helpful in future research to further explore how Aboriginal women work towards or maintain balance in their lives, and what types of services or support they feel are required to maintain balance. Although the questionnaire includes questions regarding service utilization and access to services, no reference is made to these issues in the findings section.

The in-depth interview findings are the result of analysis of responses to the first two questions of the interview guide only. The author states that remaining questions focus on the prioritization of Aboriginal women’s health needs and will be more thoroughly examined at a later date. Bent includes significant amounts of direct quotations from interviewees, clearly prioritizing the positioning of the women’s voices in her research.

This study offers as a model for engaging Aboriginal women in defining their needs and concerns regarding health and wellness. Certainly the idea of using a mixed-methods approach to exploratory research with urban Aboriginal women could be
helpful in identifying key issues and advocating for policy change, increased funding and research, and transformation of service delivery. Building understanding from the ground up by asking women to identify what is important to them in terms of health and wellness fosters an image of Aboriginal women as knowledgeable and capable of directing their own health. It is worthy of noting the strongly worded letters of support from Aboriginal community organizations included in the document’s appendices, speaking volumes to the level of community buy-in and support the author received. This also suggests that future research in this field elaborating on Bent’s work would likely be welcome and supported, assuming it is conducted in a manner that continues to incorporate and respect community values and engagement. Future research building on Bent’s model would benefit from clear description of the process of community engagement, the development of data collection tools, the processes of data analysis and the mechanisms of trust and trustworthiness (e.g. member-checking).

Kurtz et al. (2008) present preliminary findings from an ongoing community-based participatory action research study in the Okanagan Valley, British Columbia, exploring the experiences of urban Aboriginal women in accessing mainstream health services. There is minimal description of methods provided, though the authors make reference to ongoing participant interviews and forums. As with the work of Bent, more in-depth information regarding the research design would prove helpful in understanding the processes of community engagement and data collection and analysis. The findings presented represent narratives and stories from a small sample (n=13) of urban Aboriginal women from one of three participating communities in the study.
Participants identified three key interrelated issues that negatively impacted their access to health services: 1) racism; 2) discrimination; and 3) communication barriers. The women identified a direct relationship between skin tone and the type of treatment they received. Darker skin not only meant poorer treatment, but the application of more severe stereotypical assumptions about them. The stereotype of Aboriginal women as ‘unfit mothers’ and the subsequent fear of child welfare intervention were also clearly linked to experiences of racism. Closely related, women identified experiences of discrimination, particularly regarding assumptions of drug and alcohol use made by service providers. Two women who suffered ongoing health challenges following a stroke described being repeatedly asked if they had been drinking or using substances whenever they accessed care. Participants identified a number of issues under the theme of “communication barriers”, including feeling that they were being talked down to or belittled, or that they were not even being listened to at all. A number of participants also reported being told that their symptoms or concerns were “all in their heads”, an incredibly discounting response from healthcare providers. Some women described approaching family and friends to try to validate their health concerns before accessing care.

The authors state that urban Aboriginal women are left feeling ignored or silenced as a result of these repeated negative encounters with mainstream healthcare. They assert that the ignorance or discounting of the concerns expressed by Aboriginal women amounts to structural violence. This violence further marginalizes Aboriginal women, and can cause them to delay or completely avoid accessing health services.

Kurtz et al. (2008) note that since Aboriginal women also tend to be the household
decision-makers, the impact of structural violence not only affects their health, but that of their families. In response to poor experiences with mainstream healthcare, a number of participants reported seeking services at friendship centres. The characteristics of friendship centres that attracted the women included a holistic approach to care, a sense of safety, feeling heard, and providing the context of Aboriginal-run organizations. On the other hand, the authors note that friendships centres lack the funding and mandate to provide the comprehensive level of service offered by the mainstream healthcare system.

Regardless of whether services are being accessed in mainstream or Aboriginal-specific settings, there is work to be done to improve the experiences, access to and outcomes for urban Aboriginal women. The article concludes with recommendations participants offered to improve both mainstream and Aboriginal-run services, including: 1) equal treatment for all (not just Aboriginal) service users; 2) longer appointment times; 3) truly listening to services users and not trying to monopolize appointments; 4) the availability of additional health services for Aboriginal women other than walk-in clinics or emergency room services; and 5) cultural and historical education for all health and social service providers. The women stressed that Aboriginal peoples must be actively involved in health policy and health education curricula development in order to ensure that processes and outcomes are reflect the needs and realities of Aboriginal peoples. This study is exemplary in its centering of urban Aboriginal women’s voices and visions. The women clearly identify the challenges they experience in accessing healthcare, and the approach to research here also recognizes and highlights the
wisdom and agency of the women to identify solutions to transform healthcare systems and subsequently their health outcomes.

In another study from British Columbia, though focusing specifically on Aboriginal women in Vancouver’s Downtown Eastside (DTES), Benoit et al. (2003) sought to understand the extent to which Urban Aboriginal Health Centres (UAHCs) are meeting the health needs of Aboriginal women. The study paired together data collected through focus groups with Aboriginal women living in the DTES (both clients and non-clients of the UAHC), with data from semi-structured interviews with UAHC staff, health service providers, community healthcare leaders and government representatives. The gendered disparities of urban Aboriginal health are pronounced in the social context of the DTES – where Aboriginal peoples represent 40% of the impoverished urban ghetto's population. It is important to contextualize, however, that Vancouver has the highest rents of any urban centre in Canada, meaning that a large number of people (Aboriginal and non-Aboriginal alike) with low-income cannot afford to live elsewhere in the city (Culhane, as cited in Su, 2009). The DTES is also notoriously associated with both sex trade and intravenous drug use (IDU). Aboriginal women are massively overrepresented in the sex trade, accounting for approximately 70% of the area’s sex trade workers (Benoit et al., 2003). Where Aboriginal women participate in IDU, they are more likely, due to power inequities, to either share needles or to be “second on the needle” (Benoit et al., 2003). A composite of the average Aboriginal woman sex trade worker in the DTES is 26 years old, with three or more children and no high school education. Aboriginal women in the DTES represent the fastest growing HIV positive population, and are three times more likely than non-
Aboriginal women in Vancouver to die of HIV/AIDS (Benoit et al., 2003). However, as Su (2009) notes: “[t]he majority of Aboriginal women living in the inner city are neither current sex trade workers nor are they injection drug users” (p. 11).

The authors describe a case study approach involving three focus groups with Aboriginal women who were clients of either Vancouver Native Health Society (VNHS) or Sheway (its sister organization), or resided in the DTES (n=36). The study also included twenty-five semi-structured interviews with a sample of VNHS staff, health providers, community leaders and government representatives (total n=61). The data collected in this study helped to identify a number of gaps and challenges in services provided to Aboriginal women in the DTES, namely the need for services that are gender sensitive, culturally appropriate and accessible to (inclusive of) women with children. Participants envisioned gender sensitive and child-inclusive services in a number of ways: safe (women only) waiting room space, childcare, expanded eligibility for mom and child programming (i.e. not excluding children over 18 mos.), midwifery care, and services that are accessible in evenings and on weekends.

While the name of the UAHC considered in this study – Vancouver Native Health Society (VNHS) – infers an Aboriginal targeted and culturally informed service, it is actually considerably mainstream. Originally intended (as a UAHC) to be a culturally focused health centre exclusively serving Aboriginal clients, inadequate funding, lack of available Aboriginal health professionals and challenges in engaging traditional Elders and teachers, led to the present ‘open door’ policy of VNHS. The impact of an open door, bio-medical focused service is reflected in service numbers: only 40% of the clients are Aboriginal, 50% are of European descent, and the remaining 10% are visible
minorities [sic]. It is not surprising then, that participants in the study identified the need for care that integrates Aboriginal traditional practices, utilizing a holistic approach (physical, mental, emotional and spiritual health) that provides care across the life cycle and delivered by staff who understand the historical and current context of the women’s lives.

The authors are explicit in stating that despite the many challenges and disparities faced by urban Aboriginal women, they must not be seen as merely victims of broader structural forces – an image which implies a lack of agency. Instead, urban Aboriginal women should be recognized for their capacity and agency to inform how their situations can be changed, how their health can be improved, and how they can ensure a positive future for their children. As such, the authors utilized a qualitative research methodology aimed at recognizing the voice and vision of the participating women in how to create positive change to meet their needs. They noted the irony that at the time of the study, the Vancouver Regional Health Board was conducting consultations on whether to develop a full-on UAHC in the city – consultations that all of the interviewees (service providers) knew of, while most of the focus group participants (service users) did not. They highlight this as an indication of the limited extent to which urban Aboriginal women are provided the opportunity to shape the design and implementation of their health services.

While the intent and the process of this particular research very much honoured the experiences and wisdom of the urban Aboriginal women participants, it is not clear how the findings would be translated into the health system in terms of both policy and practice. The authors advocate for the women to reclaim control over their health and
social services, and appeal to policy makers to attend to these issues. Yet, the extent to which the women’s knowledge and recommendations could influence or be implemented into health policy and practices is unknown. This study provides some very positive modeling for health research with urban Aboriginal women, and also raises an important question – while research may draw on the experiences and knowledge of urban Aboriginal women – how can it, in very practical terms, compel health policies, systems and services to implement their recommendations?

In another Vancouver-based study, Salmon (2007) reflects on the methodological approach she employed in her doctoral research with six young Aboriginal mothers in the DTES who had experienced substance abuse during pregnancy and fetal alcohol syndrome/fetal alcohol (FAS/FAE) effects on their children. Her research considered how the experiences of these women could inform analysis of Canadian public health policy aimed at preventing and reducing FAS/FAE.

Salmon discusses three strategies she employed aimed at democratizing the research process to prevent what she refers to as “the all-too-common misrepresentation and appropriation of women’s experiences, which amounts to neo-colonialism in Indigenous-White [sic] research relations” (p.982). She attends to the history of White [sic] scholars undertaking research with Aboriginal communities in ways that construct participants merely as objects of study, and not as experts of their own lived experience and the conditions in which these experiences occur. Seeking to disrupt this colonial aspect of white researchers engaging with Aboriginal participants, Salmon utilized several different approaches to ensure respectful and reciprocal relationships, and accurate representation of the women’s lived experiences and
knowledge. The three specific strategies she recommends here are: 1) the provision of honoraria; 2) collaboration with community leaders in participant recruitment; and 3) the use of shared analysis. In terms of honoraria, the author draws on the voice of one of the participants, who discusses the frequent incursion of academics in the DTES who come and take the “data” but never offer anything in return. The provision of honoraria not only respects the pan-Aboriginal cultural principal of reciprocity, but also acknowledges the barriers of poverty to participation faced by many living in the DTES. Honoraria can serve to greatly increase the accessibility of participating in research, by providing means to access childcare, transportation or food. Yet, she notes that the honoraria itself is not enough to satisfy community expectations and norms – the how of collecting data or building knowledge is what distinguishes involving Aboriginal participants, versus honouring their role in knowledge production.

Salmon then discusses the role of collaboration with community leaders in participant recruitment to help develop trust with and ensure meaningful involvement of participants. In fact, she notes that traditional means of soliciting participation (posting of information flyers) generated no participants; all of the women who chose to participate had been contacted by a community leader. This leader undertook this role of outreach because she believed in the value of the research and the intent to genuinely involve the women in the research project. The community leader’s involvement served to provide credibility for the researcher, but also to help ensure that the researcher actually worked in ways that maintained this credibility.

Finally, one of the key ways in which she established credibility, ensured accurate representation and enacted genuine and integral involvement of the participants in the
process, was to develop a process of shared data analysis in group interviews. In this approach, the initial data was collected during a group interview (all six of the women had selected a group interview as opposed to an individual interview), after which the researcher summarized and developed some initial coding before presenting her findings back to the group in a second interview. During this second group interview, the women had the opportunity to revise the summarized data and initial analysis, and to actively shape the knowledge they had produced. What she found, was that the participants not only identified problems, but were developing solutions. For Salmon, the context, experiences, challenges and solutions identified by the women form the basis of critical policy analysis, aimed at advancing policy that is both decolonizing and woman-centered. Her work exemplifies the act of using research to raise the voices and vision of urban Aboriginal women.

Discussion

The violence and oppression of colonization are not artefacts of the past, they permeate the contemporary contexts in which Aboriginal peoples are born, raised, live and die. For Aboriginal women, Canada's insidious colonial legacy has had severely negative and disproportionate effects on health and well-being. Their poor health, in comparison to that of both non-Aboriginal women and Aboriginal men, reflects the impact of generations of gendered, racialized violence and marginalization. It is crucial to understand this historical context, in order to disrupt racist and blaming discourses that construct the poor health of Aboriginal women as the result of inherent pathologies or poor personal choices, or alternatively, paternalistic discourses which view Aboriginal women as helpless victims who need to be saved. Instead, we must engage in the
recovery of discourses that recognize the strength, agency and wisdom of Aboriginal women to vision and manifest their own healing and health.

In this section, literature has been reviewed which addresses the health of urban Aboriginal both directly and indirectly (i.e. articles that consider urban Aboriginal health generally). This literature reveals remnants of a colonial context that attempts to silence Aboriginal women, render them invisible or infer that they are incapable of engaging in healing and shaping health systems. This is largely due to approaches to knowledge production, including particular research methodologies, which fail to provide space for Aboriginal women’s voices or to situate findings within the broader historical/colonial context in which they occur. For example, research that approaches Aboriginal health as a general topic, with very limited or no gender-based analysis, reifies the silencing of Aboriginal women and ignores the double jeopardy they face as marginalized racialized and gendered bodies. This is well illustrated by the Levin and Herbert article (2004), which makes limited reference to the specific issues faced by urban Aboriginal women, and does so in very problematic language.

The work of both Jacobs and Gill (2002) and Luo et al. (2004) provide examples of the negative effects of providing statistical data that is not grounded by participant narrative or accompanied by a comprehensive undertaking of context. De-contextualized statistics propel negative or limiting perceptions of the ability of Aboriginal peoples to engage in healing and health, which in turn fuels paternalistic approaches that do not reflect the cultural values of Aboriginal peoples, and continue to limit the ongoing goals of Aboriginal self-governance and self-determination.
Aboriginal women’s voices and narratives can no longer be excluded, they are necessary both to ground the data and to honour their capacity and right to self-determine their health. The value of voice and self-determination is demonstrated in the articles of Kurtz et al. (2008), Benoit et al. (2003) and Salmon (2007) (and to a lesser degree, Bent), which utilize a qualitative approach to data collection that recognizes urban Aboriginal women as the experts of their own experiences. These researchers undertake their work with the aim of honouring the voices and vision of urban Aboriginal women to identify issues and create change for their health and that of their families and communities.

Salmon (2007) explicitly discusses the problematic historical relationship between researchers and Aboriginal peoples broadly, as well as the specific issues of exploitation that had occurred between researchers and the Aboriginal women participants she was engaging with in Vancouver’s DTES. She suggests specific ways of guarding against or disrupting the colonial tendencies of research relationships, including shared data analysis and engagement with community leaders as means of enhancing credibility and accountability. Although the use of qualitative methods to create space for Aboriginal women’s voices is a necessary step, the question posed in response to Benoit et al. (2003) still remains to be answered: while research may draw on the experiences and knowledge of urban Aboriginal women – how can it, in very practical terms, compel health policies, systems and services to implement their recommendations? This is a central question in thinking about how researchers and urban Aboriginal women, as co-constructors of knowledge, can create systemic change to disrupt the mechanisms of oppression that impede their health and healing. This
question should propel research that undertakes not only to create but to apply knowledge to improve the health and well-being of urban Aboriginal women. It is evident from the general dearth of literature specifically addressing the health of urban Aboriginal women, that there is a great deal to be learned.

The articles reviewed here reinforce some findings from non-urban specific Aboriginal health literature (for example, barriers to care - fear of children being apprehended, racism, discrimination, lack of culturally appropriate services), as well as beginning to highlight some of the unique needs of those living in urban settings. Small pieces of information speaking to such issues as infant mortality (Luo et al., 2004), substance abuse (Jacobs & Gill, 2002), FASD/FAE (Salmon, 2007), experiences of healthcare (Benoit et al., 2003; Herbert & Levin, 2004; Kurtz, 2008) and the identification of health concerns (Bent, 2009) provide a fragmented image of the current state of affairs in urban Aboriginal women’s health.

Moving towards a defragmented view of urban Aboriginal women’s health requires visions, strategies and action towards decolonizing research processes and outcomes; contemporary research should be crafted to honour the wisdom, strength and agency of urban Aboriginal women in the process of identifying health issues and creating change. This specifically requires an Indigenous approach to research which is much more than the incorporation of cultural principles or practices, it is an actively political project aimed towards self-determination. The project of Indigenous research is also one of decolonization, which necessitates a critical understanding and re-visioning of the underpinning assumptions, values, purposes and processes of research (Smith, 1999). It is a project of accountability to Indigenous communities, to recognize and
disrupt the colonial history of research with our peoples, and to ensure that contemporary research work honours our ways of knowing and being. Indigenous approaches to research honour the spirit and agency of Indigenous peoples, not in only in surviving a brutal history of colonization, but in imagining and enacting ways to thrive now and in the future. Indigenous research is as much about the process as the outcome. In the following sections I outline my approach to the research at hand and describe the process not only of the research, but of my learning and growing within it.

CHAPTER 3: THEORIZING URBAN ABORIGINAL WOMEN’S HEALTH FROM AN INDIGENOUS PERSPECTIVE

Indigenous health is rapidly growing as an area of interest for researchers, policymakers and service providers (Dion Stout, 2001). This growth is likely attributable to a cluster of factors, including an increase in Indigenous researchers and health (and related systems) professionals, increased public awareness of the gross disparities in health between Indigenous and non-Indigenous peoples, increased attention to culturally relevant healthcare, and a move towards decreasing public health spending. Since Indigenous peoples bear such a disproportionate burden of ill health, and at the same time represent the youngest and fastest growing population in Canada, the federal, provincial and territorial governments all have a vested interest in developing comprehensive measures for understanding and responding to the health conditions and needs of Indigenous peoples. Social determinants of health (SDOH) models are gaining increasing recognition in Canada and globally, for their potential to address health in a more proactive and in-depth manner, including a shift towards preventative care and health promotion.
The Integrated Life Course and Social Determinants of Aboriginal Health Framework

Loppie-Reading and Wien (2009) propose an Integrated Life Course and Social Determinants of Aboriginal Health (ILCSDAH) framework for understanding the various social determinants and dimensions of health across the lifespan of Aboriginal peoples. This model posits three categories of social determinants of health: distal, intermediate and proximal, all of which interact with each other in shaping the health of Aboriginal peoples at the individual and community levels. The authors assert that distal determinants, including historical, political, economic and social contexts, can have the most profound effect on the health and well-being of Aboriginal peoples. Distal determinants can be recognized in the form of colonization, racism, social exclusion, and interference in, or suppression of, self-determination. Intermediate determinants include community resources, capacity, systems and infrastructure, such as healthcare and education systems (access to and appropriateness of services within), as well as the extent of environmental stewardship and cultural continuity. Intermediate determinants are understood as the origin of proximal determinants within the ILCSDAH framework. Proximal determinants include health behaviours, social and environmental conditions that directly impact physical, mental, emotional and spiritual health. The authors provide numerous examples of proximal determinants, including physical environments (e.g. overcrowded housing, lack of access to traditional lands), education (i.e. the 50% rate of drop out and push out of Aboriginal youth from education systems), income, employment and food insecurity.
The ILCSDAH framework is very useful in illustrating the multiple forces at play in the health of Aboriginal peoples, accounting for micro, mezzo and macro issues, and temporality (inclusive of the historical context, and viewing health across the lifespan). The ILCSDAH does not, in its current form, account for gendered realities in any depth. Moreover, the authors note that at present, there is limited research demonstrating the unique influence of social determinants of health for Aboriginal peoples. The proposed study will advance the path set out by the ILCSDAH framework by deepening understanding of the unique needs, concerns and circumstances faced by Indigenous women - urban Indigenous women in particular - and by exploring the functional role of social determinants of health through the stories shared by urban Indigenous women.

The history of harmful, exploitative and culturally insensitive research is a shared phenomenon among Indigenous peoples globally. It ripples through the contemporary context, most evidently in the distrust of research and researchers. Even well-intended research based in mainstream worldviews and conceptualizations of research with Indigenous peoples continues to undermine Indigenous ways of knowing, self-determination and approaches to research. As such, developing a theoretical framework for Indigenous health research must account for not only the focal point (urban Indigenous women’s health and well-being), but also the research process itself.

Situating my own Indigenous theoretical perspective

The theoretical framework for this research centres Indigenous ways of knowing and being. This is a personal, political, conscious and necessary choice for me as an Indigenous researcher operating from an intention of decolonizing, renewal and
revitalization of Indigenous knowledge(s) and practices as a necessary part of individual and collective healing.

For me personally, it is a healing act to name, hold and act within the worldview in which I was raised, the gifts and teachings of which have enabled my survival. It is healing because it has been my overwhelming experience in the vast majority of my educational contexts to have my expressions of Indigenous ways of knowing and being met with silence, blank stares, denial, denigration or ridicule. I have also met the kind of “polite” racism of those who perceive and simultaneously marginalize Indigenous knowledge(s) as a pleasant form of magical or culturally exotic thinking, but certainly not a rational or necessarily “real” form of knowledge in the academic arena (Kovach, 2009; Steinhauer, 2002).

Politically, it is my act of resistance to place Indigenous ways of knowing and not western ways of knowing at the centre of my work. It steps around the hegemony of western ways of knowing as the required foundation and measuring stick of what constitutes knowledge and what is considered a valid form of inquiry or knowledge-building. The power to so freely reject the western knowledge monopoly is generated by the rapidly expanding body of scholarship on Indigenous research by a similarly expanding number of Indigenous scholars. This includes the work of Margaret Kovach (2009) and Shawn Wilson (2008), Kathy Absolon (2011), Cyndy Baskin (2005), Lynn Lavallee (2009), Willie Ermine (2004), Eber Hampton (1995), Marlene Brant Castellano (2004), Raven Sinclair (2003), Michael Anthony Hart (2009), Evelyn Steinhauer (2002), Cora Weber-Pillwax (1999), Debbie Danard Wilson and Jean-Paul Restoule (2010), and Angeline Letendre and Vera Caine (2004).
I also acknowledge the powerful role of feminist and critical race scholars whose voices and work pushed open space in the academy for more than one way of knowing and being, forcing light upon the structural inequities and violence reproduced through academic institutions. The work of all of these scholars has nourished and sustained me as I attended to what has felt like the perpetual task of remembering what I had come to academia for in the first place. I recognize the privilege their work has provided me to speak in this way, to remember who I am, where I come from and where I am going; their work has protected my ability to dream and imagine something different for my children and those who are yet to come. Positioning Indigenous ways of knowing and being at the centre of my theory-making is a conscious and necessary choice to counter and upend the tired stories of epistemic inferiority that seek to keep Indigenous peoples, knowledge(s) and practices at the margins. It takes up the practice of renewal and revitalization and follows the lead of Kovach (2009) in what she refers to as the work of centering tribal knowledge.

**Acknowledging diversity, finding common ground**

The tremendous diversity of Indigenous peoples within Canada and globally is also reflected in a rich diversity of Indigenous ways of knowing and worldviews. Within Canada, there are a number of recognized shared values among and across Indigenous traditions that inform my theoretical framework. This approach is not intended to pan-Indianize or pan-Indigenize and therefore erase significant variations in our histories, ways of knowing and doing, but rather to name and draw on what are generally recognized as commonly held values and practices. These values might be thought of as the sinew that binds us together across difference, or the thread that sews
each panel of our collective quilt together stitch by stitch, telling our stories as
Indigenous people both separately (like quilt panels) and together (the quilt as a whole).

In the following section I set out these values that have informed my Indigenous
theoretical understandings and recognize the contributions of other theoretical “helpers”,
including anti-colonialism, anti-oppressive practice theory, feminist and critical race
perspectives. I write with recognition that my writing will only compose part of the
whole picture; knowing extends beyond words, beyond what we are able to articulate
from our minds. Knowledge lies within our bodies, our hearts, our actions and our
spirits. Knowledge lies within our environment, the plants, the animals, our Ancestors,
and all things around us, with which we are all interconnected. In this way, knowledge
is understood as relational: shared, between all things in creation (Wilson, 2001, as
cited in Steinhauer, 2002). All things begin with spirit, all things are connected by spirit.

By extension, interconnectivity or interrelatedness is one of the key principles to
understanding an Indigenous worldview. This idea is captured in the teaching of “All my
relations” or the interconnectivity/interrelatedness of all things – this includes
relationships between all things in the natural world (plants, animals, water, air, etc.) as
well as in the spiritual world (including our Ancestors and those yet to be born) (Absolon
& Willett, 2004; Letendre & Caine, 2004). Embedded within this idea is a deep sense of
humility and of sacredness of all things. In an Indigenous worldview, humans are no
more or less important than another other part of creation – whether an animal or a
blade of grass, everyone and everything is connected in one circle (Henderson, 2000).
Interconnectivity and interrelatedness emphasize collectivity and interdependence; the
focus within this way of knowing and being in the world is on maintaining and restoring balance, within ourselves and with each other (Chenault, 2011).

The notions of interconnectivity and balance are also linked to holistic approaches to understanding health and well-being. Within Indigenous ways of knowing, health is generally conceptualized as Honouring and balancing the connections between the spirit, heart, mind and body. Further, there is an inherent recognition of the bi-directional relationship between the health of the individual and that of the community.

The linked values of identity and historicity or “knowing who you are and where you come from” are also essential to understanding an Indigenous worldview. This practice reflects traditional teachings that require us to look at the past, in the present, for the future. To walk in balance (be healthy) and maintain well-being, we must understand who we are, where we come from and what our roles are within our communities. This is directly applicable not only to understandings of health, but also to understandings of myself as an Indigenous researcher. Kenny (2000) states that Indigenous researchers must not only understand their own personal histories, but also the history of research with Indigenous peoples, in order to understand and honour themselves and their roles in contemporary research (Kenny, 2000).

Indigenous worldviews also emphasize reciprocity and relationships. In acknowledging the connections between all things and the constant striving for balance, there is a need to acknowledge our relationships and the reciprocity within these relationships. Reciprocity in nature is as clear as our relationship as humans with trees – what a tree exhales, we inhale, and a tree inhales what we exhale (Graveline, 1998). We both rely intimately on this reciprocal relationship for life. Connecting this teaching
to research suggest attention to the reciprocity in multiple relations – beyond those between the researcher and participants. For example, relationships between the researcher, participants and the environment; relationships between the research process and the health and well-being of those involved; and relationships between the researcher, participants, the Ancestors and those spirits yet to be born. Reciprocity is an act of balance, marked by humility – to (learn to) be able to recognize when to give and to receive, how to be big and small, quiet and loud, strong and focused yet flexible and adaptable. Reciprocity is about how we work to maintain balance, attending to all things around us, behind us (the past) and in front of us (the future).

Decolonizing is a fundamental part of my Indigenous theoretical framework. Indigenous researchers and indeed all researchers from communities who were and are the targets of colonization, undertake dual roles of having to learn, understand and articulate the impact of colonization upon their peoples and their knowledge(s), while also articulating epistemologies and methodologies capable of responding to the complex and complicated circumstances and challenges faced by their communities and nations. It requires the capacity to hold dual consciousness (Dubois, 1903), epistemological bi, tri or multilingualism, and the willingness to stand one’s ground in the face of potentially significant threat.

Because of the role of research and knowledge production in the colonization of millions of peoples around the world, I would argue that it is the role and responsibility of all researchers, Indigenous and non-Indigenous, to take up the task of decolonizing the ways in which we construct, teach and enact knowledge. This requires a critical consciousness of both the historical and ongoing impacts of colonization, in particular
the ways in which research has been profoundly implicated in colonial agendas and efforts. Decolonizing the way we deal with knowledge also requires an ongoing practice of reflexivity to the ways in which our social location impacts our epistemologies, ontologies and subsequently our ways of moving and being in the world; this reflexivity is crucial to be able to recognize our actions as contributing to or transforming colonialism. An Indigenous theoretical perspective implicitly takes up decolonization but with hyper-vigilant attention to ensuring that a focus on colonization does not allow its re-inscription as the centre (Smith, as cited in Kovach, 2009), instead centring the resurgence of Indigeneity.

For me, an Indigenous worldview was foundational to creating research able to rupture, rather than perpetuate, the colonial practices that have long defined the landscape of knowledge about Indigenous peoples in Canada. Diverse interpretations of Indigenous ways of knowing are increasingly utilized as the theoretical underpinning of research with Indigenous peoples and addressing the health inequities disproportionately experienced by Indigenous communities. I also draw upon anti-colonial thought (Dei & Asgharzadeh, 2001) and anti-oppressive practice (AOP) perspectives (Dominelli, 2002; Sakamoto & Pitner, 2005) to assist in articulating the theoretical framework for this program of research, particularly in establishing how research knowledge may be translated into social work and social action through education, policy, programming and services.
Connecting to Social Work: The Contributions of Anti-Colonial Thought and Anti-Oppressive Practice Theory

Anti-colonialism not only allows for theorizing the impacts of colonization and colonial relations, but for the value and importance of Indigenous knowledges as a means for moving forward, a means of decolonizing (Dei & Asgharzadeh, 2001). As a theoretical framework, anti-colonialism not only centres Indigenous knowledges, but echoes the calls of Indigenous researchers for a revisionist agenda. Research, or what I understand from Indigenous perspective as the work of gathering, caring for and sharing knowledge, must not simply focus on what is, but actively work towards what ought to be (Dei & Asgharzadeh, 2001; Smith, 1999). Anti-colonial thought provides a lens for critically analyzing the lived and living impacts of insidious structural oppression, as well as helping to identify positive means forward through Indigenous knowledge practices and the creation of solidarity towards decolonization.

In practical application, Browne, Smye and Varcoe (2005) draw on postcolonial theory to make recommendations for Aboriginal health research and healthcare practices from a nursing perspective. The use of this example is not meant to erase differences between the positions asserted by anti- and postcolonial theorists. Rather, the example is appropriate because the theoretical approach of Browne et al. (2005) shares significant commonality with its anti-colonial cousin. The postcolonial stance employed by the authors does not imply, as some postcolonial theorists do, a colonial history and a separate era of contemporary neo-colonialism. Instead, they posit colonization as continuous but evolving, effecting new or mutated forms of colonial relations and inequities in its wake. Browne et al. (2005) highlight the capacity of postcolonialism to remind us of “the deep-rooted attitudes and relations of power that
are built into the fabric of the systems in which we conduct our research and practice” (p.33). In response, they recommend a model of cultural safety to effectively shift the focus from cultural traits or differences of Aboriginal peoples as the supposed source of difficulty in healthcare and health outcomes, to examining the culture of healthcare. How does the culture of healthcare, whether through policy, practice or research, reinforce the health inequities and social marginalization rooted in historical and ongoing acts of colonialism? The authors assert that cultural safety asks researchers, policymakers and practitioners to examine how their work may inadvertently devalue or create risk for certain groups. The authors also speak to existing critiques of postcolonial theories as essentializing and reifying commonality of a given group, and therefore feeding oppositional binary relations of ‘colonizer’ and ‘colonized’. In response, they advocate the use of intersectionality to recognize the diversity of identity and experiences within groups (i.e. among Indigenous peoples, for example, the different lived experiences of an Inuit woman vs. a two-spirit First Nations man). Further, they acknowledge that a binary opposition of colonizer/colonized is not useful in creating movement and change, and instead cite McConaghy (2000) in proposing a focus on understanding and addressing specific forms of oppression operating at specific sites (p.24).

For the purposes of directing research, Browne et al. (2005) identify the strength of a postcolonial approach in requiring continuous attention to issues of voice and partnership in research processes, to the application of knowledge for social change, to the relationship of our past and our present, and to identifying and mitigating the potentially oppressive effects of research. Moreover, they identify the key role of postcolonialism in rupturing dominant knowledge practices, and centering the voices,
knowledge and lived experiences of marginalized bodies. Applying this to the health of urban Indigenous women requires the women to have a foundational role in research: defining the issues, guiding the design, implementation, analysis and application of research. Notably, this echoes key issues in Aboriginal approaches to research in terms of self-determination and control of the research process.

Originating from the context of Maori health research, cultural safety springs forth from postcolonial perspectives and provides a lens for critical analysis of the ways in which everyday policies and practices shape health inequities (Browne et al., 2005). As cultural safety gains increasing recognition in nursing, it can also contribute to social work pedagogy and practice. The proposed conceptual framework within this comprehensive paper advocates for the adoption of anti- and postcolonial perspectives within social work, to require continuous attention and social action towards the transformation of colonial power relations. Embracing and adapting models of cultural safety would also acknowledge the history of social work with Indigenous peoples, and work to prevent further reproduction of oppressive relationships between social workers and Indigenous service users, or social work researchers and Indigenous communities.

Already well-rooted in social work, AOP perspectives also undertake to identify, challenge and transform the structural roots of oppression, promoting social justice, solidarity and inclusion (Dominelli, 2002; Sakamoto & Pitner, 2005). Echoing the model of Browne et al. (2005) described above, AOP calls for ongoing reflexivity of one’s thoughts and actions. AOP perspectives contribute to the conceptual framework by helping to identify practical applications to social work pedagogy, theory, research and practice in order to advance the health of urban Indigenous women. Anti-colonial and

The Indigenous model of AOP forwarded by Thomas and Green (2007) provides a helpful framework for imagining meaningful ways of engaging social workers in the transformation of urban Indigenous women’s health and well-being. The model is based in teachings of the medicine wheel as follows. Beginning in the East, the authors state that social workers must situate their work within the context of the past. They must, the authors stress, have a thorough understanding of the histories of Indigenous peoples in Canada, including a deep appreciation of the acts and impacts of colonization. Social workers must actively examine how historical colonial policies and practices continue to affect the contemporary day to day lives of Indigenous peoples, and account for how social work has been implicated in the histories of Indigenous peoples across Canada. The authors assert that social workers must constantly work to understand the experiences of service users in the context of the past. For example, have service users had previous experiences with social work? Have they or a family member experienced residential schooling? Further, social workers must work to understand themselves within the context of their own past. In doing so, social workers become better able to understand how they have arrived at their understanding of the world around them and their role within it, and the implications of this for those they work with.
Moving to the South, the authors underline the focus on the self. Social workers need not only understand their past, but constantly examine their values and beliefs. These values and beliefs, they assert, should be continuously reflected in our behaviours and our actions. In this way, the authors view AOP not as a stance or a practice social workers do as part of their job, but as a way of life, a way of being in the world. Social work pedagogy should engage in asking students to reflect on how they have come to understand and act upon definitions of health and well-being, and how the systems that social workers are actors in enhance, impede or harm the health of those we work with.

In the West, the focus is on praxis: bringing understanding of history together with self-reflection to inform ‘best practices’. The authors provide examples of such practices, including: examining and understanding one’s assumptions, fostering and maintaining meaningful relationships, and shifting from a focus of ‘fixing’ a service user or their issues, to a focus on their strengths and resiliency. While these skills are quite recognizable within non-Indigenous approaches to AOP, Thomas & Green highlight an Indigenous teaching they consider to be crucial to transforming practice. This is the notion of the journey between the head and the heart, which empowers social workers to rupture the illusion of objectivity in practice. Thomas and Green state that Indigenous Elders have long taught that the longest journey in the world is that between our head and our heart. The practice of ‘de-objectifying’ clients and their lives is an acknowledgement of our responsibility for the relationships and connections we make with those around us. This practice should also be reflected in social work documentation, as all communication is considered sacred and should honour the
people whose lived experiences we are describing in our ‘professional’ comments. Moreover, these documents can continue to shape the lives of service users long after we have filed them away.

Finally, looking to the North, social workers must reflect on their practices and move towards a vision of the future. The authors pose some poignant considerations in this regard, such as what will children say if we ask them what a social worker is? What would our ancestors say? If we want future generations of children and adults, both Indigenous and non-Indigenous alike, to have positive views of social workers then we must enact the behaviours that will support that view now. Thomas and Green also speak directly to relations between Indigenous and non-Indigenous peoples. They state that Indigenous peoples have, as part of colonization, long been subjected and made to submit to non-Indigenous ways of knowing. Now, they assert, it is time that non-Indigenous social workers engage with Indigenous ways of knowing in order to engage in practice in ways that reflect a way of life meaningful to those they are working with (i.e. Indigenous service users). This is congruent with the model of cultural safety recommended by Browne et al. (2005), in terms of shifting the onus of adaptation to those systems and bodies providing services, rather than those accessing services.

The theoretical perspectives set out here contribute towards a more comprehensive and holistic understanding of urban Indigenous women’s health and well-being, and provide some clear directions for social work. Social work education must include thorough examination of the histories of Indigenous peoples both prior and subsequent to colonization. Social work education needs to provide models of practice that require students and therefore practitioners to understand how Canada’s colonial
histories have and continue to shape the lives of Indigenous and non-Indigenous peoples alike in Canada. This would also include in-depth examination of the historical role of social workers in colonial practices and how this impacts contemporary practice. Moreover, these theoretical perspectives compel social workers to view themselves as agents in the health and well-being of Indigenous peoples, who contribute towards transforming or maintaining inequity by either electing action or inaction. Anti-oppressive, anti- and postcolonial theories act as effective helpers in translating and fostering links between Indigenous ways of knowing (including approaches to research) and western academic institutions, social and health service systems, and pedagogical practices.

**Finding our way: A compass for moving forward in re-visioning the health of urban Indigenous women**

The theoretical framework set out below for the proposed study is grounded in an Indigenous worldview and informed by the existing literature, the ILCSDAH framework, anti-colonial, post-colonial and anti-oppressive practice theories. It has informed my preparations and process as a researcher carrying my intention to honour participants, their voices and stories.
In Figure 1, the inner circle represents the centering of urban Indigenous women’s voices in the research, policies, programs, and services relating to their health. Urban Indigenous women should hold leadership roles in transforming the systems that impact and respond to their health, and sufficient resources and support must be provided by relevant municipal, provincial, territorial, and federal agencies, and Indigenous organizations alike, in order to ensure ongoing opportunities for meaningful participation. In recognition of the barriers to participation for Indigenous women, this would include the allocation of resources to assist with childcare, transportation, the provision of food (during meetings and workshops) and access to ongoing opportunities.
to enhance knowledge and skills. Urban Indigenous women should be actively involved in service provision and management, program evaluation, policy development and research pertaining to their health. The centering of the women honours their lived experience, wisdom, strength and vision. It also aligns with NWAC’s CRGBA in contributing towards the revitalization of the value of Indigenous women’s roles in society (NWAC, 2007b); and echoes the work of Kim Anderson (2009) who notes that the management of health and well-being in communities and health research have long been “women’s work” in Indigenous societies (p.507).

The second circle represents the families, communities, Nations and broader society in which Indigenous women play integral roles in the health of, and which likewise play an integral role in the health of Indigenous women. This reflects the collectivist values of Indigenous peoples and also reinforces the role and capacity of Indigenous women in transforming the health of their families, communities and Nations. Moreover, it acknowledges that Indigenous women have wisdom and skills to offer in helping to improve health conditions in broader Canadian society, for both Indigenous and non-Indigenous peoples alike.

The four “arms” within the model encompass the health policies, programs, practices and research addressing the health of urban Indigenous women. The relationship between Indigenous women and these vehicles of the health system have overwhelmingly operated in a unidirectional manner (the system impacting the women), and this conceptual model advocates for a dramatic change in direction. These “arms” extend outward from the centre, reflecting the positioning of urban Indigenous women as the drivers of policies, programs, practices and research needed to transform their
health and that of their families and communities. The “arms” reach out and connect to the third circle which represents the systems interconnected to the health and well-being of urban Indigenous women, including but not limited to: child welfare, justice, housing, economic/labour, education and social services. This reflects Indigenous notions of interconnectivity and holistic health, recognizing that an individual’s well-being (physical, emotional, mental and spiritual) is deeply affected by access to such things as affordable, secure housing, adequate income, inclusive education, supportive social services and so on. Moreover, policies, programs, services and research need to speak to these interrelationships and help to create needed change in related systems in order to enhance Indigenous women’s health. Reflecting anti-colonial and post-colonial perspectives, requires special recognition of the ways in which colonization has and continues to shape the ways in which Indigenous peoples are monitored, regulated or treated within these systems.

Finally, the entire framework is encompassed by a traditional Indigenous teaching that asks us to attend to the past, within the present, for the future. Future research, policies, programs and services need to embody understanding of the past – starting with the histories, teachings and practices of Indigenous peoples prior to contact (specifically related to gender, health, healing and the gathering of knowledge), as well as demonstrating deep appreciation of the history of colonization of Indigenous peoples in Canada. Further, we must evaluate and re-evaluate what we know in the present time. What services, programs or policies already exist? What are the dynamics of mainstream and Indigenous governance that impact on accessibility and relevance of health and related services for Indigenous women? How is colonization actively
manifest in Canada today? How are Indigenous ways of knowing reflected in current approaches to health and healthcare? The theoretical perspectives outlined here also compel a vision of the future, of what urban Indigenous women wish to see. The future vision (or “re-vision”) provides a path forward and reminds researchers, policymakers, healthcare providers and social workers that our actions today must embody the spirit of what we wish to see in the future. The relationship is imagined as continuous, in which future vision is constantly re-imagined to reflect our rapidly transforming society, but always embodies Indigenous ways of knowing, demonstrates and responds to the impact of colonization, and appreciates how these inform our current context.
CHAPTER 4: APPROACH TO RESEARCH

Within and beyond the “city limits”: The context, challenges and possibilities of urban Indigenous health research

Indigenous health policy, programming and research in Canada have largely focused on the needs and challenges of on-reserve and rural communities (Kurtz, Nyberg, Van Den Tillaart, Mills & OUAHRC, 2008). With the tremendous growth of urban Indigenous populations, there is increased attention to gathering data to better understand and respond to the health needs and challenges of urban Indigenous peoples. Urban Indigenous health research does come with unique challenges and opportunities that are best understood in the broader context of Indigenous research ethics and Indigenous health policy in Canada.

Indigenous research: Ethical paths to revitalization and decolonization

There has been a significant increase in scholarly writing about Indigenous research practices, principles and ethics in recent years, produced by a rapidly growing body of Indigenous researchers. Many of these scholars have paid a very high price to enter, remain and make space in academic settings for Indigenous peoples. Their efforts – visible and invisible - have opened possibilities, opportunities and breathing space for those who have followed behind them and those who are yet to come. They have gathered, cared for and shared knowledge about what Indigenous research meant before contact, of what it means in the context of ongoing colonialism, and of what it can be as we move forward in the motion of transformation and revitalization.

Because of the context of colonialism, great attention has been particularly paid to the ethics of research with Indigenous peoples. This includes the OCAP (ownership,
control, access and possession) (Schnarch, 2004) and OCAS (ownership, control, access and stewardship) principles which have gained a strong footing in many First Nations and Métis communities respectively, as well as the CIHR Guidelines for Research Involving Aboriginal People and the subsequent revisions to Chapter 9 of the TCPS discussed in Chapter 2. These principles and guidelines all, in one way or another, set out to clearly protect Indigenous communities and their knowledge(s) from theft and mistreatment. The emphasis on shifting the power in the research process with Indigenous communities away from the researcher and toward the communities themselves is implicit in the language of, for example, ownership and control. Within the ethical frameworks of OCAP, OCAS and the CIHR Guidelines, there is a significant emphasis on engaging with First Nations, Métis and Inuit local governance, or where established, local First Nations, Métis, or Inuit research ethics review bodies.

For this research, this model of engagement is challenging on two accounts in terms of: 1) gender in Indigenous governance and leadership; and 2) urban governance. As described in Chapter 3, traditional forms of matriarchal governance and more generally the roles of women in leadership and decision-making were substantially impacted by colonization, particularly by the imposition of the Indian Act. The insertion of Band Chief and Council models of governance, along with stipulations that prevented women from either electing or running for Chief or Council, forcefully ruptured the traditional presence of women in decision-making until legislative amendments in 1951. This rupture remains visible in Indigenous leadership today where, for example, less than 20% of First Nations Chiefs in 2012 were women and Assembly of First Nations has to yet to elect a woman as National Chief. While Indigenous women carry multiple

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4 Aboriginal women were not able to vote in “Canadian” electoral systems until 1960.
roles of leadership in their families and communities, with increasing presence in “formal” governance structures, the male dominance in leadership institutionalized by colonization persists. Chapter 9 of the TCPS 2, recognizes the challenge this poses in the context of research:

“Gender-based analysis is being applied in First Nations, Inuit and Métis organizations and communities to promote or restore recognition of women’s responsibilities in the conduct of community life – including decision making that directly affects their welfare. The legacy of patriarchal governance structures continues to pose challenges to women’s full participation.”

In a context of ongoing patriarchy, I do not believe that it is not enough to hope or assume that engagement with Indigenous community leadership will ensure full access or participation for Indigenous women in the design, implementation or uptake of research. Rather, I believe it is incumbent and imperative to specifically attend to how Indigenous women can have access to and engage in research in ways that are meaningful to their lives, advance their health and well-being, resist patriarchy and revitalize Indigenous women’s roles in leadership and decision-making.

In the context of urban Indigenous communities, navigating engagement of the community via leadership becomes even more complicated. While there are urban reserves in Canada, they constitute only part of the geography of a given city. Beyond urban reserves, the diversity and mobility of urban Indigenous peoples in cities poses particular challenges to imagining and implementing governance structures. At present, Friendship Centres play a significant role in serving and representing urban Indigenous peoples, as do Indigenous health and social service agencies. In urban Indigenous research, these organizations frequently serve as proxies for community engagement. Friendship Centres emerged in the 1950s as increasing numbers of Indigenous peoples
moved into urban centres\textsuperscript{5}. The Native Canadian Centre of Toronto is in fact the oldest Friendship Centre in Canada, originally opening in 1951 as the North American Indian Club of Toronto. While the Centres were initially supported by volunteers and local fundraising, they slowly transitioned to more formal funding through provincial/territorial governments and then in 1972, through the federal “Migrating Native Peoples Program” (MNPP) (NAFC, 2012). The 1970s also saw an increasing move by Friendship Centres to frontline social service delivery, expanding their response to a range of issues including housing, employment, health and education (NAFC, 2012). At the national and provincial levels respectively, NAFC and the Ontario Federation of Indian Friendship Centres (OFIFC) have made tremendous efforts towards identifying and responding to the unique needs of challenges of urban Indigenous peoples, supporting and expanding the role of Friendship Centres to include policy analysis and development, research and more in-depth frontline services.

Indigenous health and social service agencies have also played significant roles in advancing the health and well-being of urban Indigenous peoples and are also recognized as a point of contact and/or proxy to community engagement. There are challenges to the reliance on either (or both) Friendship Centres or Indigenous health and social service agencies as representatives of the community in the research process (speaking in terms of research initiated outside of these organizations), including: 1) that the community does not select these organizations as their representatives; 2) that the client “reach” of these organizations does not necessarily represent the urban Indigenous population as a whole; and 3) that, similar to the Band

\textsuperscript{5} Prior to the 1950’s, movement of Indian peoples on reserve was restricted by a pass system in which Indians could only leave reserves with a pass issued by Indian Agents. This pass system was in effect from 1886 until well into the 1940s.
Chief and Council model, issues of gender in leadership and decision-making in governance also arise. Toronto’s largest and most well-resourced health and social service organizations are run by male executive directors, several of whom have held these positions for significantly lengthy periods of time. At the same time it is important to note that the number of Indigenous women leading health and social service organizations in Toronto is certainly increasing. These observations about gendered leadership are not intended in a spirit of divisiveness or meant to suggest that same-gender leadership guarantees better attention to the health needs and challenges of Indigenous women, or that opposite-gender leadership will result in less than satisfactory outcomes. Such an assumption is naïve and does not account for deeper, more complex understandings of gender within Indigenous worldviews most recognizably embodied in the contemporary context in the teachings, practices and lives of two-spirit peoples. Rather it is about attending and responding to the ways in which colonization imposed and institutionalized patriarchal governance in Indigenous communities and how this has and continues to impact Indigenous women’s ability to engage in full participation in shaping research, policy and programs relating to their health and well-being.

I would also argue that analysis of Indigenous women’s access to and participation in decision-making must also account for factors other than shifts in numbers of leaders, to examining, for example, the level and stability of funding support of different organizations. To this end, it is important to recognize the colonial context in which Indigenous health and social service organizations and programming are funded generally and how this connects to the research at hand.
The bigger picture: Aboriginal health policy and funding in Canada

Aboriginal health policy and funding in Canada is a complicated patchwork informed by historical and ongoing relationships between Aboriginal and non-Aboriginal peoples. The following section attempts to provide an overview of the complexities that shape the current state of Aboriginal health policy and funding practices. Aboriginal health policy in Canada is informed by the 1867 British North America Act which assigned health as a provincial matter and Indian affairs as a federal matter, generating ambiguity about the responsibility for Aboriginal health that persists today (NCCAH, 2011). Treaty rights also inform present access to healthcare via the "medicine chest" clause of Treaty 6, signed by the Cree Nation in 1876. This clause stipulated that a medicine chest would be made available in the home of every Indian agent and has since been interpreted in the judicial rulings Dreaver et al. v. The King (1935) and Wuskwi Sipihk Cree Nation v. Canada (Minister of National Health and Welfare) (1999) as extending the benefit of free healthcare for all treaty Indians (Boyer, 2003; Bent, Havelock & Haworth-Brockman, 2007). At present, the federal government is responsible for the healthcare of status, on-reserve Indians and Inuit people residing in their traditional territory, while hospital and physician care lies within the mandate of provincial and territorial governments (NCCAH, 2011). Through the First Nations and Inuit Health Branch (FNIHB) the federal government also provides non-insured health benefits (NIHB) for status Indians and Inuit people regardless of their place of residence. The NIHB program covers prescription medications, vision and dental care, short-term crisis intervention and mental health counselling, medical transportation and some medical supplies and equipment (Bent, Havelock & Haworth-Brockman, 2007).

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6 Status Indians who belong to a First Nation that was a signatory to a treaty with the Crown
Non-status Indians and Métis people are ineligible for NIHB coverage. The responsibility for the health of non-Status Indian and Métis peoples are generally recognized as resting with the provincial and territorial governments however, there is tremendous diversity between the Aboriginal health policy and funding frameworks of each province and territory (NCCAH, 2011).

Inter-jurisdictional in-fighting continues to be a normative aspect of Aboriginal health in Canada, excruciatingly highlighted by the experience of Jordan River Anderson, a little boy from Norway House Cree Nation in Manitoba. Jordan was born with a neuromuscular disorder and required hospital care for the initial three years of his life; he spent the remaining two years in hospital despite his family’s wish to take him home as the federal and provincial governments could not agree about which was responsible for the cost of Jordan’s homecare (NCCAH, 2011). Jordan died at the age of five in hospital, without ever having lived in his family home (NCCAH, 2011).

“Jordan’s Principle”, championed by the First Nations Child and Family Caring Society of Canada (FNCFCSC) and introduced into Parliament by a private member’s motion, was unanimously voted through in the House of Commons in 2007. The motion stipulates that whichever government has first contact in the provision of medical care for a First Nations child shall cover the cost first and then seek cost-sharing or reimbursement remedies after the fact (NCCAH, 2011; FNCFCSC, 2011). Despite its passage in the House of Commons and the endorsement of several provinces, Jordan’s Principle has had limited uptake (NCCAH, 2011; FNCFCSC, 2011). In April of 2013, a federal court decision was issued in the case of Pictou Landing Band Council and Maurina Beadle v. Attorney General of Canada ruling that the Principle is binding on the
Government of Canada. While this seemed like a positive step forward towards a more substantive response on the part of provincial, territorial and federal governments, the federal government has since filed for appeal.

In addition to inter-jurisdictional disputes, there are other chronic issues that plague the funding of Aboriginal health services in Canada. I know these well from my work life and they are also documented in research (Health Council of Canada, 2011). The roll of short-term, unstable funds often distributed right before the end of the fiscal year as governments find excesses in their budgets, leaving service organizations and frontline service providers little time to plan, deliver and evaluate services in a meaningful way. Service providers are also frequently burdened with extensive reporting requirements that can impede how much time they can actually spend delivering the service as opposed to attending to reporting on how the funds have been spent.

The month of March, bringing the end of the government fiscal year, regularly represents a time of uncertainty of employment for a portion of Aboriginal health and social service providers and similarly, uncertainty of continuation of services for service users, as it is common for many programs to receive single year funding agreements with no notice of renewal or discontinuation until March. This practice was executed by the federal government in its 2012 budget, in which severe cuts to Aboriginal health at the national level were slowly and quietly announced in April 2012. These cuts substantially gutted multiple national Aboriginal organizations, slashing all Health Canada funding to the Native Women’s Association of Canada, Pauktuutit Inuit Women of Canada and the Congress of Aboriginal Peoples, and defunding and closing the
National Aboriginal Health Organization. The Health Canada funding to the Assembly of First Nations and Inuit Tapiriit Kanatami was reduced by 40%, and the First Nations Statistical Institute funding was cut by 50% in 2012 in a step down to zero funding in 2013. Molema (2011/2012) asserts that these cuts not only impact the availability of Indigenous-led health programs and services, but that “this withdrawal of funds, and in the long-term, defunding effectively contributes to muzzling these agencies’ capacity for research, alternative policy development, and advocacy on behalf of their communities” (p. 4).

Dr. Caroline Tait, a Mêtis researcher at the University of Saskatchewan, has aptly identified the historical and ongoing poor practices in funding to Aboriginal health programming as a matter of ethics. She draws on her experience of evaluating the implementation of a locally adapted Parent-Child Assistance Program (P-CAP) for the Northern Inter-Tribal Health Authority (NITHA) in Saskatchewan. The P-CAP program, identified as a ‘best practice’, aims to reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) by pairing women who are at high risk of giving birth to a child with FASD with a woman mentor from the community; mentors typically have a background in addictions or social work (Tait, 2008). Tait (2008) writes that one particular aspect of P-CAP that is relevant to and resonates with First Nations is a foundational belief that mentors who have faced similar adversities to the women they are working with are uniquely skilled in being able to build connections and hope with their clients. This powerful, strengths-based program was funded by FNIHB and piloted in four communities identified by the NITHA. Intended as a three year pilot project, the program experienced multiple delays and shifts in funding from FNIHB that greatly impacted the
delivery of the program as well as the service users, services providers and their communities:

“Building the level of trust required to work with clients around these issues takes considerable time and close one-on-one support. However, a limited timeframe, small local project budgets, and funding uncertainties undermined the efforts of mentors when they made strong meaningful connections with these high-risk clients. Mentors also reported that community histories of inconsistent government programming meant that the women targeted by the pilot project commonly held feelings of mistrust, betrayal, marginalization, and indifference about what was being offered to them. Unfortunately these feeling were reinforced as expectations were raised and then dashed for clients when the program closed prematurely. Important to note is that many clients came to view the pilot project as a source of promise and hope that not only offered them assistance to change their life circumstances, but also simultaneously validated their citizenship within the community as being important enough to receive special attention and support. Mentors and health directors reported that once those expectations were shattered, clients, mentors and the local health care teams, experienced a collective sense of hopelessness, worthlessness, and defeat that is still felt today in the communities around the issue of pregnancy and substance abuse.” (Tait, 2008, p. 51-52)

Since writing about the experience of NITHA in receiving inadequate and delayed funding from FNIHB, Dr. Tait has developed the “Ethical Toolkit”7 for First Nations, Inuit and Métis health and social service leaders outlining ethical standards to be met by government and other outside funders in entering into funding agreements with First Nations, Inuit and Métis peoples (Tait, 2011). This approach to funding relationships emphasizes respect for and protection of the interests and integrity Aboriginal communities seeking government or other external funding, and most importantly, provides a means by which to hold funders accountable to the communities they have engaged in funding agreements (Tait, 2011).

7 For more information on the Ethical Toolkit, see: https://ethicaltoolkit.ca/content/purposetoolkit
Why does this matter to urban Indigenous health research?

It matters to speak about the historical and contemporary issues that shape Aboriginal health policy and funding in Canada to situate my decision-making in constructing my research. It also helps to resist feeding stereotypical and racist discourses that work to erase the historical and ongoing effects of colonization on the lives of Indigenous peoples and instead pathologize the contemporary challenges we face in our health and well-being as the result of poor personal choice or inferiority.

The substantial cuts to funding and chronic poor funding practices contribute to a strained state of competition between Aboriginal health and social service organizations generally chasing the same small pool of funding dollars. In my brief tenure in the Aboriginal Health Strategy Unit of the Ontario Ministry of Health and Long-term Care, I was told by a senior staffer that Aboriginal health funding is like throwing a piece of meat into a pack of dogs and having them fight over it. Beyond what I would describe as the deprivation and divide and conquer techniques of government funding for Aboriginal peoples I knew of more generally, this statement made clear how much of the politics among and between Aboriginal health and social services organizations was not only systematically created but also institutionally held in place as a normalized practice for funders.

For me as a researcher, I chose not to tie the research at hand to any specific Aboriginal organization for many of the reasons I have discussed here. I had concerns about the reach of health and social service agencies and about using these as representatives of the community, and within this I also wondered about the challenges of assuming a singular Aboriginal community in Toronto. I had concerns about the
politics within, among and between these same organizations including those fed by funding structures and practices and the territoriality that can engender. I had concerns about the presence and impact of patriarchy in Aboriginal organizing and leadership subsequent to the colonial context described herein and I thought a lot about ways to bring forward women outside of organizational contexts to help shape the research and to serve as a means of accountability and transparency for the research. All of this and my previous experience of research in my former employment at the Native Women’s Association of Canada (NWAC) led me to build the research around the engagement of a Community Advisory Council of Aboriginal women to help guide the research and to help me be accountable as a researcher and community member.

**Making myself and the research visible: The Community Advisory Council (CAC)**

*Many eyes, many ears, many hearts, many minds.* Coming from a collectivist worldview, I wanted and needed to involve other Aboriginal women – to ensure that the research was witnessed and shaped by the wisdom of more eyes, ears, hearts and minds than just my own. The CAC is a small circle of five women: a Grandmother with lengthy and ongoing experience in front-line service provision in Aboriginal and social services, an Aboriginal midwife with a wealth of practice-based knowledge including the strengths, needs and challenges of child-bearing women, an Aboriginal physician/researcher with a specialized focus in Aboriginal health and urban Aboriginal health, an Aboriginal youth who is also a student studying a health profession, and an Aboriginal community member with significant experience and understanding of both traditional and mainstream health services here in the city of Toronto. This circle of women represents a wealth of diverse knowledge and lived experience across the
lifecycle, able to draw on their personal, professional, individual and community experiences in helping to inform this research.

The CAC was gathered together to provide guidance towards ensuring that the research would be carried out in a culturally relevant, meaningful manner. I envisioned and understood it as serving an important role in ensuring researcher transparency and accountability, by making myself as the researcher and the process of my research visible to other Aboriginal women and subject to their input and approval. I was familiar with the model of community advisory councils from my work at NWAC where we had gathered together a CAC to provide guidance on (separate) national projects addressing senior abuse of Aboriginal women and the impact of neurological conditions on Aboriginal women. Because NWAC is a national Aboriginal organization (NAO) and the only NAO solely representing the interests of Aboriginal women, there was tremendous emphasis on attending to geographical, historical and cultural diversity, and centering the voices and vision of Aboriginal women. Attention was also given to gathering those who could speak to the focal issue and/or to methodology, as well as those with lived, frontline, policy or research experience in the area. Here, I emphasized gathering women across the lifecycle, reflecting a range of social locations and a breadth of experiences in accessing, utilizing or providing health care in Toronto.

With the intention of honouring self-determination within the research process, the research design was framed as “emergent” in order to allow the CAC to genuinely participate in shaping the approach to gathering, analyzing and sharing the stories of urban Aboriginal women in Toronto. Given the egregious history of research ‘on’ or ‘about’ rather than with Aboriginal peoples, ensuring that Aboriginal communities and
participants have the opportunity to meaningfully shape the research is a necessary act of decolonizing and firmly centres reciprocity within the research process (Koleszar-Green, 2007; NWAC, 2010). Honouring the role of the community in developing the focus of the research intentionally moves away from the practice of researchers prescribing the research ‘problem’ to communities (Baskin, 2005; Koleszar-Green, 2007; Lavallee, 2007; Lavallee, 2009; Letendre & Caine, 2004; Schnarch, 2004).

The CAC members not only provided input and guidance on the process of the research, but also generously and kindly provided significant care for me as the gatherer of knowledge throughout the research process. I experienced this as a very holistic form of care that acknowledged and helped me to attend to myself emotionally, physically, spiritually and mentally; I felt recognized as a whole person who was learning and growing in the process of research while juggling multiple roles, most notably as a single mom. This kind of care on the part of the CAC could be construed as caring for the researcher as the ‘tool’ or ‘instrument’ of the research. For me, it was also a remarkably encouraging and healing process of being mentored as a caregiver of knowledge and helper by incredibly humble, wise, courageous, funny and strong Indigenous women.

Communication largely consisted of email and intermittent meetings, held in small offices, over skype, telephone or at kitchen tables every couple months with some longer stretches accounting for the time demands and multiple responsibilities of both myself and the CAC members. I sought and received ongoing support from the CAC Elder which helped me tremendously in dealing with the emotional, spiritual, physical and mental impacts of listening to each woman’s story and to all of the stories.
collectively and repeatedly. During our most recent meeting, as we gathered around one member’s kitchen table, I was full of profound gratitude in realizing that I was being taught and mentored into a traditional role as a caretaker of knowledge in a traditional way by being in relation to these women and their remarkable generosity in sharing of their lived experience and knowledge. To me, this is in and of itself, a decolonizing approach to research based in active and collective remembering, revitalization and re-visioning of Indigenous ways of knowing and being.

**Gathering Knowledge**

**Research Circles and Interviews**

Within this emergent design, research circles and individual interviews were the proposed means to gather knowledge with Aboriginal women in culturally relevant and respectful ways and this was put forward to the CAC for their review and input. This reflected part of the challenge of needing to produce a thesis proposal to meet the requirements of the doctoral program, while still holding space for the guidance and decision-making of community.

Research circles were imagined as the primary mode of data collection, with individual interviews providing an option for participation for women who did not wish to, or who were unable to participate in a research circle for various reasons (e.g. scheduling; accessibility/mobility, etc.). This reflected the intent of inclusivity of the research design in anticipating and accommodating diverse needs and circumstances of potential participants, so that potential participants could self-determine which mode, if any, suited their personal needs and circumstances. The strength of this approach lies in the capacity to bring forward the stories and wisdom of Indigenous women in a good
way. While such an approach does not produce generalizable results as a quantitative
design might, I knew it could still generate meaningful knowledge for consideration and
application in other urban centres. The emergent design was employed towards
creating and implementing research that is decolonizing and culturally relevant, and
supports urban Indigenous women to steer the health research that informs the
systems and policies that affect their health and well-being and that of their families and
communities.

Research circles are a means of gathering information in a group setting in a
culturally appropriate way; they are akin to traditional sharing or talking circles and are
governed by similar protocols (Lavallee, 2009). The use of circles in research reflects
the collectivist nature of gathering and sharing knowledge in Indigenous traditions,
increasingly used by Indigenous scholars to gather information relating to a broad range
of topics including social work, health, education and child welfare (see, for example:
Baskin, 2006; Cameron, 2010; Koleszar-Green, 2007; Lavallee, 2007; Restoule, 2004).
The knowledge gathered can be applied to help raise awareness, identify directions for
change, develop or transform relationships, or build capacity to respond to the concerns
and needs of those participating, their families and communities. As with sharing or
talking circles, a research circle honours each person as having inherent gifts of
knowledge and experience to draw on in sharing, and fosters the opportunity for each
person to both share and receive knowledge. Each participant (including the
researcher) is understood to be no less or more important than anyone else in the
circle. Moreover, the nature of interaction within the circle supports the development of
social connections among those participating, as well as serving as a natural source of
support during participation. Mi’kmaq/Celtic social work scholar, Dr. Cyndy Baskin (2005), describes her approach to the use of circles in research:

“Within this methodology, participants join together, sit in a circle, incorporate spirituality through smudging, prayer, and the presence of sacred objects, follow cultural protocols of sharing food and gifts, and engage in a research process that involves the telling of their stories in relation to the topic of the project.” (p. 177)

Storytelling is an integral part of research circles, which Baskin (2005) aptly describes as a vehicle of knowledge that imbues a responsibility onto the listener and researcher to offer ways of understanding and addressing issues. Storytelling is also a source of liberation and self-determination that not only serves to gather data, but is also the means of sharing the data back whether at community gatherings, conferences or in publications (Baskin, 2005). Further, storytelling reflects the cultural and ethical protocols of Indigenous research, including reciprocal relationships, direct involvement of participants and community, honouring the goals of self-determination and decolonization, and providing for potential healing and learning (Baskin, 2005).

Like the research circles, individual interviews were also grounded in Indigenous cultural protocols, with a focus on the process of storytelling and reciprocal exchange between the interviewee and the researcher. Where research circles provided social connection, support and an opportunity for collective knowledge building, interviews were able to meet the needs of women who did not want to share in circle in relation to concerns about their privacy (for example due to overlapping roles and the smallness and interconnectedness of community), and/or due to issues of access and mobility including physical mobility as well as access limited by the busy-ness of multiple roles and demands. I also found other ways to augment access to the project including going to participant’s homes (two interviews) and conducting an interview via skype. Circles
were conducted at SGMT, Dodem Kanonhsa and the Factor-Inwentash Faculty of Social Work (FIFSW); while interviews were conducted in various locations including (as mentioned above) participant’s homes and workplaces (at their request), Dodem Kanonhsa, the FIFSW, and at the request of one participant, due to mobility challenges, in a café of a local store. All circles and interviews were conducted between November 2012 and February 2013.

Carrying my bundle

I carried my traditional medicine bundle with me to each interview and circle, setting it out on a table (for interviews) or in the middle of the circle; only one participant elected not to smudge and so I kept my bundle tucked away. This small bundle is the same bundle I carry when I teach or provide counselling. When I carry my bundle with me it is my way of physically bringing the presence of my grandmothers, my mom, my aunties and all my relations into the room with me. It is a way of reminding myself of who I am, where I come from, and of my relationships and responsibilities to those who have come before me, those who are in front of me and those who will come after me. This bundle contains medicines and sacred items passed down or gifted to me or gathered by me to help me in my work. It helps ground me to who I am and where I come from and the helpers from the bundle (stones, feathers) were also used to pass around each circle or interviewees to hold to assist them in their sharing. These helpers can be grounding, calming and help to hold the very big emotions and memories that come forward when we begin to tell our stories.

I was careful to explain why I was carrying my bundle, what my bundle was and what each item meant to me. This was meant to help participants to decide how they
wanted to engage with me, my bundle and its items and to see me in the context of my beliefs and practices. At the same time it does not assume that there is one way of being Indigenous or one set of Indigenous practices, or that even where I had a common (Anishinaabe) identity with a participant, that we held identical cultural beliefs or practices. Situating myself and my bundle in these ways was necessary and import for me in anticipating and responding to issues that I know from my own life and work. It specifically recognizes that: 1) many Indigenous peoples were dislocated and disconnected from their Indigenous knowledge(s) and practices by colonization; 2) that this dislocation and disconnection can be compounded by a sense of expectation (that may flow from non-Indigenous and Indigenous peoples alike) that all Indigenous people hold some form of Indigenous knowledge(s) and practices; 3) that a lack of access to or fluency in one’s Indigenous traditions has been or can be painfully used by others to challenge, diminish or undermine a person’s Indigenous identity; 4) that even when has had, in the face of cultural genocide, access to their traditional ways of knowing and being, they may not choose this as their way of life in the world; 5) that there is no one way of being Indigenous; and 6) that being clear and transparent about my intentions and practice with my bundle would invite and support participants to be clear about how they wished to engage with me and how much knowledge they might wish to share or not.

Generally, I found that my bundle was well received and almost all of the women engaged directly with it by smudging and/or hold a bundle item while they spoke. I even encountered an extra friendly cat in one participant’s home, who settled herself comfortably on top of my bundle and, at one point, slyly trotted off with a bundle item in
her mouth before returning it. However, I did have two participants who expressed a general discomfort about things Indigenous or traditional, not only in the context of the research circle, but also in the community more generally. Both women expressed a desire for activities in the community that weren’t necessarily “hard core” traditional to be able to meet and socialize with other community members. One of the women identified the link between her Catholic upbringing and her limited knowledge of her traditions, and the disapproval she faced from her mother whenever she had tried to engage with traditional culture.

Disapproval, shame or disconnection from family for identifying or practicing traditional ways of knowing and being was a challenge raised by a number of women who participated. While I knew of these issues from my experience of working in various communities in my time at NWAC, I had not considered the ways in which the presence of my bundle could cause discomfort for participants. It was an important learning for me and difficult to realize that by holding onto something so significant and comforting for me, I could simultaneously be causing distress for women participating. For me, it remains significant to clearly express my intentions, explain my understanding and practices, and emphasize that this is only my understanding and practice, that there is no one way and that participants get to choose how they wish to engage in ways that feel best for and make sense to them. In future research, I would still choose to carry my bundle with me, but with greater consciousness to situating its presence and accounting for what it might represent to others.
Gathering participants

In the months leading up to data collection, I attended staff meetings at the Native Women’s Resource Centre (NWRC) and the SGMT practice to promote the research. NWRC generously provided time for me to come to their meetings and offered space and time to host circles although these dates ended up conflicting with other NWRC programming and work and did not materialize. SGMT was also supportive and agreed to provide use of their practice space for two circles. The first one was sidetracked by an unintended scheduling conflict with a full clinic day, and the second one was held without a hitch. I am deeply appreciative of the time, kindness and support provided by NWRC Executive Director, Crystal Melin, SGMT Managing Partners Sara Wolfe and Cheryllee Bourgeois and all of the staff at NWRC and SGMT who were so incredibly generous with their knowledge, space, connections and the circulation of flyers to potential participants. This generosity is particularly striking given how much each of these organizations are doing without what I would consider to be commensurate financial support and resources. I also offer my great thanks to Amy Desjarlais, Manager of Dodem Kanonhsa, for her incredible support and for generously allowing me to use the Lodge space for research circles.

I also used local listservs (including the Indigenous Education Network listserv), personal and professional contacts (especially those working in Indigenous health and social services or mainstream health and social services known to serve Indigenous women) to circulate information about the research. The CAC was also very helpful in identifying contacts for outreach or referring potential participants. I also created, despite my strong aversion to social networking, a modest facebook page to help
promote the research. One participant found the call for participants in her workplace newsletter that I had not initiated contact with, so it was interesting to see that the outreach also took on its own path.

There are clear limitations to my approach to outreach. It was heavily reliant on electronic means of circulation which favours women with regular access to computers or internet capable phones. I think a richer outreach would be yielded by more in-person outreach to and posterizing at places like Wigwamen Terrace and Gabriel Dumont Non-Profit Housing (Aboriginal Housing) or programs at other health and social service organizations beyond NWRC and SGMT (such as Anduhyan, Nekenaan). NWRC, for example, offered that I could attend their regular social programs to connect with women more informally to speak about the research, but I was restricted in my own availability as a single parent and full-time student who also had to work to support my girls. I do not think these kinds of challenges are unique to my life, I expect many student researchers and paid researchers alike face such challenges and the task of trying to mitigate, adapt or otherwise manage for them. I name them here as not as an excuse but rather ownership of my own limitations as the researcher.

Toronto’s Indigenous Community – What counts, who’s counting

This research was carried out in Toronto, Ontario. According to Statistics Canada (2008), Ontario has the largest population of Indigenous peoples among the provinces and territories, and Toronto, the fourth largest urban population in Canada. While this information supports Toronto as the site for this research, it is also important to be mindful of the challenges and limitations of census data in relation to Indigenous peoples, particularly in urban settings. For example, the most recent census data
estimates Toronto’s Indigenous population as totaling 26,575 (Statistics Canada, 2008), in stark contrast to the estimated population of 70,000 asserted by Indigenous organizations and agencies in the city (City of Toronto, n.d.). Census data regarding Indigenous peoples in Canada in general is often criticized on the basis of incomplete enumeration due to non-participation of several (on-reserve) First Nations communities. At the urban level, incomplete enumeration is also a challenge in attempting to accurately project the Indigenous population size and demographics. The City of Toronto (n.d.) highlights the potential undercounting of Indigenous peoples since data is only collected for those residing in private households, and not for those residing in collective dwellings, institutions or those without housing. Enumeration issues are not a new issue to Indigenous peoples in Canada. However, I would suggest that the gross difference in populations estimates offered by Statistics Canada in contrast to that offered by the community highlights egregious power differentials in terms of who gets to say what in research, and who gets to say how that knowledge is gathered and shared. Regardless, Toronto has a vibrant and expanding Indigenous community for which this research aims to generate meaningful and useful knowledge.

**Research questions**

The same guiding questions were utilized for both the research circles and interviews covering these four areas:

1) Who are you and where do come from?

2) What helps you to be healthy and well here in the city?

3) What hinders or gets in the way of your health and well-being here in the city?
4) What do you envision as needed to support your health and well-being and the health and well-being of Indigenous women generally here in city?

The questions were set out with consideration of allowing each participant to ground themselves and contextualize their knowledge and lived experience by speaking about who they are and where they come from in whatever way made sense for them. In circle, this also allows us to have a sense of one another before we begin sharing; it highlights interconnectedness between participants and provides information to help inform participants about how much or which kind of knowledge they might want to share based on who is in the room with them. As described in Chapter 2, part of my intention for this research was to rupture the ways in which Indigenous women’s health is conceptualized and discussed, to move away from stories that start with what is wrong and instead start from the place of what we know and what we are already doing, using, or accessing to support our health and well-being. As such, the research questions were ordered to begin with what is helpful, then move to considering what hinders or gets in the way of health and well-being, and close with a visioning question that invited participants to share what they saw as needed to support their health and well-being and that of Indigenous women more generally in Toronto.

In addition to the research questions, I began all of the circles and most of the interviews with a traditional opening, which not only included an offering of smudge but also offering a prayer or a statement of gratitude and centering on the intention of coming together in a good way. As I moved through the research I also began using a closing practice of inviting participants (and myself) to end by stating something we would be taking away and something we would be leaving behind. Something to take
away was something that was helpful or useful or something that we had learned about ourselves or each other in the process; something to leave behind might be an offering of something to leave for others in the circles (or myself as researcher) or it might be something that you no longer wish to carry. For me, this practice was about helping ourselves to close up the circle or interview in a good way, but also to attend to fostering some sense of integration or closure before we all left the room to go back out into the world after sharing knowledge that required a great deal of emotional, spiritual, physical and mental energy.

**Demographic questionnaire**

All of the participants were asked to complete a very brief demographic information sheet so that I would be able to speak to the general characteristics of the women I had met with. I also emphasized the importance of choice in relation to this sheet to remind participants that they could choose which questions they felt comfortable answering. The demographic information sheet asked about the following areas: 1) Aboriginal identity; 2) age; 3) length of time living in Toronto; 4) family (having children and/or responsible for the care of an adult); 5) two-spiritedness; 6) employment; 7) education; 8) income; and 9) other.

I tried to imagine ways of structuring the questions that seemed the most open and least intrusive or directive. For example, in terms of Aboriginal identity, I asked: How do you identify yourself? I preferred this question to categories such as First Nations, Inuit, Métis, status, non-status. By positioning the question more openly I anticipated women would be able to choose a way of situating their identity that felt most meaningful to them (for example, in their own traditional language). In asking about family, I included
sub-questions about children as well as about whether a participant was responsible for the care of an adult or older adult, knowing that our women are frequently juggling multiple caregiving roles beyond parenting. I wanted a way to ask about income without using annual income scales (e.g. $0 - $10,000, $10,001 - $20,000, etc.), which I find invasive and difficult to answer when I participate in research and which do not necessarily capture fluctuations or variations in income over the course of year based on things like seasonal employment, schooling, unstable employment, etc. Further, I was mindful of the increased likelihood that I would end up with participants who I knew in some way (personally, professionally) and I wanted to provide a means of gathering information about income that did not require them to disclose their actual income level. As a result, I posed the question in the following way: “Do you have enough income to meet your basic needs (housing, food, clothing, transportation, childcare, medicines/medications)? (Circle one) No - Sometimes - Yes”.

I also chose to ask about two-spiritedness. Two-spirit is generally used as an umbrella term to refer to a rich diversity of sexual and gender variations that existed among Indigenous peoples prior to contact. It is often understood as a shorthand for Indigenous peoples who would be identified as LGBTQ in mainstream queer terminology. However, the term resists seeing one’s sexual identity as separate from one’s Indigenous identity. For different people it can mean many different things, depending upon our (access to) traditions, teachings, and the ways we know ourselves and live our lives. For me, much like Wilson (1996), it encompasses how I understand myself as a helper, my sexuality, my gender, my culture and my place in community.
As a two-spirit identified woman, I am interested and invested in making visible and normalizing the presence of two spirit identified women (and men, for that matter) as members of the community, and ensuring that our health is included as part of any discussion of Indigenous women’s health. This counters the silence around or homophobic responses to two-spirit people, whether such responses come from a hateful, fearful or confused place. Colonization brought not only physical disease and violence, but also social and spiritual disease and violence in the form of racism, patriarchy, heterosexism and homophobia. These forms of disease and violence have had significant impacts on the lives of two-spirit peoples, compounded by colonial policies and practices, most notably residential schooling. Residential schools not only embedded homophobia through Christianization, but also created fear and rage for many who survived same-sex sexual abuse at the hands of priests and nuns. There is tremendous healing, teaching and transformation happening around two-spiritedness at this moment. In Toronto, the Native Youth Sexual Health Network (NYSHN) is leading a gathering of two-spirit and ally Elders, Aunties, Uncles and Helpers to help identify, improve and mobilize support for two-spirit youth and two-spirit people generally here in the city. Attending to two-spirit women’s health and well-being is also of particular interest since the vast majority of two-spirit research, services and programming is directed towards two-spirit men.

**Brief demographic profile of the participants**

The following brief description of the participants is based both on the information provided in the demographic information sheet and within the course of the interviews and research circles. Some women chose not to answer all questions on the form, or
may not have addressed some of the demographic areas specifically in their stories; I indicate where information was not provided by all participants. There were a total of twenty-three participants who participated in either individual interviews (n=9) or one of four research circles (n=14; research circles ranged in size from 2 to 5 participants).

Women described their Aboriginal identity in a number of ways, most identifying by their First Nation (e.g. Cree, Coast Salish, Ojibwe, Haudenosaunee, etc.), or as a First Nations or Status (n=15). Two participants identified as a Métis, one as Aboriginal, and the remaining five described their unique mixed identities. Within these mixed identities some of the women also described a flow between their different heritages that either held similar practices or traditions to Aboriginal ways of knowing and being (e.g. Celtic) or within which they had also Indigenous ancestry (e.g. Carib). There were no Inuit identified women. The participants ranged from 21 to 57 years of age, with the following age range distribution: 20’s (n=3), 30’s (n=4), 40’s (n=11), and 50’s (n=5).  

While a small number of women had been born and raised in the city, most had come as children or as adults to Toronto. At the time of the interviews and research circles, participants had been in Toronto for as little as a year and a half to more than fifty years, with an average of 20 years of residency. This echoes the Urban Aboriginal Peoples Study Toronto Report, which found that while Aboriginal peoples in Toronto were mostly first generation residents, they were also likely to be long-term residents having lived in Toronto for 10 years or more (Environics Institute, 2010). Twelve women identified as having children (including step-children), with family size ranging between one to four children, with an average of two. Many were single.

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8 Average not provided as not all participants used fixed numbers, e.g. “40ish”, “late 40s”.
9 Based on the length of time in Toronto data for 21 of 23 participants; information was not provided by two participants in their demographic sheets or interviews.
parents or had been single parents for a significant period of time prior to current partnerships. Three were presently responsible for the care of an adult and four had recently been responsible for the care of one or more adults, most often ill or elderly parents. Three of the twenty-three women identified as two-spirit.

Twenty-two participants provided information about their employment status and of these, the vast majority of participants were employed at the time of the research (n=16); five reported being unemployed and one retired. Educational attainment information was provided by twenty-two of the twenty-three participants, who had collectively achieved a remarkable level of education. Nineteen women had completed one or more post-secondary education diploma or degree programs, and collectively held a total of four college diplomas, twelve undergraduate degrees, and ten graduate degrees. Six participants were also presently in educational programs (including college diploma, undergraduate and graduate degree programs), of these, four were also working while attending to school. This reflects both the greater level of access to education available in urban settings, and the increasing number of Aboriginal peoples completing post-secondary education (particularly women) despite the persisting challenges of poverty and marginalization (Place, 2012; Cairns & Flanagan, 2001).

While completing post-secondary education resulted in more economic and employment security for many of the participants, for others, their education did not necessarily provide an escape from poverty or improve their financial security. Among the twenty participants who provided information about their income, nine reported that they had enough income to meet their basic needs; two reported that they did not have enough and a further nine stated that they had enough income “sometimes”. Of the
latter two groups, all of the participants had completed some form of post-secondary education. Some of the challenges identified by women around income security included the availability of part-time work, reliance on a male partner’s income for significant basic needs (food, housing), the challenges of balancing work and school – particularly for those who were simultaneously juggling school, work and single parenting, and chronic unemployment/underemployment.

**Ethical care**

*Informed Consent & Confidentiality*

Formal ethical review for this research was provided by the Health Sciences Research Ethics Board at the University of Toronto. An informed consent form was developed however participants did have the option of providing either written or oral consent. I had learned about and utilized oral consent practices in my work at NWAC since many women participating in the research I had conducted while working there were highly nervous of signing papers. Oral consent reflects and respects the high value placed on oral traditions among many Indigenous cultures; it is also responsive to the potential hesitancy for some Indigenous peoples to sign written documentation in light of very negative historical experiences in which signed documentation was not honoured (i.e. Treaties) or was used in acts of deception (i.e. to remove children to residential schools).

While Toronto has a relatively large Indigenous community, it can still feel quite small in that many of us have multiple and overlapping relationships or connections to one another through contact in community events, gatherings, service organizations, and through family, community, personal and professional relationships. Given that
many of the women who I met with were also serving the community in various ways, whether through informal or formal roles (or both), I was also cognizant about how to protect each person’s sense of privacy and confidentiality. I offered the use of pseudonyms and the removal of potentially identifying information from the transcribed data, however for women participating in research circles, I could not guarantee their confidentiality since that would be dependent upon each of us participating to hold one another’s confidentiality individually and collectively.

Instead, I undertook to take time to remind each group of circle participants of the importance of respecting each other’s privacy with regard to the information shared within the context of the research. I also stated that they could choose how much they wanted to share in the circle based on their own comfort and needs and could always share additional information with me individually afterwards if they wished to. I think that the act of reminding ourselves and each other about the importance of choosing what and how much we wish to share is very important, generally and in the context of research. In research, participants may feel like they have to share a lot because of social desirability or the sense of wanting or needing to please or be liked by the researcher. I also think it is important to attend to the power dynamics that may arise in research that could inadvertently create a sense of pressure for participants to feel like they must answer every question or share deeply personal knowledge and experiences. Having experienced trauma and feeling powerless early in my life, I have spent a long time learning about having a sense of choice and practicing exercising choice in my life. So it was particularly important for me to emphasize choice for each woman, not only in
what she shared during the interview or circle, but being able to choose what stayed in her transcript afterwards.

While I offered pseudonyms, only one woman identified a pseudonym she wished to be used alongside her knowledge. Where women did not indicate a preferred pseudonym, I have used the names of women from my own family and community whose qualities (such as strength, humility, courage, humour) best or closely reflected the energy of the participant. These pseudonyms reflect women in my life who I love and respect deeply, who have shaped me or whose very being has made my journey in this life possible in some way. This felt like the most meaningful way that I could imagine at this point in my learning to use pseudonyms to honour and respect the knowledge of participants.

Even though I anticipated that the research questions would bring forward very powerful and emotional knowledge and experiences, I consider the research to be very low risk. While I understood that sharing, particularly around barriers or challenges to health and well-being, could potentially lead to feelings of upset, distress, embarrassment or sadness, I did not think that this in and of itself necessarily constituted risk. In fact from Indigenous approach to health and well-being, having and expressing emotions would be considered a practice and sign of health. Expressing emotionally difficult things can make us feel vulnerable but it is does not actually make us vulnerable or without agency. This is not to say that engaging in research or sharing one’s lived experience or knowledge in other ways won’t be triggering for someone or will not cause distress, it is rather to emphasize a less pathological view of emotion and emotional expression. In recognition that participation in the research may raise issues
for women for which they might want additional support, I developed a listing of relevant support services in the GTA that women could contact and access free of charge.

**Reciprocity**

As discussed earlier, reciprocity is a tremendously important practice of ethics in Indigenous traditions. It fundamentally recognizes the importance of attending to balance between giving and receiving. I did not have significant financial means to be able to provide the kind of honorarium that I thought would be able to (significantly) honour the women’s time and generosity in sharing their knowledge, so I tried to attend to honouring them in several smaller ways.

Firstly, I offered tobacco which is discussed in further detail below. Secondly, I offered food and beverages except where women declined (in a handful of individual interviews) or where it wasn’t possible (one skype interview). This included soup that my Grandmother taught me to make, or chili, bread, meat or cheese to make sandwiches, fresh fruit and sometimes a sweet for dessert. I also brought teas and juice, trying to attend to the healthiest options I could provide as I had been taught to do by numerous Elders and Indigenous nurses in my previous work at NWAC. Thirdly, I provided a small gift card for Shopper’s Drug Mart ($10.00) and two TTC tokens to every participant, though a small number of participants refused to accept this gift. Fourthly, I prepared and brought giveaway items so that each participant could select something that was meaningful to them. This included books, jewellery, small pottery items, stones and medicines, all things that were meaningful and valuable to me which I understood to be an important part of giveaways. I had experienced this form of reciprocity as a participant in another Indigenous researcher’s project and it felt like a significant and
manageable way for me to try to honour the participants. Further, since many of the items had come through my Grandmothers, it was another way of carrying them forward with me in the research. Finally, I tried to reflect back to each woman at the end of each interview or circle, my tremendous gratitude for what they had shared and to identify some of the specific things I had immediately learned from their knowledge and experience.

**Tobacco**

Tobacco is the most sacred medicine in the Anishinaabe tradition, used to carry our prayers to Creator. Tobacco is offered when we gather medicines, food or take the life of an animal to recognize the gift we are receiving. It is also used to request knowledge, teachings, guidance or help; the request for which must be clear so that the person being asked can clearly choose whether or not to accept the tobacco and the request traveling with it. Once accepted, that tobacco offering acts like a form of sacred contract between the person who has offered the tobacco and the person who has received it. In this research study, each participant was also offered a tobacco tie to recognize and honour the knowledge they were being invited to share. Grandmother Joanne Dallaire, a member of the CAC, also provided me with teachings about the tobacco serving as a helper for each woman to hold what was coming up for them in the process of sharing, which could then be offered back to Creator by being placed back on Mother Earth or burned. This is similar to several of the tobacco teachings of Elders and traditional teachers gathered together in writings on the use of tobacco in Indigenous research by Anishinaabe scholars Debby Danard Wilson and Jean-Paul Restoule (2010), however, what I have described above are not the only ways of
understanding or practicing with tobacco, nor do all Indigenous traditions utilize tobacco in research. Since there is no one essentialized or universal approach to traditional use of tobacco in research, it seems most important to be transparent about my intentions and understanding in using in my research (Wilson & Restoule, 2010).

**Caring for the Knowledge**

*Recording and transcribing the stories*

All of the interviews and three of the four circles were digitally recorded; one circle was recorded by handwritten notes as one participant did not wish to be audio-recorded. After transcription, participants were offered the opportunity to review and revise their transcripts. Transcription was perhaps one of the most challenging pieces of the research and I learned, by trial and error, to use a lot of medicines to help me in the process. This included tobacco to set down my intentions and ask for help from my spirit helpers and Ancestors, sage and sweetgrass to smudge with, and a medicine to help me listen to some of the very painful accounts of trauma with picking up all of the pain in my body. I came to using the latter after experiencing significant pain in my leg, hip and head while transcribing; I eventually learned to recognize my body’s signals of the need to stop and rest or to attend to protecting myself from going to the place of the pain being shared in a participant’s recording. I am also grateful for very clear and poignant teachings from the CAC members about how respecting each participant’s knowledge meant respecting that the pain or emotions they had experienced were their own, not mine, and therefore to not allow myself to try to go into their emotions or pain out of respect for them. For myself, this has meant really trying to sit with and understand what it means to be a listener, to be a witness and to be respectfully in relation to the
knowledge I am receiving in addition to being in respectful relationship to the person who is sharing it.

Making sense of meaning-making: The power and politics of articulating an Indigenous approach to data analysis

Deciding how to approach and make my way through the stories or “data” gathered for this research was one of the most difficult challenges of the entire research process. I felt the weight of the responsibility to handle and care for the stories shared with me in a “good way”, following cultural protocols and respecting the spirit of each story, the importance of wholeness and my role as caretaker in bringing or weaving together all of the stories. At the same time, I am not immune to the presence, power and dominance of western knowledge in the world of academic research. To step into a mode of data analysis or meaning-making that is recognizably not western seems a bit like, at this point in time, walking a tightrope across a canyon without a safety net.

Indeed, many Indigenous scholars find themselves engaging in mixed methods (blending western and Indigenous approaches to data analysis) in order to ensure that their research will be viewed as credible within academic and research communities (Kovach, 2009). Dr. Margaret Kovach, a Nehiyaw social work and education scholar, states that “[t]he use of procedures that organize knowledge to Western terms limits Indigenous cultural inquiries” (p. 132). Western research approaches have largely utilized reductionist approaches to data analysis, seeking to reduce data to small, manageable pieces in order to identify patterns and themes, while Indigenous approaches emphasize holism, resisting fragmentation and seeking to understand knowledge in relation to and inseparable from its context (Absolon & Willett, 2004; Kovach, 2009; RCAP, 1996).
The challenge of how to respectfully and meaningfully handle data, and in this case care for stories, is one faced by all researchers. The challenge for Indigenous scholars in articulating an Indigenous approach to doing so is arguably compounded by the fact that Indigenous epistemologies and theorizing, let alone Indigenous approaches to research, remain contested forms of knowledge in most mainstream universities. Even still, this challenge pales in comparison to my responsibilities to my Ancestors and All My Relations to resist fear and to remember and re-search my way home to a sense of my wholeness and interconnectedness with All My Relations.

Waziyatawin\textsuperscript{10}, a Dakota scholar in Indigenous histories and governance, has written about the tandem challenges and responsibilities for Indigenous scholars in the academy:

“\textit{As Native academics, we are in the position to use our academic research and writing skills (as well as the available academic resources) to assist in the recovery of Indigenous knowledge. However, this presents its own particular challenges, as the academy has not historically valued or respected our knowledge. Often the university has accepted only what it can appropriate for colonial purposes (the field of anthropology alone, notorious for their Indigenous data collecting, offers endless examples of this) and dismissed any knowledge that challenges the status quo and Western ways of knowing. As Indigenous scholars we simply cannot reject that which is unacceptable to the academy (because we value all Indigenous knowledge), so our task is to challenge the academy as an agent of colonialism and carve a place for our own traditions as legitimate subjects of scholarly study, but on our own terms.”} (2004, p. 73)

The work of carving out space for Indigenous ways of knowing and being in the academy began long before I was born; it is the kind of work that Kovach (2009) refers to as demanding “\textit{a long swim against a strong current}” (p. 55). Those who have passed this way before me left behind a path smoother than the one they faced. I have been well supported by my thesis supervisor and thesis committee members to

\textsuperscript{10} The traditional name of Dr. Angela Cavendar Wilson which she made her “legal” name in 2007.
undertake this work from a place of courage, not fear; this support was further bolstered by the knowledge, guidance and care I received from the CAC. It is this tremendous support that allowed me to hold fast to my responsibility and capacity to articulate an Indigenous approach to meaning-making rather than attempt to fit Indigenous knowledge (the stories) through a western approach to data analysis. This is not to diminish the value of western approaches in other places or for other researchers, both Indigenous and non-Indigenous alike. Indeed, western approaches to data analysis offer important ideas and practices such as analyzing data through constant comparison, as well as utilizing strategies like memo writing, reflexive journaling and member-checking, that can be helpful in fostering transparency and grounding interpretation in the words and voices of participants as much as possible. I acknowledge the gifts of these approaches while politely naming and dismissing the monopolistic behaviours of the western knowledge system which are not helpful or relevant to my aim of gathering, honouring and sharing the knowledge of urban Indigenous women towards improving our health and well-being.

**Locating my knowledge**

I am well trained in qualitative research and have spent the past four years teaching the applied lab sessions of the introductory qualitative research methods course in the doctoral studies program at the FIFSW. I have had the opportunity to work alongside my thesis supervisor, Dr. Izumi Sakamoto, on the Coming Together Project, an arts and community-based research project that utilized a grounded theory methodology to explore social support among women and transwomen experiencing homelessness and marginal housing here in Toronto (Sakamoto, Ricciardi, Plyler &
Wood, 2007). Within this project, I was able to work specifically with the stories of a sub-sample of Indigenous women utilizing what we named as an Indigenous approach to Grounded Theory (Allan & Sakamoto, forthcoming; Sakamoto, Ricciardi, Plyler, Wood, Chapra, Chin, Allan, Cameron, & Nunes, 2010). I have also been deeply gifted to have the opportunity to begin to learn and practice Indigenous approaches to research at NWAC and more recently, I have been gifted with the opportunity to continue this learning at the Well Living House (WLH), an Indigenous health research centre housed within the Centre for Research on Inner City Health at St. Michael’s Hospital in Toronto. As described in preceding chapters, I have benefitted greatly from the phenomenal and rapidly expanding body of Indigenous scholars who have written about their experiences of and visions for Indigenous research. I know the extraordinarily hard work of coding data from a Grounded Theory approach, and the equally difficult work of caring for and working with stories and attending to the importance of their wholeness, context and spirit.

All of these experiences shape how I think about the care of knowledge, but I am also guided by my traditional name and the role that came with it to gather old knowledge and bring it forward. The teachings of my name and all of the learning I have had in my life thus far about the care of knowledge, remind me to attend to knowledge as having spirit and to attend to this spirit when seeking, gathering, caring for and sharing knowledge.

**Making sense my way: On memory, maps and Star Blankets**

Finding my way with the knowledge shared in the participants’ stories was neither a quick or easy process. I read about, dreamt of, imagined forward and sat with a
number of ways to bring the stories together. I thought first of a Star Blanket, with each individual woman’s story representing a quilt panel, and all of them being sewn together to tell a bigger story. But there were so many stories, so much knowledge and I knew I could not hold each individual story up without writing books and books. I sat with my responsibility to listen to the stories not only individually, but collectively; to listen underneath, around and through all of the stories together to hear what bigger stories were being told. I knew from the guidance of both my thesis committee and the CAC that for now I would need to pick some stories and not all, and to trust that my work with the abundant, beautiful and powerful knowledge shared by all of the women would continue long after my doctoral thesis was done. That this was one part of my walk with this knowledge, not the whole journey.

Dr. Carolyn Kenny, a Choctaw/Haida scholar in both Indigenous research and music therapy, describes an Indigenous approach to data collection within a story of Raven:

“Raven flies. He surveys the land. He watches all of the berries. If he is using all of his ravenly skills, he is discerning. He knows which berries to pick and how to organize them and categorize them into the right baskets. When I study the transcripts of interviews, I feel a bit like Raven might feel. I wait for the words of the participants to jump out to me from the page. I survey the land over and over again. I read the transcripts many times until I have referential totality, a sense of the whole set of the transcripts, all of the stories and words of the participants. [...] I discern themes. I do not “over interpret” the data, as has been the case in much previous research in our communities. I am not the center of the research. The participants are the center. And their words, their stories, must remain central to the research telling, the research findings. In this way, the power remains with the people and it can grow.” (2000, p. 159)

I have tried with great care to hold the stories of the women who participated as the center of the research, and to attend to what I consider to be my corresponding responsibility to account for how I am understanding and describing the knowledge
within the stories in relation to who I am, where I come from and how I know. I tried multiple strategies to try to create visual ways of literally seeing the data in the way of Kenny’s Raven. I will attempt to describe these strategies here for the purposes of transparency and accountability of my process, and because it may be helpful for other researchers working to articulate their own approach to Indigenous meaning-making.

While listening to and transcribing the data I tried to map all of the information coming forward on to paper on one giant circle, with four quadrants representing each of the interview/research circle questions: 1) Who are you/where do you come from; 2) What helps you to be healthy and well; 3) What hinders or gets in the way of your health and well-being; and 4) What do you envision as needed. This was both an overwhelming exercise and helpful in that it facilitated a visual way of sitting with and thinking about the relationality and interconnectedness of everything being shared. It was overwhelming in that I suddenly realized how much knowledge I had gathered and felt terrified about my ability to speak to it all, to honour each woman in a good way. Still, I recognized that visual ways of working were very helpful to me. I began to map each research circle and interview onto smaller papers appended to my wall, listening for and capturing both the unique and common experiences across each woman’s story. I moved back and forth between transcripts, drawing and writing, sitting and listening, smudging, putting down tobacco and offering my prayers for help and guidance. I covered my walls with stick-it notes and chart paper to help me name and keep visible questions that were arising, the powerful teachings and medicines I was finding within the stories, and the ways in which I was beginning to understand each story on its own, in relation to each other, and in relation to my own story. This is what
Kovach (2009) refers to as self-in-relation analysis, which she states has not been explored in much depth and is therefore ripe for new ideas.

In my work with the stories and my presentation of the knowledge I have gathered by being with these stories and the phenomenal women from whom they were birthed, I have had to work hard to keep myself, my experiences, my intentions and motivations visible to me. There was no room to be sleepy to how my lived experiences, my own journey in health and well-being, was shaping how I was listening to, reading and writing about the women’s stories. In the following chapters, as you read through the “findings” or the knowledge gathered, you will find my own stories also woven in among those of the women. Kovach (2009) suggests that this is a useful way to assess the use of an Indigenous relational approach to research grounded in a holistic epistemology, by searching for the inclusion of stories and narratives of both the research participants and the researcher herself. In addition to serving as a means to transparency and accountability, this way of sharing knowledge also functions to acknowledge or encourage a reciprocal relationship between researcher and reader, inviting the reader to “…walk inside the story to find their own teachings” (Kovach, 2009, p. 60).

Using visual tools and mapping the knowledge onto circles on chart paper was very helpful for me in the writing process as well. I could draw and gently revise a map for myself of how I was understanding the knowledge that was coming forward, which slowly turned into maps for each chapter. These maps helped me when I felt stuck, scared or overwhelmed to remember that I was doing, the learning work of walking around a circle, and that wherever I was on that circle in my writing, I simply needed to walk/write my way back out. I envisioned it like entering and exiting the sweat lodge,
slowly making my way around the lodge floor…..in the dark, humbly on my hands and knees and gratefully knowing I was safely protected on my Mother Earth. When I felt most lost or overwhelmed, I tried to talk to or about my Grandmothers and my Mom; to recognize that the opportunity to do this work of caring for knowledge is possible in my life because of all the sacrifices they made and all of the opportunities that weren’t possible in their lives. I thought of whether they would be proud of me. I thought of how the women who participated would feel in reading my writing. Would it be enough? Would they feel honoured? Would it help? All of these questions, worries and hopes became my helpers, spurring me on and helping me to stay present and conscious to my role and responsibilities.

In addition to visual tools, being able to utilize audio recordings for field notes helped me to process my feelings and ideas in ways that easily aligned with the oral tradition and more relational/dialogical approach to knowledge I am rooted in and comfortable with. While my recording device was not necessarily “talking back” to me, being able to talk through my processing as opposed to trying to write through it helped me to be less self-critical, more open and to help me attend to my energy and well-being in a timely way after interviews and circles ended.

The “findings” chapters that follow reflect an overarching emphasis on wholeness; it was the loudest theme or teacher that kept emerging no matter which way I entered the stories. It became the sinew with which I could sew the knowledge together. I have followed the advice of my thesis committee and the CAC and chosen to hold only what I can here in this thesis and trust that I will be able to bring forward the rest of the knowledge shared by the women in good ways beyond what I am able to include here.
The chapters contain many stories that are presented, where possible, in long stretches of story to help hold the knowledge shared in its context. However, I have also used some smaller quotes to help support or demonstrate the dimensions of some issues or themes.

Shortly after I received my ethics approval for this research, I pinned a piece of paper to the wall of my library carrel with two questions written on it: 1) What are the stories we tell about our women’s health here in the city; and 2) What are the stories we want to bring forward about our women’s health here in the city. The following chapters bring forward stories of tremendous resiliency, courage, wisdom, beauty, struggle and strength. I carry forward this knowledge with the intent to honour the women who so generously shared it towards a vision supporting the health and well-being of urban Indigenous women in Toronto.
CHAPTER 5: DISLOCATION, DISCONNECTION AND THE DANGER OF A SINGLE STORY

“All of these stories make me who I am. But to insist on only these negative stories is to flatten my experience and to overlook the many other stories that formed me. The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story. [...] I’ve always felt it is impossible to engage with a person or a place without engaging with all of the stories of that place and that person. The consequence of the single story is this: It robs people of dignity. It makes our recognition of our equal humanity difficult. It emphasizes how we are different rather than how we are similar.” (Adichie, 2009)

The most profound contribution this research can make, and by this research I mean the spirit of the knowledge shared by these women, is to interrupt, disrupt and uproot the insidious lies of three “single” stories: 1) the story that our circumstances are the result only of personal choices and that we are individually, solely responsible for the outcomes of our lives; 2) the story of colonization as the beginning of history, civilization and knowledge; and 3) the story of perpetual woundedness of Indigenous peoples as the victims or collateral damage of colonizing, ‘civilizing’ and ‘settling’ this land. The first story is girded by neoliberalism and the pervading political beliefs and policy practices that situate the responsibility for health and social welfare with the individual. The second story is entrenched in the Canadian educational systems, “evidenced” in books of history and geography, naturalized and normalized across disciplines from primary schooling to graduate education. The third story is well-woven into contemporary health policy, public health discourse, and mainstream media portrayals of Indigenous peoples in Canada. As Onondaga Indigenous Studies scholar Dr. David Newhouse so sharply observes: “[t]he question in my mind is whether or not

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Canadians can deal with a “healed” Indian. So much of our public policy effort is based upon the notion of woundedness.” (as cited in Fanelli, 2013). Media coverage and portrayals of Indigenous peoples in Canada help to cement images and public “Canadian” discourses of Indigenous people has inherently wounded, unable to manage, cope, heal or govern. They invest in a story of not only wounded-ness, but hopelessness.

For example, media coverage in the early 1990’s of Innu youth sniffing gasoline was incredibly damning, and spread rapidly beyond the borders of Canada bringing international attention to the severity of conditions and challenges faced by Indigenous peoples in Canada, and at the same time feeding a virulent, racist narrative of Indigenous peoples as perpetually wounded:

“The Canadian public was jolted into the reality of a festering social problem in January, 1993 by the televised videotape of six 12 to 14 year-old Innu children at Davis Inlet attempting suicide by inhaling gasoline fumes from plastic bags. When discovered, the youth fought off attempts to be rescued and screamed that they wanted to die. In fact, suicidal activity was not uncommon among the Innu of Davis Inlet, which had become a virtual primer in communal self-destruction, with rampant solvent inhaling and alcoholism amid unseemly poverty and squalor. One local source estimated that some 25% of the community’s 500 residents had attempted suicide.” (Martin, 1994)

More recent coverage of the housing and flooding crises of Attawapiskat First Nation and responses to the Idle No More movement have illustrated the ways in which the problematic mantle of wounded-ness also extends to include our inability to govern ourselves, and to explain our apparent child-like nature, mocking our insistence upon nation to nation relations and touting it as an illustration of our lack of connection to reality:

\[12\] Encyclopaedia Britannica
“As the *Globe*’s Jeffrey Simpson noted in a recent column, one of the sadder symptoms of the pervasive ignorance plaguing much of this country’s aboriginal [sic] leadership is a bizarre belief that Canada still operates under some manner of robustly royalist government. A system where our monarchs and viceroyes are not simply -- to paraphrase my old poli-sci teacher -- folks who "cut the ribbon at the new Wal-Mart," but rather functional co-rulers of the state, à la, say, Saudi Arabia. [...] I mention this because yesterday's revelation that hunger-striking Attawapiskat chief Theresa Spence will be boycotting the Prime Minister's Friday summit so long as Governor General Johnston remains a no-show only makes sense once you've unlearned eighth grade civics in this peculiar fashion. Like many of her contemporaries, Spence evidently clings to the childishly literal notion that "the Crown," to quote Simpson, is "somehow an independent agency" within Canada's government, as opposed to merely a *synonym* for it." (McCullough, 2013)

“Large elements of aboriginal [sic] Canada live intellectually in a dream palace, a more comfortable place than where they actually reside. Inside the dream palace, there are self-reliant, self-sustaining communities – "nations," indeed – with the full panoply of sovereign capacities and the "rights" that go with sovereignty. These "nations" are the descendants of proud ancestors who, centuries ago, spread across certain territories before and, for some period, after the "settlers" arrived. [...] Much of the rhetoric surrounding Chief Spence is of the usual dreamy, flamboyant variety, a mixture of anti-capitalism and anti-colonialism, blended with the mythology (blasted by the reality of what one actually sees on too many reserves) about environmental protection and the aboriginals' sacred link to their lands.” (Simpson, 2013)

The discourses fed and nourished by this kind of media coverage normalizes racism, obscuring it in narratives that pathologize Aboriginal peoples and perpetuate a paternalistic, patronizing lenses towards the struggles faced in Aboriginal communities across Canada (Browne & Varcoe, 2006). They lend support to an attitude of fatalistic hopelessness:

“One of the complaints made about dealing with First Nations is that nothing is ever enough. No agreement ever solves problems. There’s always something more, some other offence, often intangible and difficult to comprehend, the origins lost in time. Chief Spence complains about a lack of respect, but fails to respect authentic efforts to help” (McParland, 2013)
“Every time the destitution on a First Nation reserve piques the attention of non-aboriginals - the E. coli in Kashechewan's drinking water, the gasoline-sniffing epidemic at Davis Inlet, the fetid, ramshackle housing at Attawapiskat - some commentator will insist the problem is federal indifference. But it is not a lack of money or attention that has led to such Third World conditions in the midst of one of the most prosperous nations on earth. If anything, it is too much money. We're killing our First Nations with kindness, not neglect.” (Gunter, 2013)\textsuperscript{16}

Reading and Nowgesic (2002) locate problematic representation that focuses on dysfunction and pathology as residing not only in media but in research too. The fundamental problem with a subscription to the story of woundedness in any arena is that it fixes Indigenous people in a place of pain with no exit. It buries the stories, knowledge(s) and practices of healing and wellness that Indigenous peoples have held in our bodies, our families, our communities and nations long before contact. It obscures how those stories remain in spite of the violence and inhumanity of colonization, stories that are written on our hearts, stored in our blood and cellular memory, carried in each leaf of each tree, in each stone on the Earth….in each breath that we draw and exhale. The story of woundedness is incomplete, it names our pain - of residential school, of land loss, of child theft, of cultural genocide and of social and economic exclusion – but it fixes pain as our only story. We require more, healing requires more – not only healing for Indigenous people, but for all people.

The value of a story is not only in its telling, but in the act of listening – deeply, of hearing and knowing something new by allowing the story to not only move you, but to move about in and create change within your consciousness. So it is one thing for each woman who participated in this research to have shared these stories, it is another thing entirely for myself as the researcher and for the reader to take in these stories, be moved by them and to move differently in our lives as a result.

\textsuperscript{16} Toronto Sun
Who are you, where do you come from? Entering in to the stories

The opening questions: “Who are you and where do you come from?” evoked a broad range of responses from women. Many located a land base, home community or First Nation where they had lived prior to Toronto or where their family was originally from; several identified by their traditional (spirit) names and clans and often in their (Ab)original language. They discussed how they had arrived in Toronto, or, for those whose families have been in the city for multiple generations, how they had grown up here. For those who had migrated to Toronto, their stories frequently included leaving to seek opportunity in the form of education and/or employment, or leaving to escape violence or pain.

The majority of women who participated in the study reported directly experiencing some form of trauma, disconnection and dislocation in their lives, including childhood abuse (sexual, physical, mental, emotional) and violence experienced as a young woman or as an adult (sexual violence, intimate partner violence, structural violence). A number of participants had experienced familial disruption and dislocation through child welfare intervention resulting in adoption, foster care placement, or customary care placement with a family member, while several others had experienced early loss of a parent or other primary caregiver that profoundly impacted their lives. These experiences are important to discuss here not only because they have affected their health and well-being in some way, but also because they have shaped how the women know themselves and the world around them, knowledge that subsequently informs how they think about and address their health and well-being. At the same time it is incredibly important to contextualize any experiences of pain, suffering and violence as
only part of a story and not the whole story. To situate these stories within the broader context of colonization that has generated and exacerbated the risks and challenges Indigenous women must navigate from their first breath to their last. A failure to contextualize the disproportionate risks and challenges that Indigenous women face can inadvertently contribute to and deepen stereotypes that naturalize pain and dysfunction as something inherent to being Indigenous. Moreover, these stories must be contextualized within the wholeness of each woman, whose very being is shaped by more than her pain or struggles, but also by her experiences and expressions of love, happiness, beauty, healing, achievement and growth.

**Dislocation, disconnection, trauma and relation to self**

The importance of attending to the knowledge of the women in relation to their experiences of child welfare intervention – in the form of apprehension, foster care and adoption is an important area of focus here because the realities of child welfare intervention in the lives of Indigenous peoples cannot remotely be considered a thing of the past, but one of the most pressing concerns in our communities today. Indeed there are more Indigenous children in the care of the state via contemporary child welfare agencies than at the height of the residential schools – three times more, in fact (Mandell, Clouston Carlson, Fine & Blackstock, 2007). Indigenous children have, for more than four decades, been over-represented in child welfare involvement (NCCAH, 2009), a matter in which social work not only is implicated in but greatly benefits from (Pon, Gosine & Phillips, 2011). Child welfare is a primary source of (expanding and secure) employment opportunities for frontline social workers and a bustling training ground for social work students. It also generates employment opportunities for social
work researchers and educators, serving as one of the profession’s key areas of ‘expertise’. Sinclair (2009) locates the advent of the “economy” of child welfare within the mass apprehension of and transracial adoption of Indigenous children during the Sixties Scoop era. As such, child welfare (and consequently a significant part of social work) has been largely built on the backs of Indigenous children and their families.

While the emphasis here is on looking at connections to the health and well-being of Indigenous women, I would argue that it is incumbent on social work to understand the impacts and experiences of child welfare intervention from the perspectives of Indigenous peoples, including children and youth, and to be moved by such knowledge and to move differently as a result - in application to frontline practice, classroom pedagogy, field education and approaches to research design and methodologies (see for example: Baskin, Strike, MacPherson, Smylie, Angeconeb, Sauve, McKay, Archer, Kimewon, Ross & Kakeyash, 2012; Baskin, 2007; Sinclair, 2009).

Dislocation, disconnection and the pathways to healing

Some of the participants who had early childhood experiences of child welfare intervention shared stark memories of hiding from and being taught to hide from social workers, while one woman was taken immediately after birth. While each experience of child welfare intervention was different, there were overlapping similarities that served like an insistent and dutiful reminder that these experiences were not accidental, but the result of policy practices directed towards Indigenous peoples and of the imperative for all those implicated, including social work, to take heed and respond.

The stories shared here hold teachings about healing and transformation; they demonstrate the strength, beauty and courage of women in living through painful
experiences of dislocation and disconnection. These stories refuse the single story of “woundedness” with no exit and confront the pathology and passivity implied within it. They demonstrate agency, as women share strategies, teachings, learning and practices that have helped them in attending to their own health and well-being. These stories are powerful in their fullness, they embody a resistance to “either/or” binaries (e.g. that things are all good or all bad, but instead all meaningful) emphasizing hope and the possibility for transformation without erasing or minimizing the struggles and challenges along the way.

The primary stories of Fay and Marie used in this section were chosen because each woman describes not only her experiences of disconnection and dislocation created through child welfare intervention, but also speaks to her path to healing, health and well-being centering on relationship to self (Marie) and identity through connectivity (Fay). These stories are also supported by those of other participants (Annie, Sandra, Jade, Donna, Christine, Segaine). The idea is to hold each woman’s knowledge in the context of her lived experience as much as possible to demonstrate not only how the knowledge has come through living through trauma and pursuing healing, but also seeking ways to apply that healing knowledge back to family and community, and especially to those who are coming behind us.

The first section begins with the stories of their memories relating to their experiences of adoption. As a young child, Marie experienced successive loss of two of her significant caregivers, both her father and grandmother, which resulted in her mother coming under the scrutiny of child welfare. She describes her mother’s attempt to keep her children from being taken by hiding them in the bush and begins to speak
about how she came to know who she was in reconnecting to her home community and birth family:

“I remembered my Grandmothers, but…and I remember that I loved my mother and I remember a little bit of my father, and….my grandmother passed, and that's when I knew that…the change was coming. People were running and she'd hide us in the bush at five and six years old and….I started to learn….um, fear. She never told me it was a game. She told me this was what was gonna happen, and when the lanterns went on and we were told to wake up and if we didn't wake up, we were gonna get that willow tree across our legs and that meant…get, and it was out of love, it wasn't to hurt us. […]…and the people I know as family tell me who I am. But I don't….they tell me of stories of who I was and what I was. But I don’t remember and I sit and I see the memories in their faces, that’s how I learned who I am. […] Um…I went through, um, very young at losing my father […]…I lost my grandmother then my father at six and then I came from seven, um, my mother went into giving us, putting us, taking us, people coming, locked doors, taking us from her, back and forth, um, into care. Um, what it did is…not make me… want to, like I hear you [about] stories of social work…it made me think, like, I feel in here [gesturing to her heart] – what can we do to make it, not really what the experiences we all went through, but what can we do for the future. […] Uh, as a little girl I was always, you know, um, the places we were sent I was always with my sister. […] And we….through this, are….um, through being adopted several times, through my age and through…we had not spoken….in…I think about eighteen years, because she does not want nothing to do, or anybody know that she is Native…and that, um, she came to me and said that I would have to follow her and not acknowledge and I could not do that to my…to me, or my sons. So I chose to work through, uh, my journey in truth and I think she’s doing the best she can in her truth, and I have to let be…for now. I miss her.”

Marie suffered significant losses through both death and separation by state intervention, not only as a child, but also as an adult through the death of multiple partners, and perhaps most painfully though the loss of her relationship with her sister because she would not and could not give up or hide her identity as a Native woman.

Connecting to herself, her identity and community – “remembering who she was” has, in fact, been a fundamental part of Marie’s healing and how she attends to her health and well-being. There is also a strong and reciprocal connection between her healing and her relationship with and parenting of her children, naming the act of mothering as an
important part of her wellness – something that several other participants also discussed. In the following passages Marie emphasizes the importance of remembering who she is in her own wellness, particularly in relation to her journey with the mindchanger and addictions, and describes how she encourages her children to do the same.

“I like that because I always say that, I was speaking to somebody that my motto is also not forgetting who I am. Because if I go walk something that I’m learning, yes, it’s a goal, it’s a journey, it’s not who I am. And… I have always tried to tell my sons, you know, in certain places you’re going in your wellness is that I see them, they’re…they are seers, they’re watchers, they…they’re dreamers, you know they’re thoughts are always…and I’ll get them in their moments where they’re waiting for their wives or wondering how their daughters are doing in school or a new journey that they’re going on…they’re thinkers…..and then going “just get in your memory who you are, just don’t forget who you are”, I say it’s okay, as long as you don’t forget that, you know you’re fine…I won’t ever forget who I am and I’ve learned it all from them, but when I don’t see them or I think as a mom that they’re drifting out of their wellness, that’s where I always say just don’t forget who you are. You can be anywhere. […] I just, I can be anywhere and I figured out that in my wellness, as long as I wasn’t in the mindchanger – the addiction – then I was here, in the right mind. If I went to the mindchanger I was forgetting everything, who I was, and I didn’t like that about the mindchanging drugs. I didn’t like forgetting that Marie is bouncy and funny and likes to go out and get up and you know, cook and….the mindchanger made me just not want to do any of that. So that was really…I didn’t like forgetting who I was. […]

I’m…..if it wasn’t…for my sons and their teachings, I don’t think I’d love men like I do. They give me such teachings of…um..boys, boy babies, baby boys to baby men to, you know, to man child, to different stages so, um…..they are who I would want in my life. Yeah, they are who, the man I would want to walk through that door…and I just want me just to be that little piece of woman that I’m gonna see, and I’ve seen it in two of them, of who they’re gonna bring through the door…because if I’ve ever done something and never apologized, I’ve always told them that I wish I would have did it in another way because I’m that woman, showing you, I apologize because I’m that woman that is teaching you, and I’m that woman that is the woman that you’re gonna wanna love and you’re gonna wanna bring through that door. Do you know? I just, whatever I’ve done and what I, you know my mistakes, I’ve always been humble and told them – this isn’t how it
is, this isn't how, you know what I mean? But...just because I've gone through homelessness, addiction, mental illness...you're still gonna love, you know how to love, it's just unconditional. So if I'm not being that...that mother, even though they're on their own, or they don't pick up that phone, I just feel like that hinders my wellness.

“[…] I've learned what it's all, what my journey's taken me to....and....the last six years have been figuring out and self-educating, and...figuring out [Marie]. Just.....going in and getting the teachings and being a part of community and giving back into community and...learning about...me, and where I wanted to be. So...that's been a real difficult one because being [mixed] and being Status, it's...being First Nations it's....I don't know, it's not confusing to me, it's confusing to.....not where I belong. It's....finding the right place where.....it's comfortable and safe for me. Because I deal with anxiety and PTS, so I just....a concurrent disorder, so I'm on that physical part of doing and actually starting medicines in the last two weeks, and finding it safe to do so. So, I feel like I'm at the beginning of the beginning again for me....and I really find it important that you, you as sisters, are here giving that and having that and it makes me feel good and safe that....the ripples going and it’s, you know, that you're hearing it and we're hearing it as a community and.....the supports.”

Marie carries this wealth of knowledge and strength from her lived experience that helps her in her own healing journey. She described throughout the circle her efforts in working at her relationship with herself and navigating each day through the challenges of anxiety and post-traumatic stress to find her own sense of safety and wellness and to stay connected to who she is. Marie bears the scars of colonial interruption of identity through child welfare and the dislocation from her birth family and home community and she describes actively attending to her own sense of connection to self and identity and fostering the same within her children. Her gentleness, humility, courage and tremendous love for her children shines like an incredible light in the midst of the struggles she has experienced in addictions, poverty, homelessness and mental health. These struggles are among the most highly stigmatized that one can face in Canadian
society, stigmas that faithfully serve a functional role of obscuring structural and colonial determinants of their existence. Facing any of these issues unto themselves one is likely to be met with judgment that feeds a multitude of barriers to health and well-being; experiencing all four of these together creates a compounded effect, seriously constricting life choices and opportunities. Consider that Marie has faced these struggles as an Aboriginal woman in a pervasively racist society and her efforts in sharing and applying her lived experience and knowledge in giving back through community-building and advocacy work are a remarkable demonstration of her generosity, resiliency and agency.

Helping others is something Marie described in circle as important part of her wellness. Helping others while also working through her own healing journey is not considered unusual in an Indigenous framework of health and well-being, where we are all valued and understood as having something to give and something to receive. However, in a western framework the tendency towards deficit-based and dichotomized approaches to health and helping (e.g. sick versus healthy, those who need help versus those who give it) implicitly construct helping as a unidirectional process in which health care is given by the “healthy” “helper” to the “sick” person in need of help. Such models obfuscate the agency, knowledge and gifts of those who are seeking or who are perceived to be the “targets” in need of “help”. This echoes findings from the Coming Together project, an arts and community-based participatory action research study exploring social support among women and transwomen experiencing homelessness in the city of Toronto, in particular the findings from the Aboriginal subsample that called out and upended problematic, stereotypical discourses of Aboriginal women
experiencing homelessness as ‘helpless’ (Allan & Sakamoto, forthcoming; Sakamoto, Ricciardi, Plyler, Wood, Chapra, Chin, Allan, Cameron, & Nunes, 2010).

It is also quite striking to really focus in on the reciprocal relationship between mothering and healing in Marie’s life – that her healing has informed her mothering and her mothering has served as important part of her healing. She describes lovingly how much she has learned from her children, which reflects traditional teachings that understand our children as gifts and teachers. She speaks to her efforts to share the teachings she has learned from her own journey with her children, particularly around identity (not forgetting who you are) but also around humility in acknowledging her mistakes and challenges. Moreover, she ruptures stigma filled discourses about those who experience challenges such as homelessness and addiction that dehumanize people and, particularly in the case of women, demonize or erase their capacity to parent in the passage in which she is speaking directly about love in the context of her relationship with her children:

“I just, whatever I’ve done and what I, you know my mistakes, I’ve always been humble and told them – this isn’t how it is, this isn’t how, you know what I mean? But…just because I’ve gone through homelessness, addiction, mental illness…you’re still gonna love, you know how to love, it’s just unconditional.”

It may seem for some unnecessary for me to reiterate here, but I think Marie’s point is an incredibly powerful one that actively combats dehumanizing discourses of so-called “woundedness” that, through pathologizing, reduces people only to the pain or struggle they are facing. These discourses would have us erase our capacity to love and be loved, to simultaneously give and receive care or knowledge, to be able to bring and contribute something even while in the struggle, and that in fact that struggle is actually part of healing, both individually and collectively.
While Marie is now a Grandmother and her children are grown, her story has teachings to offer to social work and child welfare in understanding the ways in which healing work and parenting are not separate as they may sometimes be imagined to be in a western framework. For example, a child welfare plan of care that would imagine a parent as needing to be in a state of health or ‘healed’ first in order to parent (e.g. remove the child until parent has recovered or is abstaining from substance use), as opposed to working from a grounding in this kind of knowledge shared by Marie that understands healing and parenting as inextricably linked. Coming from this place would seek to, above all else, prioritize a plan of care that attended to the reciprocal flow of energy between parenting and healing, ideally keeping mom and child together while attending to and supporting healing and wellness for both. To this extent, Annie, another participant who had been adopted out, argued for a Foster Grandparent program in which older couples who had space in their homes, time and knowledge to offer, would support both a mom and a child in their home:

“If you can take a baby then you can take a mother and a baby and it’s really simple. So there’s a service…of foster-grandparenting, for single moms and babies that need assistance. Don’t put them through some hoop-jumping thing about how much money they’re gonna get and make them live in poverty. Arrange, help, coordinate them meeting an older couple and this is where the church is really interesting because they’re, they do this thing, they’re really good at it. These older people who are really into social justice, they don’t….they don’t have a lot of money, they don’t have a lot of physical energy and all of that, but quite often they have big homes that have a room that they’re willing…but they want some kind of commitment, they want somebody to…so something like that. A foster grandparenting program, which is what they have, […] you know, they do it in Australia, they do it in England, they do it in…..everywhere, they have this foster grandparents. That mother and that child are a unit, a primary unit and to have that split up is just asking for trouble down the road. The idea you know of a single mom, an expectant single mother whose been abandoned by….whose, you know, it’s like looking for older, stable couples to make a commitment and, and she gets
the funding. I mean there’s a….you know you gotta sit down and work the nuts and bolts of it, but the thing is if you’re gonna give her so little money anyway, you might as well give her that little bit of money and get her a stable place and know that she’s got….’cause quite often they don’t need the money, there’s some people that don’t need the money, and there’s some people who are gonna need some money but they can’t have more than half of that, and that she gets to go to school and that, and there’s a commitment of guaranteed of three years minimum, until the child starts going to school…and then things can change up. She can go back to school, she can finish her high school and help with that…”

In severe circumstances where apprehension or separation does occur, it would still be necessary for workers to attend to how they could support the reciprocal relationship between parenting and healing work. This kind of approach requires workers to stay conscious to the impact of their decisions on healing whether or not a child remains in or is removed from a home, and to acknowledge healing as a lifelong process that will be occurring for both child and parent and the ways in which a worker’s involvement or plan of care supports or obstructs the healing process. A focus on supporting the process of healing, which is an inherent part of our lifeways, is likely to yield significantly different outcomes than the current models of child welfare practice that are underpinned by risk management or limited liability paradigms.

I am following the knowledge offered by Marie with that of Fay, who also had the experience of apprehension and adoption and shares her own efforts towards her personal healing. Like Marie, Fay has also chosen to apply her lived experience and knowledge to helping others in the community. Fay was apprehended at birth and placed with a white adoptive family in which racism had a sort of normalized and invisible presence. Fay’s story begins by describing her early experience and some of the ways in which it impacted her sense of identity:
“Who I am is...um...I was apprehended at birth...which I don’t have any memory of. Um... and often I’d wonder sort of what went on there, and I was put in foster care for about a couple of months and then placed...in my adoptive home [...]...um, so what was interesting about that later in life was that I found out that my mom was actually raised in a very racist...home, um, her mother was British, very straight-laced, very don’t show your feelings, you know, British woman who really was racist against many different...others than herself. So my mom also seeps a lot of that. So a lot of my journey has been acknowledging, um, a lot of the things that actually went on when I was being raised in that home that...were on a very subconscious level, right? And sometimes very conscious....and understanding my mother’s accountability to that but also forgiving her for not really, not really understanding and knowing herself enough to be conscious and aware and go on her path. So it was interesting, her needs of wanting a baby, she couldn’t get pregnant, so wanting a baby was stronger than the fact that she may not have wanted an Aboriginal baby. . Like I don’t know, but I arrived at her doorstep she said and there I was, right? So, um....but, uh, being adopted...I mean it comes with so many...um.....the path to being adopted, when you’re growing in that secretiveness, because there still is a lot today right? So much secretiveness around...[...] CAS [wasn’t] allowed to say who my Nation was and any identifying information, right? So I grew up thinking, like my mom said to me “You’re an Indian baby” but, um...you know, that’s all I can tell you....’cause she didn’t know, and it’s still that way today, like legally, it’s still that way today, right? Like you can’t see your long-form birth certificate, you’re not allowed to see your file, you can have non-identifying information but nothing...to find out who you are as an Indian...a little Indian girl growing up right? So I’d walk down the street and I’d think “I wonder if that’s my brother, I wonder if that’s my sister” because people would look, I would look for people that looked like me. That’s what my idea of identity felt like, well if you looked like me then...that’s, um, that’s what my identity sort of felt like to me.”

The state obstruction from one’s identity for adoptees is a systemic issue that persists today, an issue raised by other participants in the research who had also been adopted out. Despite obstruction, all participants who had experienced adoption had made multiple and persistent efforts to connect to, nurture and nourish their identities. For some this meant drawing on the Adoptee Circle facilitated by Anishnawbe Health, and for all this meant trying to connect to their histories, traditional knowledge(s) and practices by attending teachings and ceremony, utilizing Aboriginal community, health or social services, or seeking employment within the Aboriginal community.
Fay’s sense of her mother’s simultaneous wanting (of a baby) and not wanting (of an Indian baby) could create a kind of fragmentation of one’s sense of self in which part of you is invited in to your adoptive family but not all. It is a fragmentation seeded and nourished by racism and whiteness in Canadian society. While the Sixties Scoop (and the contemporary Millennial Scoop) is now generally recognized for the profoundly injurious effect it had and continues to have on Aboriginal children and their families, there were also significant numbers of children being taken before the scoop including Annie who, like Fay, had also met with racism but in the form of physical violence:

“…for every person in residential school there’s a hundred of us over three or four generations who have been disappeared by adoption, who have nothing, no connection. So it’s people who get…of course you need to know and I’ll meet people every once in a while and they’ll be like “oh Christmas is coming, time to spend time with the family” and I’m like (sigh) ……and they kinda “what, what, what?” I says that’s just a trigger for me, it’s a trigger for me all my life – Christmas, Easter, Mother’s Day, Father’s Day, my birthday. It’s like I’m adopted, I was beaten senseless for wanting to know who I am.”

The impacts of racism on the identity and life experiences of Aboriginal adoptees is documented in the work Dr. Raven Sinclair, an Anishinaabe and Nehiyaw social work scholar who herself was adopted out during the Sixties Scoop (see for example, Sinclair 2009). Building on Dr. Sinclair’s work, the knowledge that participants shared in this research spoke to the challenges that adoptees face in terms of dislocation and disconnection, but also the ways in which their experiences of adoption have informed their healing, health and well-being, and the ways in which they carry and share their knowledge back in helping others. In this way, the efforts of Fay and other adoptees to pursue connections to culture, community and self as a way of knowing themselves more fully as a person resists fragmentation and insists on wholeness.
Like Marie, Fay chooses to share her knowledge and lived experience with others. Here, she speaks to how helping others has been healing for her in nurturing a more integrated sense of herself and her identity.

“Definitely I would say the very….somehow or other helping others helps me, right, so when you’re – I just learn so much from my clients, you know, I….somehow just the integration of understanding everyone’s stories helps integrate who I am and where I come from, right? So that’s really helpful.”

What Fay is sharing here reflects multiple Indigenous teachings about helping that I have learned in my own life and which are also documented in the writings of Indigenous social work scholars. This includes an implicit understanding of the reciprocity involved in helping relationships in which both helper and “helpee” have the opportunity to share knowledge, to learn, grow, transform and heal. This stands in contrast to western models that imagine the helper as neutral or personally divested from the process of the helping relationship. An Indigenous understanding recognizes both the healing inherent in helping for the helpers themselves, as well as the importance of helpers undertaking and actively attending to the responsibility of their own healing (understood as a lifelong journey) in order to help in a good way. In setting out a framework for healing approaches in working with Aboriginal adults, Dr. Cyndy Baskin, a Mi’kmaq social work scholar, further links the ways in which helping relationships underpinned by reciprocity by their nature address issues of stigma:

“Within Indigenous worldviews there is a strong emphasis on relationships. The relationship between a person giving help and a person receiving help is seen as a natural part of life. If you need some help, because I can, I will help you. Tomorrow, next month or next year, when I need help, you will help me because you can. When relationships are built on reciprocity, there is no stigma attached to requiring assistance.” (2009, p 140-141)
This kind of model of helping was something frequently brought forward in the stories of other participants and Fay also reflected this in her interview. She stated that in her view and based on her frontline experience in the community, what was needed in the city was a place where women could gather together on a level playing field to share knowledge, connect and help each other: “from what I can feel and know, is they wanna be in a space where they’re not being judged, where it’s not power over, where you’re just being with them, and listening…right?”

Fay’s own healing work led her to apply her knowledge towards trying to decrease and halt the steady stream of apprehensions of children in our community. In the following passage, she speaks to some of the problems and challenges of the current child welfare system that are impacting the lives of Aboriginal women and their families, highlighting the structural violence enacted by both funding and policy practices:

“It’s a paradigm, right? Like the whole, well a lot of the way the family service workers work […] in that paradigm, and [are] very prescriptive to these poor women. Like the family service worker says I have to do this and I have to say yes. It’s not even like, sorry I can only actually maybe once a week going to see a, a healer at Anishnawbe Health or something. I can’t get out five days a week or something and do this and do that. It’s horrible and I mean you think about, okay. If you’ve had your baby, let’s say you’ve had a c-section and you’ve had an apprehension, holy crap just saying those two things in the same sentence? And that woman’s like, first of all, her kid goes into care….um, do you know how much that costs a month? About, you know, two thousand dollars a month to have a kid in care, you know? She’s been given nothing from, from the welfare system, like maybe eight hundred bucks a month to survive when rent’s even like nine hundred for a small bachelor apartment here in Toronto somewhere. So it’s like…she’s been given nothing prenatally and then she’s had her, she’s had a c-section, her baby’s been apprehended…she is supposed to be in court five days later, including weekends. Five days later she has to be in court. That’s the, that’s the system…right? And then she’s supposed to come and start seeing her baby be brought into the agency for, um, for visits, right? How can you be in court when you’ve just had a c-section? You look at the other people, they’re at home, they’re being nurtured, they’re being supported, people are making soup, they have family around them, people are bringing the baby to breastfeed. They can’t stand or move around too much because they’ve just had a section and yet our women are
supposed to go out and be in court five days later with a c-section? What the heck. And the cost to the system, um, for putting a child in care is like two thousand bucks a month versus let’s just pour some money on this side of the balance scale, support her and…work with her.”

In fact, this work of supporting in a preventative and supportive approach is the work that Fay has undertaken. She has created and utilizes a model of care of helping women who would be considered at risk of having their babies apprehended that emphasizes their strengths and what they are doing well while also being very clear and honest about what the perceived risks and concerns would be in terms of child welfare involvement. This work stands in contrast to what is known in child welfare as “birth alerts” which involves tracking pregnant women whose babies are already considered to be ‘at risk’ by the actions of their mothers and requesting that hospitals notify child welfare authorities when the mother arrives at the hospital to birth her child (Denison, 2012; Richard, 2009). In Canada, legislation and case law prevent child welfare from opening a formal child protection file prior to birth since ‘legal personhood’ only accrues at birth (Richard, 2009). As such, birth alerts function as a pre-emptive form of child protection intervention, enabling the practice of apprehension at birth that Fay herself had experienced as a baby and something she is working hard to prevent.

Fay’s story and her work underline the urgency of trying to find a better way to support Aboriginal women in culturally meaningful, non-judgmental, strengths-based ways through prenatal care, birthing and afterwards, since, she states, a “baby or babies who are apprehended are disconnected, are experiencing that disconnection. That’s a life time impact, right?” Fay identified the positive impact of the SGMT midwives who work from the same strengths-based, non-judgmental, culturally grounded approach to supporting Aboriginal women through their pregnancies, births,
and the six week postnatal care period of midwifery care, associating SGMT with a decrease in the number of apprehensions at birth. Part of the success of these approaches to care is in the ability of care providers to meet women where they are at, without judgment, to see each woman as more than the trauma she has experienced or may be currently experiencing.

Her story also pulls into light some of the policy and funding practices that create an increased likelihood of apprehension for Aboriginal women giving birth, as well as barriers to responding to apprehension once it has occurred (specifically in the case of women who have birthed by caesarean section). She reveals the discrepancies between funding provided for a child in the care of the state, and funding provided for a child in the care of their mother living in poverty. This begs serious attention to the ways in which the current system of child welfare is organized to better financially support foster or institutional care than it is to support an Aboriginal mother to care for her own child or children. In what ways does this system of funding simply extend the legacy of residential schools, transracial adoption and the seemingly unending agenda of cultural genocide? The extraordinary rates of Aboriginal children in care and the profound impact that apprehension has on the lives of those affected ought to compel more serious attention on the part of social work practitioners, educators and researchers towards transforming the ways in which the work of child protection is imagined and carried out (Baskin, 2007).

Given the disproportionate rates of poverty experienced by Aboriginal women and by Aboriginal peoples more generally, addressing issues of economic exclusion and marginalization is fundamental to changing the relationship between child welfare and
Aboriginal peoples, and to supporting the health, well-being and cohesion of Aboriginal families. Poverty is, as Marie described in her interview, one of the worst forms of violence one can experience. Tangled within the challenges of poverty is the issue of inadequate housing, which Faye identified as one of the most pressing issues she saw facing the women she was working with:

“Housing. I would have to say that’s a huge one, right, that’s probably the biggest is that the places where my clients live is all Toronto housing and whatever, and I would say 80% of it? Is crap, it’s horrible, they’re horrible places to live. So no matter how much money you have, living in these spaces is absolutely, like…beyond depressing, right? So to me, if you could provide…an incredible, like spaces around the city that have, that are small. You know I’m not talking about huge apartments, but like small spaces where people could live in clean, healthy environments, right, to start with and then you could create your own space and I think even just coming into a, into a nice place to live…..lifts you on some level and then you can kind of, kind of go from, you can go from there, right? And it’s almost like there needs to be a whole community of women that help other women but how do we get resources to do that, like you know?”

The need for increased and improved low-rent or subsidized housing is not an unknown concern to the city of Toronto, and the implications between housing and health have been substantially explored by researchers like Dr. Stephen Hwang of the Centre for Research on Inner City Health at St. Michael's Hospital in Toronto. In proposing a life course approach to the social determinants of health, Dr. Jeff Reading (2009), a Kanien'kehà:ka public health scholar and Director of the Centre for Aboriginal Health Research\textsuperscript{17}, identifies poverty eradication as a key priority given that income is the means through which so many other determinants of health are purchased including but not limited to housing, access to healthcare, nutritious food and potable water.

\textsuperscript{17} Dr. Reading is also a former Director of the Institute of Aboriginal Peoples Health of the Canadian Institutes of Health Research
When asked what else she thought was needed to support the health and well-being of Aboriginal girls and women here in the city, Fay spoke of the possibility of a model that reduced the role and impact of child welfare. She also suggested the creation of a circle to support women whose children have been taken:

“...I know there’s another area in Ontario where they’re trying to create community circles where...child welfare is sitting at the table but they’re only one player and the circles are being held outside of child welfare, you know. So I feel like there needs to be, and in Toronto there needs to be a support for the apprehended women’s, that if you had your baby apprehended we need a circle for those women, they’re being left raw. They have no idea what they’re doing, they can’t think, how can they go to court and even speak....when you’re in that state of emotion, like your child’s just been ripped out of your arms? Like, so it..., again, like a space like we just talked about, where circles could be held and she’d feel safe to go over there would be, um....really, really important in healing. That would really make a huge difference in her healing, right?”

These suggestions are arguably readily applicable and possible though the first (reduction of the role of child welfare) requires a substantial paradigm shift that could be encouraged and supported by legislative changes and advocacy on the part of implicated parties, namely social workers. The second is a form of care or service that could be immediately developed to help provide care, support and advocacy for Aboriginal women who have had their children apprehended. The logistical issues would require attention to the political and funding landscape of Aboriginal health and social services described in previous chapters, to really think through who is providing the service, within the context of which agency or physical space and how these factors may be addressed to increase the likelihood of women engaging with the circle.

Transforming the ways in which Aboriginal women, babies and families are met by health and social services including child welfare, requires a basic understanding of the trauma that Aboriginal peoples have experienced whether individually or collectively.
Fay described the overwhelming amount of trauma experienced by the women she works with, estimating that approximately 80% of the women she sees have experienced sexual abuse. She emphasized the importance of being able to meet women where they are at, non-judgmentally and also of trying to share knowledge about how histories of trauma and abuse impact pregnancy, the growing baby, as well as childbirth. Awareness of and the ability to attend to the impacts of trauma constitute a significant area of knowledge and skill required to support the health and well-being of Aboriginal women, their families and communities.

**Trauma, trauma-informed and Indigenous approaches to helping**

Trauma caused by dislocation or disconnection whether through apprehension, adoption, abuse or violence has serious implications for health and well-being and for health-seeking behaviours. Historical, collective and individual trauma in the lives of Aboriginal peoples has been documented and explored widely in the Royal Commission on Aboriginal Peoples (1996), the research reports of the Aboriginal Healing Foundation, and in the work of a multitude of Aboriginal authors and scholars (see, for example: Brave Heart & DeBruyn, 1998; Brave Heart, 2000, 2003; Knockwood, 1992; Menzies, 2008). In inviting the women who chose to participate in this research to share their stories of who they are, where they come from, what they feel helps or hinders their health and well-being here in Toronto, and what they see as needed, a wealth of knowledge came forward from the women that spoke not only to how trauma had, in some form or other, informed their lives, but also what has helped them in navigating their health and well-being even in the face of it. This knowledge is tremendously valuable in that it illustrates the strength, agency and resiliency of our
women and demonstrates the ways in which Aboriginal women continue to be leaders in the care of health knowledge, carrying roles and responsibilities as knowledge and vision keepers, healers, helpers and caregivers despite the mass devastation caused by colonization. The knowledge shared by each woman individually and all of the women collectively are neither single nor simple stories, their lives and challenges, dreams and goals are complex and complicated – like the world they have emerged into. I would argue that the strength of their knowledge and skills lies in that they are able to hold and speak to both brutal challenges, pain and trauma, as well as beauty, joy, love and a vision and action towards something more whole, more healing, more positive.

While speaking to the impact of trauma, a number of participants underlined the need for a greater awareness of the impact of trauma on the lives of Aboriginal women (and Aboriginal peoples generally) on the part of healthcare and social service providers. It was not simply a matter of knowing more about the occurrence or increased likelihood of trauma due to colonization, but to shift the ways in which Aboriginal women and peoples are mistakenly constructed as bodies of trauma due to racist stereotypes, as opposed to whole people who have experienced trauma and are navigating its impacts. Jade addresses this directly in describing what she is seeing in the movement towards trauma-informed care:

“I….really like what I see around trauma-informed care…um, which is less about focusing on trauma. For example, I haven’t experienced a lot of the individual trauma that a lot of, statistically, Native women experience, um, but nonetheless, to be informed that that’s a possibility of somebody’s experience or know that that’s an experience that a lot of my friends and family have, um…that the care that I receive would then be informed by, by that experience but not focus on it.”

Trauma-informed approaches to care are gaining popularity and traction in Canada, with a provincial framework for trauma-informed care rolling out in Manitoba.
and a province wide trauma-informed training initiative in British Columbia. Generally speaking, trauma-informed practice seeks to anticipate and attend to the needs of survivors of trauma, aiming to avoid or reduce the likelihood of re-traumatization in the course of care and improve service experiences and outcomes for service users (Klinic Community Health Centre, 2013). There is an inherent understanding that accessing care has the potential be either helpful or harmful depending on the approach taken.

Trauma-informed care includes promoting awareness of how common the occurrence of trauma is, the impact on development and the differential impact on different groups based on collective experiences, the broad range of coping and survival strategies people take up in response, and the relationship between trauma and physical health, mental health and substance abuse (Poole, 2012). It does not require that a service user disclose trauma, rather that the physical location of the service, its policies and providers are organized to facilitate a sense of physical and emotional safety and to enact collaborative, non-hierarchical approaches that centre client choice, participation and control (Poole, 2012; Klinic Community Health Centre, 2013). Based on the following definition, trauma-informed care could be characterized as a strengths and empowerment based approach that seeks to promote and enhance resiliency:

“Trauma-informed services create safe environments that foster a client’s sense of efficacy, self-determination, dignity and personal control. Service providers try to communicate openly, equalize power imbalances in relationships, allow the expression of feelings without fear of judgment, provide choices as to treatment preferences, and work collaboratively. In addition, having the opportunity to establish safe connections—with treatment providers, peers and the wider community—is reparative for those with early/ongoing experiences of trauma. This experience of choice, collaboration and connection is often extended to client involvement in evaluating the treatment services, and forming consumer representation councils that provide advice on service design, consumer rights and grievances.” (Poole, 2012, p. 4)
This does, to do some degree, describe the kind of approach that Fay is taking in her work, as well as that of the SGMT midwives. My own experience of midwifery care with SGMT in many ways mirrors this description – I was received by non-judgmental, supportive care providers – both Aboriginal and non-Aboriginal, in a physical environment that fostered a sense of safety and ease, and I did not have to explain my trauma history nor the intergenerational legacy from which it emerged. Moreover, I was provided with and supported through multiple opportunities to practice exercising choice and control over my health care, something I had struggled to experience previously. My challenges in exercising choice and control, and for that matter my voice, prior to midwifery care were not simply a matter of individual or collective trauma, but also of the actual choices and level of control available in the context of mainstream healthcare for Indigenous people. One piece that is lacking from the trauma-informed model as described above is an emphasis on identity, specifically Indigenous identity. This was perhaps the most profound aspect of my care with the SGMT midwives: a recognition of my Indigenous womanhood, a celebration of my role as a life-giver, and acceptance, support and even facilitated access to cultural knowledge and ceremony. In the course of my care with the midwives, I experienced a profound sense of acceptance of who I was and where I was at in my own healing as a client of SGMT, as a mother and as a community member. Being held as a whole person, a whole Indigenous person, in an Indigenous model of care not only facilitated my access to and experience of prenatal care, but the courage and capacity to practice choice and control in the care of my health moving forward.
I would suggest that this is a model of Indigenous care that by its nature is able to account for and meaningfully respond to issues of trauma because it centres the person and their identity within the broader context that informs their life – both historically and contemporarily. This would be in contrast to a model of trauma-informed care that tries to account for Indigenous peoples, Indigenous ways of knowing and being and the impacts of colonization. In reflecting on the ways in which she sees trauma impacting on the lives of the women and families she is working with, Fay also lands on the idea of identity as a central focus in responding to the challenges faced by our community:

“Because really when I see the women and the families I work with…they’re all impacted by trauma, and they’re not even close to being…to having the time or the energy to be…..um, to start on their healing path. When you can’t even, you know, don’t have enough money for, for dinner for your kids and things like that, you’re in crisis all the time, so who has time for trauma work. But…creating a space where I guess….you know we could keep spinning our wheels, like I could keep going out and giving people food cards and tokens to get places and all these kinds of things, but it…like how do you actually…how do you actually shift…..the community? I mean what level do we wanna talk about here? You know it’s hard to talk about how come we can help….right? I’ve just kind of taken that word and thrown it away anyways because…people just have to, they just need whatever support, you just need to meet them to wherever they’re at…right? I mean all….and money’s not the answer…it’s really…working the mystery and the magic of…supporting people in their identity, right? So…maybe the birthing centre is something where people will go. Maybe there just needs to be something that’s…..run by women and for women and…a place where people could just come and…have kitchen table talks and have soup and just….I know there are some agencies that are attempting to do things on a….like that, right? But I think it’s more of a service oriented for…clients, but clients and community workers, are they not the same thing really? So could we not have some space where we’re all sort of…the playing field is, there’s no power structure so it’s, it’s set up like a traditional, in a traditional circular way, right, where we’re all there.”

The centrality of identity to healing is reinforced in the work of Indigenous scholars and helpers, including Baskin (2009) who states that acceptance of oneself as an Indigenous person is not enough, instead, we must be able to “embrace, cherish and celebrate Indigenous identities in order to be whole and healthy. Whole means, of
course, including all aspects of our Indigenous identity – sexual orientation, gender, abilities and so on” (p. 139). Supporting and nurturing positive identity with individuals and families does not absolve the broader Indigenous community from addressing issues of internalized racism and lateral violence, nor the broader Canadian society from collectively addressing the racist, colonial systems, thinking and practices that have exerted these problems onto the lives of Aboriginal peoples in the first place.

Issues of identity and healing are not, as a neoliberal model might wish to insist, simply an individual affair, but rather necessitate and beckon collective attention, healing and transformation. Empowering individuals to navigate care in an actively racist society is one piece of work, and undertaking activism, advocacy, research and policy analysis to rupture and transform the racism that underpins mainstream education, health and social service systems is another.

Fay also reinforces the importance of more equalized ways of being in relation to each other, and the importance of “by women, for women” approaches to healing, two pieces that several other women raised in the course of the research. In sharing her story and stressing the importance of a broader understanding of trauma, Sandra also alludes to more levelled out or equalized relationships of helping when she speaks of co-counseling or re-evaluation counselling:

“…all my siblings except me went to residential school, they all went there, and I got to stay home with my parents, I got to speak my language and, uh…..but I also lived in a lot of the…devastation, it was just…I don’t know how I got out of there (laughing) but uh, I think it was having my cousins, like they took me in as their sister and so they’re my sisters today. But anyway, this whole fantasy around, uh, finding help, like I just never stopped looking for help, you know. I, I’ve been looking for help a long, long time, and I’ve looked everywhere and uh, I came across this, um, it’s called “re-evaluation counseling” or co-counseling, uh, but the whole idea of understanding trauma is really, really so essential for all of these helpers and healers and Elders and…even policemen, for goodness sake,
somebody can teach the policemen...about trauma (laughing). I remember when, the last time I called the cops for help from my, you know my, my husband was abusive, and when....they arrested me too, you know. I got hauled off to jail (laughing) with my baby, and they threatened to take my baby...oooh. But anyway, if people could just understand, um, trauma and what that does to you. Um, I think about, when I was about twenty-one, twenty-two, I had an abortion and, because all I wanted to do was just cry, I just wanted to go and tell the lady, you know I’m scared, you know I’m pregnant and I’m scared, and if she could just have been able to listen to me, and just be present, and let me just cry and tell her what it felt like to be pregnant at such a young age....well I felt like I was being raped again you know? And uh...but no she made the appointment and everything was set up and the next thing you know, you know I regretted the instant that it happened, the instant that it happened. I regretted it for many, many, many years. So trauma, trauma is not, is not often the truth about that person, it’s their trauma, and the truth about that person is that, that the healing that they need, you know they’re really actually very good people, they’re beautiful peoples [emphasis added]. So, that would be my fantasy, my vision is...there’d be more of a, a social, or community, or you know just, popular education, you know what you’d even call it, of understanding trauma, and knowing that, like I had this, I had this idea just recently that if each adult who was well enough, could be connected with ten kids in their neighbourhood, or even in their own family, [...] just to be connected with those ten kids and check in with them all the time, you would know what was going on in their life, if they were either being, you know if somebody was after them, trying to victimize them or whatever, or if they were being bullied in the school or whatever it is [...]"

There is so much knowledge held in Sandra’s story about living through, seeking to understand trauma and then applying her knowledge back in helping others. In referencing re-evaluation counselling and co-counselling, she is pulling forward the thread raised by Fay in identifying the need for ways of engaging beyond the model of service provider and service user. Re-evaluation counselling or co-counselling are models of peer to peer counseling that position and value both parties as being able to give and receive help; they emphasize the value and importance of emotional ‘discharge’ as a path way to well-being (Kauffman & New, 2004). In addition to a shared valuing of emotion as a core part of well-being, this orientation to a helping
relationship also reflects an Indigenous view of helping as described earlier by Baskin (2009) and echoed by other women who participated in the research:

“As helpers, who...you know there’s that dichotomy [of] the helper, and you know, service user and we as “helpers” are services users too, and why don’t we have places that...you know, you can be a service user and a helper and, because that is our traditional ways as Natives as well – the reciprocity. I may be helping you today, but tomorrow I may need your help, and that doesn’t make me vulnerable, because I know stuff about you and vice versa.” (Christine)

“...it’s just about clients and service providers, and that’s the dichotomy. You’re this well person and you provide services, or you’re an unwell person who goes and seeks services, and I...I think what we’re actually talking about here is creating a community of support where we are all those things for each other, we can kind of step in and out of those roles as necessary.” (Jade)

These ways of thinking about helping, helpers and helping relationships all centre the capacity of each person, just as the teachings of the circle do, valuing and recognizing each person as having something to give and something to receive from the process. In an Indigenous helping approach (and it would seem to also be the case in a co-counselling or re-evaluation counselling model), there is no dogmatic expectation that a person be in some magical state of total health, well-being and balance in order to engage with or help another. Rather, the expectation is that we make efforts to attend to our own healing journey, which includes an ongoing, lifelong process of working to identify and maintain awareness of our own healing needs, including triggers, as well as supports, strategies, medicines, ceremonies or other practices that are helpful to us.

Having experienced trauma does not preclude one from being able to learn, grow or help another. Sandra’s story poignantly articulates an understanding that a person is more than the trauma they have met with in their life, which reaches back to the idea of the danger of a single story and resists the “flattening” that Adichie (2009) warns of, of not only a person’s knowledge, experiences and context; but also as Sandra so clearly
states, their goodness and beauty. This stands in contradiction to Harris and Fallot (2001), leading scholars in the area of trauma-informed care, who state that:

“In a trauma-informed system, trauma is viewed not as a single, discrete event, but rather as a defining and organizing experience that forms the core of an individual’s identity. The far-reaching impact, and the attempts to cope with the aftermath of the traumatic experience, come to define who the trauma survivor is.” (as cited in Klinic Community Health Centre, 2013, p. 10)

I prefer Sandra’s understanding that trauma is not the truth of a person, or does not as Harris and Fallot (2001) suggest, define and constitute the core of a person’s identity. Prescribing to a belief of the latter seems to prescribe pain in perpetuity. This is not to suggest that experiencing trauma, particularly severe and protracted trauma, does not significantly impact our lives and our subsequent beliefs and actions. I would assert that as human beings, we experience pain, we are not pain. However, pain has come to occupy significant space in the collective lives of Aboriginal peoples.

**Vicarious trauma and help for the helper**

Like Sandra and Marie, Fay not only sought her own healing through identity, connection to community and helping others, she shares and applies her knowledge and lived experience of her healing in her work. This is also not a ‘single story’. She, like many other women who participated, spoke about the impact of doing her work on her health and well-being:

“…you know there is a point in time when you’re working, when you’re in the road, in your car, going to see people, *my own people*, you know I take…I connect with….I am the community, right? So when I go to see the spaces where…our families have to live? The impact of the trauma, um, that intergenerational trauma, that violence, all the things that I see in my work…..seeps….no matter how much you try to protect yourself, because I’ve been taught by some – like by my mentor […] – like you need to protect yourself. But it doesn’t matter how much I try to protect myself, the things that I see and the people and what they’re working with is, um….just this…devastating….energy, that they’ve been impacted by and then
you get impacted by that in your work, right? So….no matter what I, I do, I…I get very, like it seeps into my body and it makes me really tired.”

Fay speaks to the exhaustion she experiences in witnessing and working within what she describes as the devastating energy permeating the lives of those she is working with; the overwhelming exhaustion that she describes would be recognized and understood by many in helping professions as vicarious trauma. Richardson (2001) provides the following in-depth definition of vicarious trauma in a guidebook prepared for anti-violence workers on behalf of Health Canada:

“…the experience of bearing witness to the atrocities committed against another. It is the result of absorbing the sight, smell, sound, touch and feel of the stories told in detail by victims searching for a way to release their own pain. It is the instant physical reaction that occurs when a particularly horrific story is told or an event is uncovered. It is the insidious way that the experiences slip under the door, finding ways to permeate the counsellor’s life, accumulating in different ways, creating changes that are both subtle and pronounced. Vicarious trauma is the energy that comes from being in the presence of trauma and it is how our bodies and psyche react to the profound despair, rage and pain. Personal balance can be lost for a moment or for a long time. The invasive and intrusive horrors infiltrate and make their mark. The waves of agony and pain bombard the spirit and seep in, draining strength, confidence, desire, friendship, calmness, laughter and good health. Confusion, apathy, isolation, anxiety, sadness and illness are often the result.” (p. 7)

Dr. Kathy Absolon, an Anishinaabe social work scholar, questions the usefulness of the language of vicarious for Indigenous helpers since we also “carry our own colonial baggage” and are more likely to be exposed to and as impacted by trauma as the community, particularly if it is one’s home community (p. 190). Chansonneuve (2005) also cautions that the vast majority of work in the area of vicarious trauma has been generated by non-Aboriginal therapists trained in western ways of knowing which presents limitations in application to the experiences of Indigenous peoples working in our own communities. For example, vicarious trauma models of care are aimed at
frontline workers and spoken about in the context of professional settings and responsibilities. While Fay is, on one hand, speaking to her experience in her formal, professional role as a helper, she is also very clear in stating that she is not separate from those she is working with – they are and she is, as she states, the community. How might a model of vicarious trauma account for this aspect of Fay’s experience that I suggest might be understood as a collective or communal dimension of vicarious trauma? Since Indigenous understandings of health and well-being are grounded in relationality and interconnectedness, the experience of the individual is not separate from that of the collective. Fay’s sense of personal well-being is not disconnected from that of others in her community. She chose to work in her own community as part of her healing in understanding her identity, and she simultaneously offers the knowledge she gains back to others in the community; she both impacts and is impacted by the health and well-being of those she works alongside. Given that Indigenous helpers like Fay are navigating the impacts of both historical and ongoing colonial policies and practices as both a part of the work and a part of their own lives, having meaningful ways to understand to respond to the challenges they face is important.

**Dear mainstream knowledge(s), you are not the centre of our universe**

In the previous sections, I have discussed ideas arising from the fields of knowledge around trauma-informed care and vicarious trauma and how these relate to the experiences of the participants in the study as well as to Indigenous peoples and contexts more generally. While I am critiquing these ideas, I am attempting to demonstrate and hold carefully my responsibility to recognize that all knowledge has a spirit and an inherent value, but this does not necessarily make all knowledge
universally applicable to every person and every situation. So I recognize that both of these areas of knowledge bring something to offer to and have something to receive from Indigenous ways of knowing and being.

I do think it is helpful in the face of an ongoing assault on and attempted erasure of Indigenous knowledge(s), to be clear that I recognize Indigenous ways of knowing and being as both dynamic and whole unto themselves, as ancient, sophisticated knowledge systems which hold intimate, familial relationship to and ‘seniority’ on the lands of Turtle Island, relative to more ‘junior’ knowledge systems introduced by different waves of settlers since first contact. It is an important framing for me to situate Indigenous ways of knowing as vast and whole, in contrast to mainstream models which more typically treat Indigenous knowledge(s) as, at best, marginal or peripheral and at worst, primitive. Such understandings of Indigenous knowledge(s) give license to the common practices of tokenistic engagement of or an additive approach to the inclusion of Indigenous ways of knowing in such arenas as health, education, governance, justice, etc. In this way I am interested in speaking to how different issues or areas of knowledge raised by the participants in this study can help to inform us in advancing the health and well-being of our women and considering what they mean in relation to Indigenous approaches to helping, health and well-being. This is a conscious attempt to move away from a practice of trying to see how Indigenous peoples could be accounted for within or Indigenous knowledge(s) might be tacked onto mainstream models of knowing and doing.

For example, the bodies of knowledge surrounding vicarious trauma and trauma-informed care both recognize the importance of addressing trauma at multiple levels
(e.g. policy, organizational practices) in order to attend the impact of care on service users and the impact of caring on service providers (Klinic Community Health Centre, 2013; Poole, 2012; Richardson, 2001). In an Indigenous worldview, these approaches fall under the framework of ‘help for the helper’ (Baskin, 2009). Help for the helper recognizes a helper’s responsibility and need to practice self-care, and equally the need for family, community and organizational support and care (Baskin, 2009, 2011). Generally, participants who were in formal helping roles described being well supported by family, a close network of women friends or both. Both community level and organizational level support did emerge as areas of concern for participants.

**Community and organizational level supports and challenges**

In the course of her interview, Fay expressed that a lack of organizational support and care for her and impact of the work on her had a substantial effect on her health. Baskin (2009) provides the following suggestions for organizational or agency level help for the helper:

“…providing appropriate resources, adequate pay, manageable case loads, hearing their suggestions for improvements, honouring their strengths and assisting them to learn new skills, ensuring access to Elders and ceremonies and involving them in decision-making. Such an approach conforms to the values of Indigenous worldviews, which emphasize collectivity, consensus and that each person has something important to contribute to the whole.” (p. 140)

Such practices contribute to the sustainability, health and well-being of our helpers, nurturing and renewing their strengths and abilities so that they can continue to engage in a good way. Just as Fay’s health and well-being is linked to that of those she is working with, so too is the health and well-being of workers linked to that of the organizations they work within – which together also impact the health, well-being, service experiences and outcomes of service users. Our organizations are not
unscathed by the impacts of colonization and, in fact, a strong reliance on government funding can require governance models, service delivery, evaluation and reporting practices that exacerbate the stress of staff or obscure the importance of attending to the impact of the trauma encountered, witnessed and experienced in their work. Racist treatment by funders and problematic funding practices can also more generally impact morale and impede the work of Indigenous organizations. This is something JoAnne spoke to her experience of having worked with Indigenous organizations:

“...we're at the mercy of the provincial government. We have money earmarked for us and it's like, you know what? I would rather take money from [private corporations] than the frickin’ government, because the...the ties...just what you have to do for it and how they treat you and how they belittle you, right? And just because you're Native too, it's not – all organizations don’t go through this, you know? It's very, very clear.....so when I see our organizations being dependent [I think we just need to get away from it].”

What JoAnne raises here echoes the issues discussed in Chapter 6 and highlighted by the work of Dr. Caroline Tait. I would argue that the legacy of colonialism, patriarchy and racism upon which Canadian systems of governance are built is reflected in hierarchical models of legislation, funding and organizational management models that favour western values of individualism and practices aimed to minimize risk and reduce liability for funders (namely governments), organizations and their leadership. These models contravene a more communal, collectivist stance embodied in Indigenous worldviews, and instead foster more competitive rather than cooperative environments that prize dominance and reward it with more power.

The impact of competitive work environments can be compounded by racism inflicted upon and/or internalized by Indigenous peoples resulting in dynamics of 'divide and conquer', which may also be further aggravated by patriarchy, ableism, classism
and homophobia. The result can be exclusionary behaviour and lateral violence among and between our peoples that may range from ignoring, slandering, undermining, blaming, intimidation and other abuses of personal and organizational power. These may be understood as expressions of disempowerment, which can be addressed in part by trying to raise consciousness (among helpers and service users alike) of what Absolon (2009) refers to as the “turbulent landscape” in which we are navigating towards personal and collective healing in the context of an actively racist and colonialist society. Such behaviours and actions are faced by Indigenous workers whether they are working in an Indigenous or mainstream organizations.

JoAnne spoke briefly to how the challenges she faces in her mainstream work environment are impacting her health and well-being:

“…we just don’t all get along, and we don’t have to, it’s like the Idle No More, right? They say ‘oh well you’re divided’. Well of course we’re not all gonna have the same view point, right? But I think that we have to work together and, you know, that’s where the dysfunction comes in, right? And some people can’t work with some people and that leaves us in a position where we’re not united as Indigenous [staff] here. So I think that…that’s, that contributes the most to my….my ill-health, right? And trying to just work…kind of….navigate it, but to navigate it you need to know where the issues are…”

I would suggest that responding to the kinds of challenges exemplified by Fay and JoAnne’s stories, requires attention to and action towards healing dysfunctional dynamics not only at the individual and family levels, but also the organizational, community and societal levels.

**Standing in what we know: Indigenous approaches to helping and healing**

What gifts do our traditional ways of helping and healing offer to addressing and transforming the challenges we face in helping ourselves and each other in the face of individual, historical, intergenerational and collective trauma that manifests in our
personal and work lives, and in our interactions in our broader community and society? Dr. Michael Anthony Hart, a Nehiyaw social work scholar, describes healing as “…a daily practice that is orientated to the restoration of wholeness, balance, relationships and harmony” that necessarily requires us to attend to matters not only of illness, but also of disharmony, disconnection and imbalance (2009, p. 36). Moreover, in the discussing the concept of mino-pimatsiwin (the good life) as the goal of Indigenous healing efforts, he describes within it an implicit understanding of a person as both in a state of being and a state of becoming (Hart, 2009). This invites and allows for a person to be seen not only in the context of their history and present circumstances, but also in the broader context of what they are moving towards and working out. Stated differently, it holds a person in view of what they have lived through, the strengths, skills and knowledge they have used to survive and thrive, as well as their ability to grow and change as part of their journey into the future. It also mirrors and reminds us of our connections and responsibilities to those who have come before us and those who will come after. From a Métis worldview, people are recognized as having pre-existing abilities and an inherent knowledge of how to be well (Richardson & Seaborn, 2009).

Both Baskin (2009) and Absolon (2009) provide multiple suggestions for attending to ourselves and to each other as helpers and as community members. This includes building and creating space for circles of support to help us debrief and attend to the impacts of our work on ourselves, to share and learn from each other and take care of each other (Baskin, 2009); this can include sharing food and utilizing ceremony (Absolon, 2009). These circles of support can also help to attend to issues of balanced and shared responsibility, recognizing – not denying – and responding to exhaustion:
“[w]hen one is tired, the rest of us need to work a little harder. And when one of us cannot meet the high expectations that are placed upon us, or stumbles or even falls, the rest of us need to care for that person, rather than pass judgment upon them, knowing that one day, we will likely be in that place of need as well.”

(Baskin, 2009, p. 140)

This importance of sharing the weight of responsibility and holding each other with acceptance instead of judgment was also raised directly in the research by Segaine who spoke of the privilege of being a helper as well as the challenges of the expectations she has met from others about what this means. This included what she felt was a sort of permanent sense of her availability and ability to help, as well as expectations about how she must be in her own life in order to undertake her role:

“… it’s a real privilege to be able to assist people on whatever their journey is. But I think that along with that comes… with certain expectations, expectations that I will behave in certain ways, and that, um, my life should be completely in order, um… in order for me to be able to do what I do. It’s those kinds of things, and I guess this is somewhat of I’m talking a little about the judgment part of it, um, which says to me sometimes I just feel like rebelling and saying you know what, if I wanna drink alcohol and smoke dope and take, and snort cocaine that’s my business. If I want to be in an abusive relationship, that’s my business, like I, sometimes I just feel like, you know what, like there’s a whole package here and it doesn’t (laughing) it doesn’t match up to who, who you may think….about me. And yet I always feel like I’m, I put it all out there, I don’t really ever feel like I’m “oh dear I gotta hide this part of myself”, that’s just not… I just don’t do that. But I guess in the not doing it in, maybe sometimes that’s where the judgments come from and I guess the other part of that piece of it is…you know what, sometimes I’m just so frigging tired.”

That judgment or expectation of being ‘completely in order’ that Segaine is describing stands in contradiction to my earlier assertion that there is no expectation of helpers being in a “magical” state of wellness in order to undertake their work. It has a painful impact on Segaine and others navigating similar experiences and I would suggest may cause or contribute to the kind of fragmentation Fay experienced in her adoption in which she was desired for one aspect of herself (providing a baby for her
adoptive mother) but not necessarily all of her (being an Indian baby). Likewise, Segaine is wanted for her helping skills and knowledge, but does not necessarily feel accepted for her whole self; in frustration with the same she expresses an intermittent urge to rebel. This urge to rebel is a very clear push back against the pain of judgment and a deep sense of exhaustion from the expectations and demands she faces in her work, which she attributes in part to a general shortage of Indigenous helpers in formal roles.

For me, this again brings forward Hart’s (2009) discussion of mino-pimatsiwin and the importance of attending to and holding all members of our communities, including our helpers, as simultaneously in a state of being and becoming. This pulls at and makes visible the old familiar dichotomy of the ‘healed’ or ‘healthy’ helper and the ‘ill’ or ‘sick’ person seeking help. Indeed a trap for both parties, each left holding a single story of self (of either ‘healthy’ or ‘sick’) that denies their full personhood and experiences, past, present and future. Busting the ‘either/or’ trap of dichotomized thinking inherent in western worldviews is, in my view, a significant step towards protecting and revitalizing Indigenous ways of knowing and being that are vital to reclaiming our health and well-being. When we cease to buy into the idea that things can only be one way or another we re-open ourselves to possibilities of dreaming and birthing change and transformation.

“The little girl was scared because: The power of telling our stories”

Another pathway to transformation and change carried with Indigenous ways of helping is the practice of storytelling. The healing power of storytelling is recognized in Indigenous traditions the world round, and also shows up in mainstream approaches in
the form of narrative therapies which are arguably a gross form of appropriation (Baskin, 2009). Storytelling allows for a re-story-ing to help process and understand one’s experiences toward restoring a sense of wholeness in oneself and in relation to those around us (Absolon, 2009). It is also a way of passing on the knowledge (Denham, 2008; Baskin, 2009). For example, in the course of her interview, Donna shared experiences of severe violence and substantial challenges in navigating the healthcare system, but she identified the very act of story-telling as helpful and healing to her, particularly the hope that the knowledge she shared might be helpful and healing to others. This part of her story came as we closed up our interview with each of us saying something we would like to take away and something we wanted to leave behind; this small piece embodied the spirit of kindness and deep courage that Donna demonstrated throughout her whole interview:

“I think the… I have to say that the things that I wanna leave….here are…not so much leave, but I think that, um…I think that things I wanna leave here are a lot of the memories and I think that it was, it was good to share those….and it was good to share them in a way that it might helpful for someone, because I think that there’s a path that’s been created that, um, that I go and I share my story, whether it could help teams, or it could somebody, um, that’s going through something, maybe it’s abuse or something. I always wanted to public speak about what I have gone through and, um, what I take away is leaving the story with you and the hope that it will be used in a way that, um, that might help someone and that’s very, that’s healing for me in itself. So, um, while I’m not leaving everything here, um, I will take away with me, um, knowing that….perhaps it will, it will help somebody else. That perhaps somebody else might be able to, even yourself, might be able to…to learn from, might be able to help you, um, to go on through daily life and feel happier. That’s my….that’s my goal. Even if I just help one person, if I’ve reached someone then…my day is done (laughing)…and I think that in doing this, it really spoke to me. It really spoke to me when I saw it and I thought I’m gonna do this. Because when it comes to public speaking, um, I went to a Toastmasters once and, um, one of the things there…we have table topics and you have to pick a table, and people would be picking things like “oh, I love spaghetti because….” Or, um, “I make peanut butter sandwiches” or something like that, something
related to food or whatever. So I come along and I go up there and pick up a card and what does it say? “The little girl was scared because” and it took me right back to the, uh, closet that I was hiding in when I was adopted….and, uh, when my parents came to get me, my sister and I hid in this broom closet. So it took me right back to there and I couldn’t speak. I said…and I couldn’t talk, and so I asked him, I said “I need time, I can’t speak about this, I have to sit down” and I went and sat down. So I went to him afterwards and said could I write about it because maybe if I could write about it, I could speak about it next week, and he said “You know the whole point of it is to do it on the spot” and then, um, he said…it was like he saw something, like a light went on in his head or something and he says “You know what, go home and write about and present next week”. So I went home and I…wrote a little piece about it and, uh, I went back and presented it, but….I couldn’t breathe when I was presenting it. I was still having a hard time. I can talk one-on-one, but when it comes to crowds…I still get very…It gets a little unnerving for me. But, um, but yeah….I’m glad I did this. I’m glad I shared…my story.”

Even as she speaks to the challenge of public speaking, Donna is claiming and exercising her voice, a profoundly important part of healing (Absolon, 2009), particularly for Indigenous women who have faced violent and persistent attempts to silence us. Our stories contain our knowledge and the learning we have gathered from our experiences, which may shift and change over time as we become more aware of our relations, as we navigate challenges and as we celebrate our strengths, gifts, courage and successes. These stories contain medicine for us that can become part of what Absolon (2009) refers to as our kandossiwin dkobjiganan or "knowledge bundles". These bundles include knowledge we need and have gathered along the way, such as knowledge about the impacts of colonization and the ways in which it can manifest in disempowerment, blaming and the need for power (2009). Our bundles are meant to be perpetually renewed and maintained – reflecting a stance of lifelong learning. This bundle not only includes our practice approaches for helping others, but also for helping ourselves, which I would argue from the teachings I have received should really be the
same if not remarkably similar. I have long been taught by many Grandmothers, Grandfathers, Aunties and Uncles who I have met in my journey and learning about Indigenous helping, that we cannot take anyone any further than we have been ourselves. Therefore, the attention to our own healing and growth is paramount, as is committing to practice the care and kindness with ourselves that we would offer to anyone else we were in a helping relationship with - this is a teaching I received from Grandmother Joanne Dallaire while I was in the process of this research. The way we treat ourselves is very important; we are, after all, in a lifelong helping relationship with ourselves.

As I write, I wonder about how all of these teachings would apply to our organizations as beings, and to our communities as beings. Applying the teachings of mino-pimatsiwin, could I hold an Indigenous (or mainstream for that matter) organization as both in a state of being and a state of becoming? I am challenged to think of the ways in which I have been inclined to see different organizations as all good or all bad, or as culturally grounded or as tokenistic. These binaries are dangerous but they have been fostered and nurtured by western thinking embedded in my formal education from the time I was old enough to walk and talk. Moreover, they festered in the face of my experiences of lateral violence and disenchantment while working within Indigenous organizations. As I step back and hold my hurt feelings from these experiences in my own hands and try to see the people involved, the organizations and our broader communities as both being and becoming, I am forced to recognize the ways in which accepting and wielding those binaries allowed me to avoid my own personal responsibilities for not speaking up in response to painful dynamics or murky politics. I
am also forced to see the ways in which those binaries allowed me to saddle a high
horse of moral righteousness (Dallaire, personal communication, May 2013), choosing
the easy work of judgment over the harder work of acceptance and harnessing my own
voice – work that waited patiently for me to finally pick it up.

I thought about the ways in which storytelling also relates to the health and well-
being of our organizations and communities – what are the stories we tell ourselves and
each other about them? What stories do organizations tell about themselves and what
opportunities do they provide and protect for collective re-storying and restoring? How
might, for example, the stories of Fay, JoAnne or Segaine contribute to or shift the
broader story of each organization they work within and of the collective stories of our
women and communities? Further, what might it mean to attend to – as all staff in an
organization, or all members of a community – the knowledge bundle of that
organization or community – to regularly acknowledge, name, tend to and revise the
collective knowledge bundle held by staff of the organization or members of the
community over time, effectively honouring both those who have come before us and
those who will come after us?

Discussion: On trauma, pain and healing

As previously stated, I believe that we, as humans, experience pain, we are not
pain. However, pain has come to occupy significant space in the collective lives of
Aboriginal peoples. Nigerian author Chimamanda Adichie (2009) states that the way to
create a single story is to “show a people as one thing, as only one thing, over and over
again, and that is what they become” (n.p.). Through the power of a single story, fed
and nourished by racism and seemingly tireless colonial machinery, Aboriginal peoples
have arguably come to represent pain in the psyche of Canadian society. But this pain is held distant, effectively individualized and pathologized into the bodies of Aboriginal peoples and maintained by an ongoing ontology of forgetting that actively erases and silences histories of colonialism, racism and cultural genocide (Pon, Gosine & Phillips, 2011). I would suggest that this ontology of forgetting has significant ramifications for the healing of Aboriginal peoples, since it is difficult to speak to, let alone 'let go' of, pain in a societal context in which the source, occurrence or impact of that pain is not recognized or acknowledged. While one might argue that the residential school apology or the Truth and Reconciliation Commission represent a shift towards improving awareness of the broader Canadian society of the histories, knowledge(s), practices, beauty, strengths, challenges and needs of Indigenous peoples, the vile racism experienced by Idle No More activists and levelled at Chief Theresa Spence in the wake of the crisis at Attawapiskat and her subsequent fasting, suggests that we have a very long way to go.

Women who participated in the research shared multiple experiences of disconnection and dislocation – not only through apprehension and adoption, but through multiple forms of violence (structural, intimate partner, lateral), abuse (physical, sexual, emotional and psychological) and racism. The pain and trauma they experienced in their lives is not their whole story, it does not define their whole being. In fact, every woman was working out what was helpful to them, what was healing to them and how to create a sense of wholeness that worked for them. For me, it echoes back to the tenets shared by Richardson & Seaborn (2009) that people come with pre-existing abilities and that we already know how to be well. Colonialism has, and
continues to create, enable and maintain policies, practices and structures that attempt to dislocate and disconnect Indigenous peoples from that inherent knowledge that lies within us at our very core – the knowledge of our abilities and our wellness. The stories and knowledge shared by the women here are about resisting and healing from those dislocations and disconnections -- they reject the fragmentation of ourselves and embody practices of and movement towards what I would call “defragmentation” or our path back to wholeness. In closing, I share a story from my own life of my path to remembering and returning to wholeness:

The deer hide rattle and de-fragmentation

As a little girl when I would visit my Grandma’s house she would give me a deer hide rattle to play with. I remember dancing around in her living room shaking the rattle before she sent me off home with my mom or my Nan. When I was in my second year of my PhD program, my Grandma became very ill. She had already managed through a previous diagnosis and successful treatment of breast cancer, but now cancer had found its way across her body and most dangerously into her brain. As I began increasing trips home to see her in our local hospital, I was thinking more and more about wanting to have something physical of hers that I could hold onto even after her spirit had journeyed from this world. I asked her about that rattle and where it was, I wanted it badly to hold onto it as a connection to her and to that time of innocence and protection in her care. It also represented to me how much effort she had made to make culture a part of my life in whatever way she could, cultural knowledge and practices she had to struggle hard to regain for herself first and then to share with others. When she told me that she had given the rattle away to someone else I felt a grief, like I had
lost something. At the time I could only begin to appreciate that the rattle was not for me specifically, but for babies and little ones. This fall I was at a gathering at the Native Women’s Resource Centre of Toronto about the importance of sharing birth stories. I was facilitating a circle on behalf of the Seventh Generation Midwives of Toronto (SGMT), and the midwives had also invited Steve Teekens to provide the balance of a father’s perspective on birth stories. Steve is well recognized in the community as a helper, a traditional teacher, a drummer and a dancer; he is incredibly humble, kind and generous with his time. Steve told a story about making rattles for his babies when they were born and I share what I remember and learned from it here – this may include unintentional variations of his story on my part. He said that before Creator created the universe we were all together as one; when Creator imagined the universe into existence we all divided to take different forms – plants, water, land, two-legged, four-legged, swimmers, crawlers, winged and so on. In that moment of creation there was a sound and that sound was like a rattle, so that when babies are given a rattle to shake it reminds of them of that time when we were all together as one. I thought of my Grandma’s rattle again and realized that she had already given me everything I needed. She had connected me to who I was spiritually, reminded me of the deep knowing and sense of wholeness that I would now say underpins every traditional teaching I have ever learned and informs everything I know and do as an Anishinaabe-kwe. That rattle reminds me of my inherent wholeness even living in this physical world, heavily seamed with structures and systems that seem to insist on fragmentation. I hold her rattle in my mind and on my heart, and walk my own path of defragmentation.
CHAPTER 6: MAKING WHOLE: CREATING (W)HOLISTIC HEALTH SERVICES

A number of women described a strategic use of multiple forms of healthcare to meet their needs, including physicians, naturopaths, homeopaths, traditional healers and seers, registered massage therapists, chiropractors, physiotherapists, acupuncturists, and therapists or counsellors (namely, social workers, psychologists and psychiatrists). The primary stories of Segaine and Susan used in this section were chosen because they are very clear and distinct illustrations of how each woman is thinking about and navigating and balancing multiple forms of care to create a more holistic approach suited to her. These stories also reflected knowledge shared by several other participants some of whom I draw on towards the end of the chapter (Christine, Donna, Amy, Ada) to offer further insight into what might help other Aboriginal women create an approach to healthcare that will work for them, some of the barriers they may face and some suggestions for how the path to holistic care might be improved.

Generally speaking, access to holistic health practitioners outside of mainstream medicine requires substantive resources either in the form of income or employer health benefits programs (including spousal employer health benefits). Anishinaabe Health Toronto (AHT) does offer access to naturopathic doctors (who offer nutritional and lifestyle counseling, homeopathy, acupuncture, herbal and eastern medicine), massage therapists, chiropractors, traditional counselors, Elders, seers and healers at no cost to clients. Women who were regularly utilizing a combination of holistic practitioners independent of AHT acknowledged the burden of cost that would exclude many others from being able to access such care on a regular basis or at all.
Indigenous approaches to health and well-being, including but not limited to ceremonies and medicines, were significantly denigrated by colonization, disparaged and criminalized by Christianity and legislation, undermined and yet ironically appropriated by western science (Health Council of Canada, 2012; Kirmayer & Valaskis, 2007; Robbins & Dewar, 2011). In response, many have had to fight long and hard to have Indigenous approaches to health and well-being recognized as a) existing; b) a valid form of health care; and c) worthy of resources, funding support, space, education and research (Robbins & Dewar, 2011; Waldram, Herring & Young, 2007). A fight to prove existence, validity and worth – essentially truth and being – with those who have propagated and/or benefited from the structural exclusion of Indigenous ways of knowing and being is prone to polemics. There has been pressure to establish just how different and separate Indigenous health knowledge(s) and practices are from western or mainstream approaches in order to demonstrate the need for their inclusion in what gets funded, supported, normalized and institutionalized as “healthcare”. This is ironic, given the unacknowledged use of Indigenous knowledge(s) by multiple professions, including social work (Baskin, 2009), that necessarily result in similarities and overlap between mainstream and Indigenous approaches. Likewise, a fight for revitalization in the face of cultural genocide with those who propagated and/or benefit from it can also result in polarized, strict approaches to the use and practices of Indigenous approaches to health, including the use of medicines. I would argue that this contributes towards the presence among some Indigenous peoples of an implied and sometimes explicit belief that Indigenous people should rely solely on Indigenous approaches to health and healing. This issue is raised in the participant stories shared below.
The following stories are about two different women’s health journeys, both of which involve using multiple approaches to healing and healthcare to take care of themselves and to find what they needed for their wellness. These stories emerged from different participants in the same research circle and, in my listening, highlight ideas of choice and of resisting the dichotomy of either/or in engaging different approaches to health and healing. They emphasize agency in the importance of knowing and choosing what will work best for one’s own health, and of being able to find a balance among different forms of care. At the same time, the stories emphasize poignant aspects of each woman’s different experiences such as the role of dreams (Susan) and the experience of judgment from within the community (Segaine).

In this first story, Segaine begins by describing the different practitioners and practices she engages to care for her health, then discusses how her mixed blood identity normalized the experience of walking in two worlds in navigating her wellness. She draws on two experiences that emphasize the importance of being able to balance what would work for her: one in relation to her pregnancy and the birth of her daughter, and another in relation to her mental health.

“I guess it would be a lot of different things, um for….I, I um, utilize a lot of different sort of, um, wellness, I guess….things. So I have a medical doctor who I go to if I absolutely have to, for certain things I have to seek her help, but then I make a lot of use of massage therapy, I go to a chiropractor, I have a naturopathic doctor, so I have all of those kinds of things that, um, I implement into my life…which, which I find help in a lot of ways, um, particularly around sort of, uh, physical stress, right? That kind of thing. Um…I…have, in the past, also, um, accessed a lot of services at Anishnawbe Health, so I’ve seen traditional healers there, um, an acupuncturist and a few other different people I saw there….um, I’ve kind of drifted away from Anishnawbe Health…um…I find that there’s a lot of things too, uh, that I just do that are on my own, that are not connected, necessarily, to any place or any people, um and that’s, um, so I meditate, um, yoga, things like that. I find that for me, um, if I’m not meditating sort of regularly, I really notice the changes in
...um, I start to get, I feel the stress more, um, I will feel...start to feel overwhelmed, like all those kinds of things. So it’s kind of like a prevention kind of thing for me and what it does, in addition, it just slows me down and it gets me to focus on this particular moment, um, so that when I’m just out walking around in Toronto, I can focus on “oh, there’s a bird in the tree” as I’m walking along, or I can focus on exactly how it feels, on the bottom of my feet to be walking, like all these kinds of things and...and that’s what really helps me a lot. [...] Because the [non-Native] teachings I received were so similar any way to what my [Native] teachings were that I never felt like I was two divided people, like I know a lot of mixed blood people do have that experience, which is unfortunate, but I never ever had that. I was always, it always fit together for me. So I don’t, I don’t think that it’s difficult for me to kind of, um, walk in both of those worlds when it comes to wellness right? I was kind of reminded of what you said about, um, your child and, um, and well it’s a similar thing for me, is that, um, you know I was with a...a Native, um, midwives too [...] Right up until I went into labour it was going to be at...I was going to be having birth at home, I had like, the perfect pregnancy, man I was just great. I was just great. Um, and then I go into labour and she discovers that she’s turned upside down, and so I was rushed to the hospital (laughing) and after an examination being told, well if you really want to, you know, try natural birth....there’s no way this child will make it, she will die, right. So I mean, you know of course there’s no choice, you do what you have to do, so I had a caesarean. But that’s what I mean about, you know, okay it was this way but then when it flipped, it was like all I could think about was no, just get her out (laughing) right? You know, that kind of a thing right. So being able to balance them I think is important, for all us, that we can make use of those. And...I guess the other thing for me that is, um, that is a barrier, it’s a barrier for me personally and it’s also I think a structural barrier as well, but that’s, um, when they refer to mental health. Uh...it’s only not so long ago that’s I’ve actually said out loud that I have very serious mental health, um, challenges, that’s what I like to call them, um, and they are most definitely part of who I am and I’ve come to grips with not thinking that there’s a cure, or if you just do this ceremony and that ceremony, it will take it away, you can’t...you have no clue how many ceremonies and healing this and healing that, that I have been through over the years in attempts to...make it go away. Um, there’s no going away, it ain’t going anywhere. Sometimes it’s...fairly calm and sometimes it’s....causes me to try to kill myself, and that’s the world that I have, unfortunately, I’m, I have to I live in, and I always have to be in that place, right? Um, so one of the barriers is around...medication helps me, smudging helps me, so does a whole bunch of anti-depressant, anti-anxiety and anti-psychotic drugs, and when I don’t take ‘em...I’m in a lot of trouble. So the answer to that is, just like with my daughter, I choose to take the medication. But in saying that to
certain people, and explaining it the way I just did, come the judgments, right? I just find that in a lot of, you know with, in Aboriginal healing and Aboriginal service providers, it’s, it’s all about…having us not take medication and somehow….being able to…be okay all the time, by using medicines. And I don’t want to belittle that because I know there’s lots of people who don’t need the medications, and I wish I was one of them, but that’s just not how I operate. So, I think, yeah, it is still the same thing, that I think I’m still talking about judgment, that…even though as Aboriginal people we talk so much of being accepting and there are so many ways of seeing the world and dah dah dah dah dah dah, right? It’s like we talk that all the time, but….sometimes, when you get down to the real day to day stuff, I don’t find all of us all that accepting. And if I feel that from people, there’s no doubt that lots of other women and families feel that too.”

Segaine’s story emphasizes balance, as well as acceptance and resistance. While a (Aboriginal) mid-wife attended birth was what she had identified and prioritized for her health and that of her baby, she was glad for the availability of a caesarean birth in the face of imminent danger to her daughter. She shared this story as an example of being able to access and balance multiple forms of care: “So being able to balance them I think is important, for all us, that we can make use of those”. Likewise, she could choose to use medications as a fundamental part of her care for her mental health. She describes an acceptance of her mental health challenges as a part of her, of the need for more than ceremony and traditional medicines to attend to her mental wellness, and at the same time, acceptance that others experiencing mental health challenges may not need western medications as part of their care. In accepting her mental health challenges she is simultaneously resisting a single story of a “cure”; in accepting the need for and importance of medications in caring for her well-being, while at the same time accepting that others may manage with traditional medicines alone, she is resisting the idea that there is only one way to attend to and care for mental health – for her or for anyone else. She refuses the dichotomy of either/or (Indigenous/western), she refuses
the essentialist positioning that Indigenous people should only need and use Indigenous medicines or ceremonies. She also pulls into the light the painful presence of judgment experienced from within community and in doing so, challenges the community to walk its talk in terms of acceptance of many ways of knowing and of each other.

The second story, Susan’s story, addresses her engagement with various forms of healthcare towards what she describes as a “more complete way of being”. She first speaks generally about her use of the different practitioners and then describes her knowledge of and decision to use different forms of care in treating cancer. Her story also foregrounds the powerful role of dreams as knowledge to guide action and inform health and well-being.

“In terms of here in the city, uh….I’d say in terms of my own healthcare it’s a mixture of a few things. Like you, I have a massage therapist, and I have a chiropractor that I go see. I use my doctor to tell me if anything is wrong and then I go to my homeopath to fix it, or use traditional healers to augment all those different things. So that, I’d say is a more, more complete way of being perhaps. I also recognize that, unless you have money to do these things then you’re outta luck. Um ‘cause you know my homeopath and my chiropractor and my massage therapist all cost money, as well as the treatments that they give you. And the best example I can give for that is two years ago I had cancer, I had uterine cancer. So I went to the doctor, he told me I had cancer and I freaked out right, but that night I had a dream. I had a dream that I was in my doctor’s office and he was trying to make me guess about what I had. He had a piece of paper like far from me, saying what do you think you have and I’m sitting there like freaking out right, and another doctor, in my dream, came in and said oh I need you to, to come see my patient and my doctor left and I’m sitting there like “what the heck?” (all: laughing), getting really mad and down the hallway came my homeopath and he just took my hand and led me out. So when I woke up that morning I thought, I got to talk to him. So I called him: “I need to see you”. So he gave me a treatment plan, um, based on his assessment of me – what they do with their little pendulum, I don’t know what goes on precisely but…and…but my surgery was scheduled for two weeks later, so this didn’t give me a lot of time to prep, for me to be away from work and knowing that I’d probably be away for at least five to six weeks after. So I was taking the medicine but kind of panicky about it and then he, my homeopath, had recommend
I stop taking it a couple days before my surgery, then starting taking it a couple days after. But it actually came to the day of my surgery I was sick, so they wouldn’t do the surgery on me and I was kind of panicking for me because I thought the doctor had said we need to get, um, do a hysterectomy pretty much, because they need to test the.....the, um, lining, because if it went deep enough that it’s in your bloodstream, then you have to do chemo. So this is going through my head, thinking you’re not going to do this surgery, it’s going to go into my bloodstream and then I’ll have to do chemo, you know these different things. And my sister had, um, gone through cancer, so I knew what chemo could do. So I was, I was all scared to not do the surgery, I don’t care if I’m sick but they wouldn’t do it, and I had um, I had a cough I couldn’t get rid of. So afterwards, you know they reschedule my surgery for four weeks later and I’m panicking the whole time. But what it did though, was I stopped and I looked at the instructions given to me by my homeopathy, and I wasn’t taking them right. At the same time I recalled....uh, work that we had been doing, uh, this is around H1N1 had come out and they were talking about all the medicines, so I actually went up to a medicine camp at [...] for a week, to learn about the different medicines and how to prepare them, and one of the things they had done at the end of this week, was one of things they called a binding ceremony, where they were binding the medicine to the individuals. So, as I came out of this thing of panic and.......whatnot, I thought, I didn’t bind this medicine to me, and my mother had come down so I told her I need to bind this medicine to me and so we did that.....and I took all the medicines, I actually finished almost all of it by the time I actually had the surgery. I did the surgery and they came back to me and the cancer was gone and I didn’t need it after all (laughing) but it was just for me, the understanding that you still need that, those systems to tell you, but I didn’t...I mean I went ahead with the, um.....surgery and stuff like this, but it was the actual medicine and that connection and understanding of what I needed to do, in order to...have the medicine help me. So it’s, it’s taught me a lot about all those different relationships and how they need to play a role, and what happens, uh, in your own health.”

Like Segaine, Susan brings forward the power and importance of being able to choose from and draw on multiple approaches to health care that fit for her; each approach was valuable onto itself (medical doctor for diagnosis, homeopathic doctor for medicines, and ceremony to bind the medicines to her) and together created powerful, transformative healing. Indigenous worldviews permeate through Susan’s story, drawing in and lifting up the value of the spiritual component of health: the spiritual knowledge
gathered through dreams and the spiritual practices applied in ceremony. Her description of binding the medicines to her recognizes the medicines not as an inanimate thing to simply take into her body, but as an important helper who she was in relationship to, a relationship that required specific and clear intention and care.

Both Segaine’s and Susan’s stories illustrate the ways in which they have sought out and brought together various forms of care and approaches to health in attempting to find something that works for them and for who they are. Their stories reminded me of teachings I had received about seeking help and about circle. The first teaching is one that I received from my Grandma after I had left my home community and was struggling to find connection to my identity and culture away from home. She gave me very clear and repeated advice about seeking help from traditional teachers and Elders, telling me that if I came across someone who knew everything, to promptly get up and walk the other way and never look back. She said that it wasn’t possible for any one person to know everything and anyone who thought they did was very dangerous. This is a teaching I hold dear and apply to teachers, Elders or ‘experts’, whether they are Indigenous or non-Indigenous. The second teaching is about circle, one that I have learned from ceremony, teachings and practice, and that I continue to learn about. It is the idea that within the circle everyone has something to give and something to receive, that no one in the circle is any more or less important than anyone else; everyone plays an important part in that circle. Similarly, in medicine wheel teachings, my Grandma taught me that each of the four directions of the circle, people from all the directions of the Earth, have special gifts and knowledge and that these work together as and
compose a *whole* body of knowledge and practices that are needed to attend to, care for and maintain balance of our Mother Earth and All Our Relations.

Returning to Segaine and Susan, these teachings guide my understanding of their experiences in several ways. Firstly, each woman describes engaging several means of care to attend to their health and well-being, actions I would understand as demonstrating a belief that no one approach holds all of the answers and that each approach has something to offer. By resisting a division of different approaches to health into either/or, they are moving towards and creating a more holistic approach to care that works for themselves as whole women. Their experiences, though distinctively different, both embody a vision of and action towards creating and practicing a (w)holistic approach to health and well-being.

**What helps? What gets in the way?**

This idea of (w)holistic health creates, for me, a very beautiful and powerful image. I think it is important to hold this image to light in order to better understand what helps or hinders Aboriginal women in locating, accessing and utilizing these kinds of models of care. For Segaine, she clearly names how her mixed identity naturalized her ability to “walk in two worlds” in relation to her wellness – her ability to hold and value different approaches to health seems inherently tied to her ability to hold and value different parts of herself. She also discusses the experience of *knowing by doing* – having tried multiple ceremonies over the years in order to come to know for herself and accept her mental health challenges as part of her. Susan had a strong sense of determination in being able to access the care she needed, though she was not necessarily certain
where that came from – when asked about what gets in the way of her health and well-being she replied:

“You know, honestly, uh, in terms of the healthcare system, I haven’t encountered a lot, um…I think maybe because I’m more…open or, I don’t know specifically what it is …’cause I think if I’m, someone who is to provide care to me, if you can’t do it then I’ll find someone else who can, and that’s seems to be…how I think about things.”

Just as Susan held tremendous clarity about being able to find people who could help her in attending to her health, Christine, a participant in another circle, held a similar clarity about ensuring her physician understood her desire for holistic care:

“Luckily I have a health practitioner who…at least…is willing, um, I don’t know that she practices holistic medicine with everybody that comes across her path, um, but I’ve beaten it enough into her head, that she will, um, humour me, and she does now believe that I know my body and my health, um and so she will listen to me when I say, um, there’s something wrong, and not see it as…in my head, which for many years they did. Um, so I’m lucky that I’ve at least had a western practitioner want to shift, and actually has come to me and said, you know, if it hadn’t been for you, I would not have known these things. So I’m glad she’s open to getting teachings […]”

Like Segaine and Susan, Christine demonstrates a strong sense of knowing what she needs for her - of knowing both her own body and health. She also shows great tenacity in insisting that her physician get on board with the more holistic approach to health she wishes to take. Earlier in the circle Christine described how her doctor’s responsive attitude had been helpful to her, as well as how her access to healthcare, specifically medications, massage and physiotherapy, had been improved by being able to utilize her partner’s health benefits. While these benefits had significantly helped Christine, they did not alleviate all of the barriers to her desire for more holistic care:

“Um…but access, to those…ways of healing, you know I don’t know where to go. I don’t, you know, I can’t afford….to go, you know, and…it’s, It’s very difficult for me.
I want to be able to access, you know, some of the, ‘cause I have a close friend whose doing homeopathic healing, that she pays out of pocket, for her…medicines, and they’re not cheap….and, and they shouldn’t be cheap. I mean don’t misunderstand me, they shouldn’t be cheap, because that is…a gift, and I understand that, um, but I can’t afford that with my other responsibilities on this…earth, you know. I…..take care of my children first, and then, if there’s anything left over….maybe me.”

Here, Christine names two issues that were reflected in the stories of other participants: 1) the financial costs associated with holistic or ‘alternative’ practitioners that acts as a significant barrier to care; and 2) the issue of prioritizing the use of energy and resources (e.g. time, money, etc.) to care for one’s children, or, some cases, a parent or other family member, ahead of attending to one’s own health. The challenges of negotiating access to healthcare varied but remained present across different women’s stories whether they were constrained by juggling multiple roles (full-time school, full-time work, single parent) or by geography and poverty. For some, even the availability of free access to holistic health practitioners at organizations such as Anishnawbe Health did not mitigate the restrictions of distance (for those living outside of the downtown core) and the financial resources needed to get there. For women with very limited financial resources, even a single TTC fare to travel to a service provider created an extraordinary barrier, as did the tremendous exhaustion and weight of living in constant poverty. The majority of Aboriginal health and social service agencies are clustered in the downtown core and women living outside of this area identified, in addition to the cost of travel, the challenge of being able to get to agencies during their hours of operation.
Looking and moving forward

Across different circles and interviews, the issues of availability, access, options and funding arose in relation to what women felt impacted their ability to find and utilize the care they wanted, as well as what they envisioned or identified as needed moving forward here in the city.

Toronto has an abundance of Aboriginal health and social service agencies that reflect decades and decades of tremendous efforts of the many who dreamed them into being, identifying gaps and opportunities, and carving out space and resources to create services and programs to support our ever growing community. These services have significantly contributed to the health and well-being of our women, who identified a range of community services that they had engaged with as part of their journeys of healing and wellness, including: Anishnawbe Health Toronto, Native Women’s Resource Centre, Native Canadian Centre of Toronto, Council Fire, Seventh Generation Midwives of Toronto and CAMH Aboriginal Services. Other Aboriginal services that women identified as having contributed to their health and wellness by alleviating or helping to address financial, educational, legal and housing challenges or barriers, included First Nations House (University of Toronto), Miziwe Biik, Aboriginal Legal Services of Toronto, Anduhyaun and Nekenaan. Alongside recognition of these many services and organizations, some participants also identified concerns and suggestions about availability, access and the need for more choices among service providers.

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18 Miziwe Biik is an Aboriginal employment agency that provides significant support to Aboriginal peoples in seeking employment as well as supporting access to educational pathways and financial support for Aboriginal students.
19 Anduhyaun is shelter for Aboriginal women and children fleeing violence; Nekenaan is second stage housing provided through Anduhyaun.
Traditional helpers

Traditional Indigenous help was one area of concern, both in terms of the availability and choice of traditional teachers, healers, counselors and Elders generally, and the need for more women in these roles specifically. Donna, an interviewee, outlined her view on the need for more options and more choice:

“But I think that’s another thing with the healthcare part, is I think that for….for people that, um, need the care and wanna go back to their…their ways, um, their traditional ways, that I think that more traditional healers need to be available. I know there’s quite a list now at Anishnawbe Health and[…] I think that we could use more of those so that there would be an option, because much like Bell and Rogers you have an option. You don’t have much of an option but you have an option. I think that it should be, because we’re a rising number of populace of Native people here in the city, I think that if we don’t get, if we don’t get, uh…more healing centres, if we don’t get….more education to our young people that we will die, and that it will be no fault of our own….[…]. So…I think it works for me that there are options out there, but I think that there should just be more options for us and more for us to choose from.”

To be clear, Donna reported having happily utilized traditional helpers at Anishnawbe Health, but wanted to express her desire for a greater number of options to meet her needs and the needs of an ever and rapidly growing Aboriginal population in Toronto. As Donna continued to discuss her thoughts on the availability of traditional helpers in her interview, she also raised a very strong concern about navigating compensation of traditional helpers when sought out on a private or individual basis (e.g. not through Anishnawbe Health other organizations, such as Dodem Kanonhsa, in which access to traditional helpers is provided free of charge), whom she felt were increasingly expecting monetary payment in amounts that may prevent many, especially younger generations, from accessing traditional care. In fact, she reported that her nieces, who experience a lot of financial strain, “wouldn’t consider going the Native way
because well, you know, it might cost a lot”. These concerns and challenges about access to, availability of and choice among traditional helpers are important to bring out into the light to discuss in community forums and provide information about so that Aboriginal women (and men) seeking traditional care in the city can make informed choices about how to get the care they want and need.

Anishnawbe Health (2000) published an excellent series of educational pamphlets to provide helpful information to those seeking or wanting to learn more about traditional healing, ceremonies and medicines, including “Approaching a Traditional Healer, Elder or Medicine Person”\(^20\). This pamphlet touches briefly on issues of gift-giving as a means to express gratitude for the help provided, and perhaps this information could be expanded to include the concerns raised by Donna. For example, how to gauge what a reasonable gift or amount of money might be, including discussion of the rationale and traditional teachings around honouring the time of traditional helpers, and perhaps providing resources for further information about various options to access free of charge care, or where to go if you have more questions or concerns about how to honour a traditional helper’s time and care (particularly if you are accessing outside of an organizational context).

“\textit{We are the ones we’ve been waiting for}” (Jordan, 1980). As mentioned above, another layer of consideration in the availability and choice of traditional helpers is the need for more female healers, seers, Elders, traditional teachers and traditional counsellors. I know from my own experience, which is underlined by that of the participants, that we have lost many Grandmothers in recent years – traditional Elders, teachers, seers and healers – who either lived or worked in the Toronto community.

\(^{20}\) These pamphlets are available through the Anishnawbe Health website: \url{http://www.aht.ca/}
These women, Grandmothers like Lillian Pitawanakwat, Lillian McGregor and Rose Logan, gave so much to the community, sharing their knowledge and teachings and their absence was felt readily. The loss of and challenge in finding a female traditional helper was expressed by Ada: “I would say it’s difficult to find a woman...healer....um, or medicine person or counselor who you can talk to because I think a lot of them have passed on and no one has...filled their shoes. Or a lot of them leave the city, for good reasons probably”. It was very powerful then to hear Amy, another participant, in acknowledging the loss, also discuss the subsequent realization of a shift in roles: “the place that we’re in now, with so many of our grandmas and our grandpas leaving us, many of us aunties are starting to go....is it, is it our turn? (both: laughing) oh my god, really? We’re the ones now? There’s nobody around, where are they?” In reflecting on this shift in responsibilities to aunties (and uncles) – those coming behind and picking up the knowledge, roles and responsibilities carried by our Grandparents, Amy also expressed the importance of thinking about how to do this in a good way:

“...and it’s like, you, you know, you’re auntie...you need to start picking up that role....and, and doing, you know and the realization is like, holy crap, okay, you know, how do we support each other? How do we be there and how do we, how do we talk to each other? How do we....trust each other?”

Amy’s words reflected conversations I have had with many friends and colleagues in the community who were finding themselves picking up more roles and responsibilities and trying to figure out how to do this in a good way – how to be clear and to create boundaries around their time and energy, how to attend to their own balance and well-being while being a helper, how to be accountable – to walk in a good way, and to do all of this with a good sense of humour and humility. Amy brought forward incredible clarity and agency about moving forward, helping ourselves, helping
each other, and about accepting and picking roles and responsibilities. So while we have experienced a recent loss of Grandmothers in the city, and participants identified limited availability of female traditional helpers more generally, there are also aunties preparing, practicing and/or sharing what they know – picking up their roles as Oshkebewis (helper). In this sense, we are, as June Jordan (1980) would say, the ones we have been waiting for.

**Navigating healthcare systems: Additional considerations**

**Maternal, child health**

Participants in the study described a range of experiences with mainstream healthcare. For some, they had remarkably positive experiences, particularly mothers of children who had accessed care at SickKids Hospital\(^{21}\), where they expressed feeling received and treated with great care. Several women also described positive experiences with Aboriginal midwives, whether at SGMT or elsewhere, as constituting an important positive healthcare experience in their lives. However access to such care was not always possible, one participant described a difficult experience of being turned away from midwifery care because she could not commit to having her baby in the city. It was a painful experience since most of all she described wanting to have a connection to traditional teachings around pregnancy and childrearing that she had not had access to in her own family.

The challenges of geography, particularly in relation to where midwives hold hospital privileges, as well as funding models (midwives are paid on a “per course of care” basis that requires a minimum 12 week course of care or attendance at the birth in

\(^{21}\) Formally known as the Hospital for Sick Children and more commonly referred to in Toronto as “SickKids”.}
order for the midwife to be eligible for payment) impact all midwives, Aboriginal and non-
Aboriginal. This is not to say that there are not midwives working around and extending
their services outside of and beyond what is funded in the per client model, but rather to
highlight the ways in which funding policies and practices can impact service delivery
and healthcare experiences for women seeking care. Aboriginal midwives, like
Aboriginal social workers and child welfare workers, do not receive extra funding or
resource support to address the extra care factors that Aboriginal women and families
often present with due to the impacts of colonization which may include issues related
to poverty (housing instability, food insecurity, under or unemployment), violence
(structural, interpersonal, intimate partner, childhood and/or intergenerational trauma),
child welfare involvement or surveillance, and complex health needs. Further attention
by policy makers and funders to the complexity of needs of Indigenous peoples
subsequent to colonization is needed to ensure that service providers are also being
provided with meaningful resources to provide complex and culturally relevant and safe
care.

It may be that the new (and first) birth centre set to open in Toronto in the fall of
2013 will be able to provide a community gathering space and knowledge-sharing
centre where our women and our community can come to share and receive teachings
about pregnancy, birth and child-rearing, including teachings about sex and sexual
health. The birth centre was proposed and is being led by the SGMT practice which will
also be housed in the centre. While the centre will be available to and used by other
midwifery practices in Toronto, its physical design will reflect Indigenous ways of
knowing and being, including the placement of teaching/gathering space in the middle of the centre.

As part of its proposal development process, SGMT hosted a birth centre visioning gathering at the Native Canadian Centre of Toronto to invite community members and stakeholders to come together and set forth a vision for what an Aboriginal birth centre could be. At the time of interviews and data collection, the provincial government had not yet announced which proposed birth centres (across the province) they would be funding, and community hopes were running high. In the following passage, Jade shares some of her hopes for the birth centre and for the role of midwives in the community towards improving the health of our women, families and community:

“Um, there is something else, I would love for the Aboriginal birthing centre to happen, um, I know we’ve been lobbying so hard, and SGMT and all of everybody who supports them has been lobbying really hard and working really hard to make that happen, and I would really love if the Ministry of Health sees this research (laughing), it needs to be approved. Um, I would also like to see midwives and see Aboriginal midwifery practices expand, um, to include support for miscarriage and abortion (participant: mmhm), because we know that our midwives traditionally dealt with death, as well as life (participant: mmmhmm), um, and so expanding…not making our midwives do more (laughing) because I’m sure they’re over-worked as it is, um, but expanding the circle, so that we can also have support for people who either choose not to stay pregnant or lose a pregnancy, um….and make that available in a culturally safe way. I would also love for midwives to [assist with] sex ed and workshops and stuff in community, because it’s great for young people to see that, um, especially for young parents, they’re so stigmatized, um, being a young parent is such a….people label you, you’re the teen pregnancy statistic, and actually they’re just really loving people (laughing) who happened to get pregnant and have kids (participant: Yeah), like…so, um, to have support specifically for young parents and to be exposed to midwives before pregnancy is even, um, a possibility, so that they know that that’s a resource, um, and they know that they’re also keepers of knowledge about our bodies, about our sexual reproductive health and rights."

This view towards revitalizing the role of midwifery in our community and particularly its capacity to help address and resist issues of stigma and to create
culturally safe care, in my view, emphasizes an insistence on wholeness in many ways. Firstly, that traditional midwifery approaches hold powerful teachings and understandings of both life and death as part of the whole of the lifecycle. Secondly, that making visible, normalizing and sharing teachings about sex and sexual health, recognizes sexuality as an important and natural part of each person’s whole self. This is particularly important in light of the violence and stigmatization that has been visited upon Indigenous sexualities as part of a colonial agenda. Thirdly, Jade’s view of the role of midwives in being able to support young parents and youth as whole people is healing and ruptures the single story of what it means to be a teen parent, and the double stigmatization of being an Indigenous teen parent. Finally, in sharing her vision, Jade is highlighting the importance of restoring and revitalizing the roles of midwives in our community as a critical part of our collective health and well-being. Restoring midwifery is a necessary part of restoring our collective wholeness.

Given that fear of child welfare intervention is a known barrier accessing healthcare for Aboriginal women (Levin & Herbert, 2004; Kurtz et al., 2008), I think it is significant that participants identified overwhelmingly positive experiences with both SickKids and Aboriginal midwifery. Future research might explore what informs the approaches to care of service providers in these settings to identify wise practices or encourage knowledge sharing among and between service users and service providers about what can be done to help improve access and decrease barriers to care across various settings, including other hospitals, health and social service settings.
Sexual health

Sexual health is unto itself a significant area of concern. As set out in Chapter 3, Indigenous women were historically targeted for violence as an integral approach to fragmenting Indigenous societies as part of the colonial agenda of “settlement”, dominance and resource extraction. In addition to continuing to face sexual violence, the sexuality of Indigenous women remains stigmatized by colonial narratives of the “squaw”. Histories of sexual trauma and the presence of stigma impact access to sexual health care and locating a service provider who can offer culturally safe care is a challenge. In the following passage, Jade shares some of the services she has found helpful here in the city:

“I really like having anonymous sexual health services (laughing) in Toronto, um…(Participant: Where’s that), so whether that’s Hassle Free Clinic, Planned Parenthood, um there’s, there’s so many options for anonymous, um, STI testing in the city, that um, that makes me, that makes me feel really good. Um, I like not having to have a GP and having one person, um, because then you’re susceptible to their judgments, to their understandings, whatever, I’m never gonna find one GP that, that is my…maybe I will one day (laughing) but I don’t think I would find one that I’m in line with enough, thinking wise, that I would trust…”

Just by sharing her knowledge and experience in the research circle, Jade opened up space for another participant (Sadie) to begin to speak about sexual health. Sadie spoke to her need for more sexual health knowledge and to some of the challenges she was experiencing in relation to sexual health care:

“Um, the other big thing is for me is that I just realized that I have very little knowledge of sexual health. I don’t know where I was during sex ed class, but I was not at this place that everyone has gone to (laughing) (Participant: Don’t worry, nobody was). It never existed in my world, but apparently everyone has gone to this and uh, uh I had no idea there was all these resources here in Toronto, um, because it’s just not something that you are just gonna talk about with your friends (laughing)...and I’m actually so far behind, like I, I’ve never been
tested before and, like, I need to make sure I do this now. Um, my…family doctor’s in [my home community], and they recently traded, or my parents recently went to a different doctor once I moved, so I’ve only met him like (laughing) a couple of times. He’s a male doctor, I don’t really feel comfortable talking about my…sexual health with this stranger. Um, he’s also…uh, pressuring me to take the, I don’t know what it’s called, the…like the cervix shot to help prevent the…(Participant: HPV? Participant: Gardisil?) Gardisil, and I’ve heard so much negative things and things about it, and I said no way, and then when I went to see him this last time, uh, he just put me on the list, without my consent and….but I’m not going back to [my home community] for, until December, so….like, I don’t want to go back to my doctor, because I’m being forced into this situation. Um, he’s also a male doctor, so uh, to have like my first pap test (laughing) with a male doctor is very frightening. Um, and I don’t know where I picked it up…some, because, there’s never been anything said by my parents or…not sure where but for some reason in my mind sex is a negative thing. Um, I have no idea where that comes from….uh, but it seems very uncomfortable talking to somebody about my partners, or (laughing) I feel like I’m gonna get punished or something? Um…so I, and I, I don’t…that’s just a huge barrier for me that I just didn’t even know…existed for a really long time…and I need to find this awareness, somewhere.”

Sadie’s experience with her family physician of being signed up for the Gardisil vaccine without her consent echoes back to the practices of the not so distant past in which physicians enacted other sexual health procedures, namely sterilization, without consent as described in Chapter 3. It sounds the alarm of a serious need for training and re-training of physicians with regard to the past and present experiences of Indigenous peoples in accessing or being used as a subject within Canadian healthcare systems and to the ubiquity of racism that circulates in and through our day to day interactions. The need for training of healthcare service providers is discussed further in later sections of this chapter.

For me, the stories shared by and between Jade and Sadie epitomized the need for spaces for our women to gather (perhaps spaces like the birth centre) and share knowledge together about sexual health and well-being as we would have done
traditionally. It also underscores the importance of being able to collectively unpack and evict the insidious negativity and stigma that lingers around our sexuality and instead moving forward in a more sex-positive stance. Sexual health is about more than risk management, prevention or procreation; it is also profoundly about pleasure, joy and the recognition of our sexuality as a natural part of our being (part of our wholeness).

Having and enjoying sex was raised across two different research circles as an important part of health, and lack of sex or sexual interest on the part of a partner was correspondingly identified as having a negative impact on well-being. Information was exchanged between the women about sex positive resources here in Toronto, like the sex shops Good For Her and Come As You Are. It was incredibly beautiful and healing to witness other Indigenous women speaking joyfully about their desire for and appreciation of sex as an important part of their well-being, a pushback against the mess of racist stereotypes and violence heaped upon our sexualities as a necessary part of colonization (Smith, 2007). It was an open refusal of trauma, violence or stigma as the single story of our sexuality, without pretending that these aspects of our experiences (whether personal or collective) do not exist. It was the first time I had witnessed, outside of the phenomenal work of the Native Youth Sexual Health Network, open, sex-positive conversations among women in our community.

Sex positivity is not a framing that necessarily comes easily in a population of women who have long been the targets of sexual violence (Smith, 2007), as such, an important part of decolonizing and revitalizing our health also means decolonizing and revitalizing our sexualities. This work importantly includes unpacking the ways in which Indigenous understandings of and practices around sex, sexuality and gender have
been impacted by colonization. This means attending to the ways in which heteronormativity and homophobia manifest in Indigenous communities and the ways in which these affect the health and well-being of Two Spirit people specifically and our broader communities more generally. Moreover, it means unpacking the ways in which shame, judgment and stigma circulate around our ideas about gender and sexuality as Indigenous peoples now, both from outside and inside our communities, and how this impacts on our health and well-being. These issues were brought forward in Jade’s story:

“I don’t find I fit a lot of the expectations of what it is to be a woman, and so I have a lot of trouble identifying with that. I...think there’s a lot of healing that needs to happen in, in the women’s circles that have to do with our gender, our sexualities, the ways that we hurt each other, um, the ways that we judge and shame each other around our sexual behaviours, around our gender presentation, our expectations and assumptions of each other as well. And I’ve learned from two-spirit people in my life that that is my responsibility, um, to go and do that work so that, our two-spirit people can take back their leadership roles and do what traditionally we need them to do. But in order for them to do that (laughing) we need to make a little space and sort of get over some shit ourselves. So that’s what I’ve been, I’ve been endeavouring to do. Um, I hope to have more conversations today about holistic health and be able to create some space to talk about gender and sexuality within that, because I find it’s a big source of, of health and unhealth for me...um and how to navigate those spaces.”

I am attentive to Jade’s statement that she does not necessarily identify with the term “woman” and consciously and cautiously hold and use the term here with recognition that it is at best a general “container” for the diverse experiences and sense of gender and self of those who participated in the research. Drawing back to the earlier exchange between Jade and Sadie, I would re-emphasize the importance of providing, promoting and protecting spaces for Indigenous women to gather, share and unpack what we know about sex, sexuality and gender as both a means of revitalizing Indigenous ways of knowing and being, and of promoting our health and well-being.
Additionally, the development of new services or promoting awareness of and increasing access to existing sexual health services that provide non-judgmental, culturally safe, Indigenous informed and sex positive care is an important step towards supporting the health and well-being of urban Aboriginal women.

*Racism in the healthcare experience*

“When Aboriginal women access health services, their concerns are often ignored or disregarded (Dodgson & Struthers, 2005). This silencing – an act of structural violence – often causes women to set aside their health concerns or delay seeking health services to avoid racist interactions. These decisions subsequently endanger women’s personal health and – as women tend to be the household decision-makers – the health of their families.” (Kurtz et al., 2008)

There is increasing acknowledgement and awareness of the issues of racism faced by Indigenous peoples, and specifically by Indigenous women, in attempting to access healthcare (Browne & Fiske, 2001; Browne & Varcoe, 2006; Browne et al., 2011; Dion-Stout et al., 2001; Kurtz et al., 2008), although the research in this area is largely from western Canada. However, participants spoke to the same challenges of racism they had faced in negotiating their access to healthcare here in Toronto and some of the visions they had for improving healthcare experiences for themselves and other Aboriginal peoples. Below Donna begins to share some of her experiences of racism in healthcare:

“I think that a lot of the doctors feel very powerful and very, um, and take advantage of you. I’ve had run-ins with, and I call them run-ins because that’s how I feel, I’ve been.....I’ve been....what’s the word, sort of you almost get the sense of being raped or something, you know, or stereotyped. I mean I went to a hospital visit at Women’s College Hospital and their first question out of their mouth was “You’re Aboriginal when was the last time you had alcohol or you did drugs?” I said I haven’t had a drink in years, uh I don’t remember the last time I had a drink…and as far as drugs, I only do the drugs that are given to me because I have to, it
maintains my well-being. Um, so….and it’s not the first time it’s happened. Um, my sister has complained of….has had that experience. They just think that we’re in there looking for drugs or for…for…for drugs I guess, so and they’re always sort of leading the questions of “So are you an alcoholic?” and so the stereotype is still there. Uh…going forward I’d like to see that removed. I think that there should be more training for doctors, um, about Aboriginal people, who we are…”

In using the word raped Donna immediately brings forward the severity of the danger and damage produced by racist stereotypes and the poor treatment they sanction. Stereotypical perceptions of Aboriginal peoples as alcoholics and drug addicts are rampant in broader society and within healthcare settings (Browne et al., 2011; Kurtz et al., 2008). It has serious implications for how Aboriginal people are received into care and whether or not their reported symptoms and concerns are taken up and responded to. I know of several friends and colleagues who have received poor treatment in emergency departments in Toronto where their symptoms of pain or illness were grossly misinterpreted as symptoms of intoxication. Donna also spoke to the challenges faced by both her and her sister in trying to seek help for severe and chronic pain. Here she stresses her concern about the kind of care being provided by physicians as they age and the ways in which racism impacts how complaints of pain are received and subsequently the kind of care that follows:

“Um….so…it’s…yeah I think the challenge is the wait times and getting to my appointments and….I think that we will face, um, as we grow older, that the doctors are getting older, and that’s my worry – that we’re not getting the proper care. As I said, my sister had this doctor who was, uh….eighty years old. This doctor was eighty years old and still practicing…and I said to her Sister…..please, go and change your doctor. You need a doctor that’s young now, that has been on the computer since he’s been eight years old…has, knows the heart inside out already before he even went to school and, um, and I really need you to have that kind of doctor so….that next week she picked up, because her old doctor wasn’t….wasn’t writing her notes for work because she couldn’t see the pain. That’s, that’s a big thing is people kind of say…well a lot of caregivers can’t see
the pain, they don’t think that we are in pain….and **then put on the stigma of being Native then…they stop looking** [emphasis added], and…if it hadn’t been for me being so very strong and…voiced my opinion about my illness, I said “Just because you can’t see my pain, doesn’t mean my pain’s not there” and, um, I think that….I think a lot more seniors will, have probably experienced that or will experience it.”

Racism in healthcare has serious consequences. As Donna described in her story, it causes harm (whether emotional, spiritual, mental or physical) and result in inadequate, ineffective care. Fear of racism can also impede Aboriginal women from seeking care at all, or lead to strategic engagement such as withholding information.

Jade speaks to the impact of racism and fear of racist treatment on how she navigates her healthcare:

“…actually I want to respond a little to the access to services, because I think that’s a big, um, I…I hear a lot of people say that, and for me, um, I actually don’t want access to services that are racist and hate me and (laughing) and have committed, like is not to say that yeah, I get that…I just think that it’s something that we need to deconstruct together, um, because it goes way beyond access for me, because the services that I am currently accessing, um, I have a lot of fear around them, because of the judgment, and that judgment is from inside our communities, um, but primarily with mainstream organizations…uh, I have a lot of fear. That’s my main barrier to access, I’m afraid to tell the doctor…that I’m Native, because they’re gonna send me for all kinds of tests and stuff. I’m afraid to tell them my family history because there’s a lot of…um, mental illness and, um, health problems and, um, all kinds of things because my family has been through a lot, um, there’s also a lot we don’t know, um, because of adoption and just silence in general, um and domestic violence. So it’s a huge amount of fear, both like from systems of power, and I know that you know a doctor has power over me and so I’ll, I’ll restrict the kind of information, um, that I’ll give them because I have that fear.”

As I listened and re-listened to these stories I began to think a lot about how making our pain (or other health needs) visible fundamentally means making racism visible - in health and social services and in society more generally. This is no small
task in a society that is wilfully amnesiac to colonial histories of genocide and slavery, an amnesia that serves as the foundation for its major institutions. Addressing racism in the context of Canada’s multicultural policy framework requires working towards individual and collective critical consciousness that recognizes and responds to racism as more than unfortunate or malicious actions of individuals, but as profoundly entrenched and active at the structural level (Williams, 2001). Moreover, such conversations require at their core, recognition of the lands and Indigenous peoples on which the imposed nation state of Canada is built; this includes learning about and acting with an understanding of the pre and post contact realities of Indigenous peoples and our collective responsibilities to the future (Lawrence & Dua, 2005). Embedding Indigenous histories, ways of knowing and being within educational curriculums, along with pedagogies that embody decolonizing and anti-racist approaches is something that would benefit not only trainees in health and helping professions, but should begin in grade school. Such an approach to educational practice would instill a constant means of remembering for all of us collectively, whether original citizen, settler or made of both, our responsibilities to the land, to ourselves and each other.

**Funding**

A number of participants spoke to funding as an issue of concern in relation to health and well-being in a number of ways. Firstly, as with the challenges of funding discussed in relation to midwifery care, participants identified gaps in current government funding models and suggested changes for moving forward. Across Turtle Island, perceptions and opinions among Indigenous peoples of the role and responsibilities of governments in providing funding to Indigenous peoples are diverse
and often contentious. For some, government funding is fundamentally about upholding treaty rights, for others it is about recognition of and reparation of the damages caused by colonization, and still for others reliance on government based funding is a trap of dependency that undermines movement towards Indigenous sovereignty. Expanding on the challenges of funding briefly touched upon in Chapter 7, JoAnne speaks to how the restraints of government funding models are also compounded by the complex health needs of Indigenous peoples that attracted a range of trainees or interns from various health and social service disciplines which in turn meant a frequent turnover in staff due to the timelines of student placements, internships and residencies.

“Some of our health service providers they’re funded by, you know, municipal government, provincial government and they’re stuck, they’re bound within that. So when it comes to places like that, it’s kind of like a walk-in clinic, you don’t have the same doctor, people are there, you know, you get the practitioners who wanna come because you know we’re a great population to work with. […] Well people wanna do work with us because we’re sick! They’re going to get a lot of experience, right? And they’re there for, like, six months, a year? There’s no continuity there, so I think it’s…these are great places, but they’re bound by the funding that they get which is the western model, right, so it’s not always the best service, but [within that] you can have phenomenal practitioners…”

The challenges of service provider continuity described here by JoAnne are not necessarily unique to Indigenous organizations. However, I would suggest that it has a differential impact on Indigenous people given the legacy of mistrust of those in positions of authority, including health service providers, subsequent to more than five centuries of colonial harm and abuse (Health Council of Canada, 2012). In light of this legacy, consistency and stability of service providers is an important means of building relationships, trust and a sense of safety for those accessing services. Christine also
spoke to the issue of funding in relation to service providers, with an eye to an alternative model of funding to improve access:

“…being able to choose who you want for your health practitioner is another access I want to see. Being able to say, I want to go to that person who calls themselves a health practitioner and have our government support that person…is important to me. We’re making strides, oh yeah we can write off social work services now…that’s brand new, it only took forty years, but hey! You know, it benefits me now. But …I can’t take my OHIP card and go see that person I wanna go see. Somebody can’t come to me and say I have OHIP, will you see me…and I want to be able to say, I take OHIP, I take this, I take that, you know what? Come off the street and I’ll take ya, because…we support a healthy community, a healthy society, at whatever cost and however…and we’re not gonna diminish our practitioners who are doing that. We’re gonna make it so that they can survive and be healthy, but so that you have access to who you choose. I think that’s, I think the biggest thing thinking about access is: I want who I choose, not who the government tells me I should be choosing from. You’ve got pile A or you’ve got pile B, pick. Well, huh, pile A sucks and pile B sucks I think I’ll go with, you know, pile J…that’s not even on the scope. So that for me, and it sure would help me make a living (laughing) so it’s a barrier for me too, that people can’t access my services privately without killing themselves…figuratively, not literally, um, so yeah. Those are…if I had my “epiphany” moment, when I woke up in the morning, it would be that….I could walk into any health practitioner and say, I wanna sit and talk with you….because I trust you, and that, to me, gets at so many things we’ve talked about: safety….uh, you can have a woman, you can have a man, you can have thank god a trans, you know, woman if you want, um, because there are so many wonderful transwomen out there who are great with sexual health, who I happen to know (laughing), who I would love to be able to access service from, but I can’t…’cause you know their services are specific. So yeah, just being able to choose whoever I damn well want.”

Christine’s vision emphasizes choice and implicitly recognizes each person’s capacity to best identify the kind of help that would work best for them. As with service provider continuity, the desire for increased choice of service providers is not an issue unique to Aboriginal peoples. However, given the documented challenges of racism in existing health services and the challenges of finding an Indigenous-based or culturally
safe program or practitioners within an OHIP covered or otherwise financially accessible service, an increase in the range of practitioners and services (specifically grounded in Indigenous ways of knowing and being) could substantially increase access to care for Aboriginal peoples. In a similar vein, part of Donna’s vision for increasing access to services was to encourage employers to consider increasing coverage for alternative health services under employee benefit packages.

Some participants reported what might be considered age or life stage specific funding concerns. Segaine spoke to issues around funding for services and programming for girls and young women, while Ada pointed to some of the challenges faced by seniors. In setting her vision for supporting our girls and young women, Segaine points to the gap caused by current health funding practices that are problem or risk-based as opposed to prevention oriented:

“One of the things….that I’ve noticed, is that I find that there are, um, services for little kids, through things like Aboriginal Headstart- which is like from three to six kind of thing, and then I find there’s pretty much nothing until they become youth. And when…and the services for youth……almost seem to be services for youth who are already getting themselves into trouble, or at risk, what have you. Um…and I think that’s a real problem, because there’s a huge group of our, our girls, that there isn’t anything for and I always find it so strange that they go to Headstart for three years and you learn all these and you learn all these teachings and stuff, and then if you don’t have a family who can support that, that’s it, you’re done right? Um, so I think that there’s a real gap in terms of the age of girls, and I think that something really needs to be done about that. I think there also has to be, I think we also need something that is…um, for, um, our girls where there are traditional helpers, teachers, Elders who will sit with those girls to pass on some of those teachings about health and well-being and so on. Um, and again, not about a group for at-risk girls, in other words, not, not when it’s like…make it like a…problem, like you know there’s problems here so you need to go to this service. And I find that most of the services that we have here, actually, are when you’re in trouble. So I find that there’s not very much available around just…I guess it’s the same old thing right - prevention as opposed (laughing), the other things. And when I sort of dream about those kinds of things for girls and stuff, right, I’ve had again, another privilege of being able to be a part of this, when the young women, um, first start their moon time and the ceremony and the teachings that go with
that. So I’ve had the privilege of being able to…be a part of those things sometimes, but that’s what I think about. I think about…wouldn’t it be nice just to have circles or places of women, like that girls could go, just get the girls, and the women who could pass the teachings on, and do those kind of ceremonies and teachings, specifically about women. So that, as they get older it will give them – I think - the strength and identity, um, to fight against all that stuff that comes at them. All girls are subjected to it but Native girls in particular too, because of the so many horrible stereotypes and stigmas that get thrown at them. When you see them like you know in advertising, you know what girls are supposed to look like, it’s….you know what do we do about that before it becomes almost too late. Um….So yeah, to just have places where those things can be offered, so that they get, um, those kinds of learnings, as well as everything else and then they can choose what they wish to do, right? So, I’d like to see things like that happening. [...]…and again it’s like…don’t wait until we’re all completely falling apart or, or you know, don’t wait ‘til those girls are….injured, right? Don’t wait, like do it now, before, before these things happen and maybe they won’t happen. So that’s my idea.”

Segaine’s plea is a powerful one, to move away funding and policy practices that only seem to respond to the needs of Aboriginal youth when they are considered “at-risk”. In fact having youth services that are predominantly targeted towards Aboriginal youth at-risk can contribute towards a conflation of Aboriginal youth as risk. Segaine emphasizes the importance of a continuity of support for girls and young women (and adult women for that matter) that supports a strong sense of identity and self, that connects them to their histories and to Indigenous ways of knowing and being – and recognizing all of these pieces as a measure of health promotion and as important protection against damaging stereotypes and stigma.

For Ada, who had been a caregiver for both of her elderly parents, funding was also an issue as she described some of the changes she would like to see to improve care and service provision for seniors:

“Financially, when you become a senior it’s like your dirt, or mud, to government. There’s not enough money to help them get to their doctor’s appointments and specialists and…get tokens and things like that. And you have to give a reason, like even you get service from the centre or the health centre you have to tell them
why you need those tokens. Well, you know, just say I have an appointment and let it go, you don’t have to divulge your health history, or you can say contact my doctor just to confirm. I wish there was something like that because my parents were very…..private people and I think that now to get health services in Toronto you have to divulge your whole…..life, if you wanna get service, even for tokens….."

Part of what Ada raises is the challenge around maintaining privacy or dignity in seeking care and services. It is a challenge all too familiar to anyone who has experienced or is currently living in poverty and accessing services that require you to demonstrate your ‘worthiness’ or ‘deservedness’ of service by disclosing financial, health or other personal information. This is the kind of practice that social workers and other helping and health professionals are frequently engaged in as part of tracking service use and service user demographic information in order to demonstrate the need for and maintain funding. It can be a very difficult experience or even constitute a barrier to access for Aboriginal peoples who have experienced severe and prolonged institutional discrimination and abuse.

The critiques and visions of health service provision and funding practices shared by the women who participated in this research are rooted in their lived experiences as not only service users or providers, but as daughters, sisters, mothers, aunties, grandmothers and community members. Their stories highlight challenges and opportunities for change, both big and small. In the context of policy and funding, engaging urban Aboriginal women in the development, implementation and evaluation of health and social service policies and practices, and in the identification of meaningful and effective funding priorities and practices, can have a tremendous impact on our health and well-being and that of our families and communities. In the context of program and service delivery, how might service providers and educators in the health
and helping professions engage Aboriginal women in the development culturally safe approaches to practice? In writing on the general health of urban Aboriginal peoples in Canada, Place (2012) states that Aboriginal women are most affected by the lack of culturally safe care. Engagement of Aboriginal women as leaders in the development of culturally safe curriculum, models of care and approaches to practice will not only work to improve access to and experiences of healthcare, but also contribute towards recognizing and revitalizing the roles of Aboriginal women as leaders and knowledge keepers in the area of health and well-being (Anderson, 2009). This echoes the findings of Kurtz et al. (2008) in their research exploring health and social service provision for urban Aboriginal peoples in the Okanagan valley and their specific findings and recommendations in relation to the experiences of the structural violence faced by urban Aboriginal women. Building on the recommendations of the women in their study with regard to improving access to service (such as the implementation of cultural education for health policy makers and practitioners), the authors conclude that:

“….the voices of urban Aboriginal women and men must be the ones informing healthcare providers and policy makers about the health care gaps and inequities that exist within their communities. The inclusion of local Aboriginal people in decision-making can help to improve relationships between health care providers, policy makers and community members by having them work together to eliminate structural violence. Learning from the lived experience, stories and insights of urban Aboriginal people will prompt new ideas about health care delivery, education, practice, and policy that will help to close the current gap in health status between Aboriginal and non-Aboriginal people.” (Kurtz et al., 2008, p. 60)
CHAPTER 7: DEFRAGMENTATION AND RECONCILIATION

I have heard Grandmother Joanne Dallaire describe the impact of and recovery from colonization in a metaphor of a jigsaw puzzle. It involves imagining everyone working together on the puzzle around a table and colonization as being like someone knocking that table upside down. The pieces of the puzzle fly everywhere and our job is to gather them back up and put them back together again. Colonization caused a fragmentation of Indigenous ways of knowing and being, and a fragmentation of Indigenous self. What I witnessed as I met each woman who participated in this research were women who are in all kinds of different ways putting the pieces back together. Defragmenting themselves, seeking that sense of wholeness like the story of the babies shaking the rattle to remember when we were all together as one.

In this chapter, I reflect on the stories and knowledge shared in the preceding chapters and articulate the ways in which I understand the concepts of wholeness and defragmentation as contributing towards the health and well-being of urban Indigenous women. I discuss the implications for moving forward emphasizing Indigenous ways of knowing and being and the practice of reconciliation.

Rupture and (de)fragmentation

“We were “legislated” into trauma on a national scale and every legislative, judicial and executive weapon was used towards eradicating Indigenous identity.”
(Desjarlais, 2012, p. 66)

Colonization caused a profound rupture in and fragmentation of Indigenous identity and ways of knowing and being. While my framing and use of the notion of defragmentation is directly related to the fragmentation caused by colonization, the idea
and centrality of wholeness in Indigenous life that underpins the concept long precedes contact. It was and is a way of being in the world that many people, Indigenous and non-Indigenous alike, are seeking to revitalize and promote. As I gathered and listened to the stories of the women who participated in this research, I understood more deeply something I had already known – that our health and well-being is not separate from who we are – meaning our identities and histories. In fact, who we are informs how we think about and act in relation to our health, but for Indigenous peoples (and arguably all people who have been the subject of colonization) it is not a simple transaction.

More than five hundred years of colonization has included a significant effort to undermine, destroy and erase our ways of knowing – attacking all of the places in which our knowledge is held: in our languages, our bodies, our ceremonies, our relations and our lands. Where Aboriginal peoples and our ways of knowing and being could not be extinguished or destroyed outright, policy efforts turned towards assimilation by intentionally attempting to disconnect and dislocate our children from their families and communities, and subsequently our ways of knowing and being. Residential schools aiming to “kill the Indian in the child”, mass apprehensions and cross-cultural adoptions were all significant arms of a colonial agenda aimed at “civilizing” Aboriginal peoples by removing and replacing Indigenous ways of knowing and being with Eurocentric ways of knowing and being.

Indigenous peoples have resisted persistent and large scale efforts to dislocate and disconnect us from our lands, languages and inherent ways of knowing and being – essentially from ourselves, but not without impact. The contemporary impacts of colonization are visible in the social exclusion and marginalization faced by Indigenous
peoples manifested in gross economic disparities and structural barriers to such basic needs as adequate housing, education, food, potable water and safety. Racism and stereotypes are important tools of colonization, playing an integral role in maintaining the lies that underpin the Canadian nation state by locating the contemporary challenges faced by Indigenous peoples outside of the historical and ongoing context in which they occur. They enable and rationalize the over-policing and under-protection of Indigenous people in Canada and the appalling violence levelled at our women. Colonization delivered on to Indigenous peoples a profound level of trauma that ripples across time and space, trauma that is felt collectively, individually, and inter-generationally. But that trauma is not our single story.

The fragmentation of Indigenous ways of knowing and being and of Indigenous identity caused by colonization is countered by the incredible efforts of those who strive to protect and revitalize our languages, knowledge(s), ceremonies and ways of being, and by those who strive to reclaim our sovereignty and protect our relationship to the land. The single story of fragmentation is ruptured by the persistence of Indigenous ways of knowing and being that exist within us, held within our bones, our memories, our hearts, and our prayers.

**Defragmentation and the recognition of being: Being seen, being heard**

Defragmentation as I have set it out here in this thesis, recognizes both the fragmentation caused by colonization and the movement towards wholeness that I witnessed in the stories of the women and that I have tried to demonstrate in documenting and sharing their knowledge and my learning here. Wholeness is not a new concept but rather a very old and fundamental one in Indigenous ways of knowing;
it is about a way of being and a way of being in relation to all things around us. It recognizes the interconnectedness between all things and across time and space (e.g. connections between the past, present and future, connections between the physical and spirit world). At its core is a fundamental recognition of our being as Indigenous peoples, and in the case of this research, of our being as Indigenous women. Naming and (re)claiming our identities, our sense of self in a profoundly racist society is no small task in a nation built and sustained on systems of colonization that impact our daily lives but are rarely acknowledged in our major institutions (e.g. education, criminal justice, social welfare, etc.).

In her writings on culturally appropriate consultation, Anishinawbekwe scholar S. Amy Desjarlais (2012) uses the metaphor of “emptying the cup” to speak to the healing of fragmented identity for Indigenous peoples in the face of historic trauma:

“The metaphor of “Emptying the Cup” implies that our human bodies are physical vessels that contain our spiritual, emotional, and mental energies. I assert that as indigenous beings, subjected to colonization, our vessels have been filled with negative ideals about our indigenous ways of being which has resulted in a fragmented perspective of identity. It is through self-awareness, that we learn how to empty the vessel of these negative, colonial ideals. We re-position ourselves to begin healing by filling our vessel with positive, empowering messages and strategies, through re-integration of our indigenous spiritual practices, belief systems and culture.” (p. 44)

Drawing on the work of Maria Yellow Horse Brave Heart (2003), Desjarlais emphasizes the importance of reconnection to Indigenous ways of knowing and being as a means of limiting or preventing further transmission of trauma. To this extent, she grounds her work in Anishinawbeg teachings and Anishinawbeg psychology, which I will pull from here in framing my understanding of the knowledge gathered with the women who participated in this research. Desjarlais shares the Anishinawbeg seven stages of
life teaching as taught to her by John Rice; this teaching describes how we enter our lives in the physical world from the spirit world, our journey through the stages of the life cycle, and our eventual return to the spirit world. Fittingly, in light of my beginning story of my experiences of birthing, I am concerned here with the part of the teaching that focuses on birth, which Desjarlais describes as follows:

“In the moment of our first breath, we achieve perfection and we are the perfect human being. Our loved ones, gathered around us saying “Giiwabama” <you are seen>. We cried and made our first sound. Again, our loved ones said “Giinohndawah” - <you made a noise and we let you know you were heard>.” (p. 46)

This part of the teaching struck me because it acknowledges our wholeness from birth, because the practice of the loved ones described is about a fundamental recognition of being and of voice – you are seen, you are heard. While this practice of the recognition of being and of what Desjarlais describes as perfection and what I would name as wholeness, has been ruptured and fragmented by colonization, it is not lost. It is, in fact, a part of us, something that we seek consciously or unconsciously. It ties us to our Ancestors and to All Our Relations around us, it grounds us a part of the circle of all things, helping us to remember our gifts, to pick up our roles and responsibilities, and to move in a good way. The participants in this research described experiences of seeking, practicing, reclaiming or being received in wholeness; they also described creating an experience of wholeness in health care by gathering together and engaging with service providers in ways that lined up with their whole selves. Additionally, they identified challenges and experiences of being received in ways that denied, erased or ignored their wholeness through racism, stereotypes, silencing, and failure to acknowledge or address the structural barriers and violence seeded by colonization and
embedded in the major institutions of Canada that impact the health and well-being of Indigenous women, their families and communities (e.g. health and social services, education, justice).

**Defragmentation: Health and social service provision**

In Chapter 6, Donna discusses experiences of racism in healthcare in two different ways – the assumption of alcohol or substance use on the part of healthcare providers, and the failure to look for or adequately respond to complaints of pain reported by Aboriginal people seeking care. In these examples, Aboriginal women (as represented by Donna and her sister) are neither seen (Giiwabama) as whole beings nor heard (Giinohndawah), but instead taken up in a fragmented view as stereotypes resulting in poor treatment. This reflects the findings of Kurtz et al. (2008) in their research on the health care experiences of urban Aboriginal women in the Okanagan Valley of British Columbia, in which women reported assumptions of alcohol and drug addiction by healthcare providers, feeling judged by providers as a poor mother and fearing apprehension of their children; being treated as if or told that their health concerns were “all in their head”, and experiencing generally poor and problematic communication when interacting with service providers. The authors assert that the result is a silencing of voice of urban Aboriginal women and name this as an act of structural violence that frequently causes women to delay accessing health services to avoid racism.

In contrast, in Chapter 5, the stories of Sandra and Marie emphasize seeing a person as more than the trauma they have experienced, seeing them as a *whole* person, as a beautiful person. The description of the approach to care that Fay uses and my own experience of the care provided by the SGMT midwives, is fundamentally
about Giiwabama and Giinohndawah – being seen and being heard, being recognized not only as a whole being, but as a whole Indigenous being. Rather than silencing, this kind of practice – grounded in Indigenous ways of knowing and helping - opens up space for, encourages and supports the use of voice and the exercise of choice. It recognizes each woman (or each person) as having inherent knowledge of themselves and their health and well-being; it acknowledges their strength and resilience and recognizes them as both being and becoming (Hart, 2009). Indigenous approaches to helping not only help to heal the impacts of fragmentation on the lives of Indigenous women, but also actively resist fragmentation by remembering, revitalizing and reasserting Indigenous ways of knowing and being.

Transformation of health and social service provision towards the goal of enhancing, promoting and supporting the health and well-being of urban Aboriginal women, requires more than a recognition of Indigenous being; it also requires a recognition of Indigenous ways of knowing. Just as Indigenous peoples are marginalized in the health and social service systems, so too are Indigenous worldviews. The dominance of western worldviews in the construction, regulation, delivery and evaluation of health and social services is well documented (Ahenikew, 2011; Cunningham, 2009; O’Neil, Reading & Leader, 1998) and the disjunction between western and Indigenous worldviews is recognized as a barrier to care for Indigenous peoples (Cunningham, 2009; Durey & Thompson, 2012; Mundel & Chapman, 2010; Place, 2012). Western biomedical understandings of health that emphasize a view of health and wellness as the absence of disease implicitly infer being healthy as a state rather than a process. This kind of dichotomous thinking would
similarly frame notions like healing, balance or wholeness as a state of being, as opposed to an Indigenous worldview in which they are understood as a process, a practice, a way of being. A biomedical approach can hold health as something separate from us, as an elusive state we seek to find or achieve, as opposed to something that exists within us and through our thoughts and actions. This issue arose in the participants’ stories. In sharing her knowledge, Jade identified the ways in which a western, biomedical conceptualization of health creates a barrier or challenge to her health and wellbeing. At the same time, she describes how reconnecting to and relearning Indigenous ways of knowing and doing are a foundational part of her health and well-being:

“….idea that health is a goal, whereas for me health is a process, and I know I’m doing well in that process if I’m being challenged, if I’m…um, able to make decisions for myself that I trust, and I can follow through on….but when it’s a goal, when it’s like a, an ideal weight, or um, an absence of disease or…um, or blood levels or vitamin, whatever….um, those particular regiments, um, don’t work. I find I will never meet them (laughing), but I am nonetheless a functioning individual, so what else is there? Um, so, having health as a process ‘cause I don’t ever think we’ll get to a point where our communities are one hundred percent healthy and decolonized and amazing….I think it’s process, and we will relearn the tools that we have, and that I will relearn the tools that, that my Nation has had, and still has, and that I will then know better how to use them and share them. Um…that is, that’s what I’m interested in, but because health, as it is currently, is put as a goal, um, an unreachable goal, an unattainable goal, that’s a huge barrier to anything…”

Jade firmly positions health and well-being as a process - as a way of being; perhaps that is the gift that lies within the use of not only the word “health” in this research, but also well-being which could be employed to emphasize an Indigenous focus on health and wellness as contained within our being and doing. Jade rejects the idea of her health as existing outside of her. Instead she identifies her movement towards and valuing of the tools and knowledge held within her Nation as important, not
only for herself but also to share with others. In the following passage, she speaks to the ways in which a western biomedical approach specifically works to dislocate women from their bodies, and describes her own process of reconnecting to her body and to her learning about her body by *being* and *doing*:

“[...] I think that’s especially problematic for women, because we are taught that we don’t know our bodies, and somebody else always knows better….we’re taught to fear, um…I wanna stop using we, I don’t want to include you all in that because that would be totally not your experience at all (laughing). Um, I was taught to fear and not question my body, if something hurt it meant there was something wrong with me, it didn’t mean that there was maybe something that I needed, or my body was trying to tell me something, um, so…I had to relearn a lot, of like, my body signals and that my body wasn’t trying to punish me for anything. It wasn’t like a judgment or a priest or somebody saying that I was bad, it was just, that my body was trying to communicate with me, um, and to open that communication more to include things like pain and distress and discomfort…and try and learn the language of that, and learn how to interpret those signals so that I can respond appropriately, um, but that it’s not, I’m not at war, there’s a lot of like….I read in, in um…health resources and things, there’s a lot of kind of…fighting language and vocabulary that’s used to talk about our body, um…that’s not the relationship I want with my body, it’s my physical vehicle in this world, it’s kind of important. Um…and not only do I want to know how to take care of it, I also want to know how to communicate with it, how to push it, how to challenge it, um….and not be afraid of maybe doing something wrong, ‘cause that’s how we learn, make a mistake – that’s how I learn, is by making mistakes, suffering the consequences (laughing) “oh I ate too much and now I feel like crap” (laughing) like now I know that this is how much, um…that’s how I learn best, so that….and I find that I learned that in school, I learned that from my, like family doctors growing up, um, that I wasn’t taught about my body and what it does…um, what its functions are, um, and not overly body topping on that? Um, so actually looking at that as whole and not just saying “this is what your vagina is for, and that’s all it’s for is procreation”, well actually…. (laughing) it’s got a lot more capabilities. Um, and that they’re not just sources of, not just sources of pain or…potential illness, and that you’re healthy only when you’re in the absence of illness.”

What Jade is describing in part is her process of *reconnecting* to her body and her own ability to listen, understand and respond to what she refers to as the language of her body. This way of knowing and being that she is discussing notably rejects fear and instead promotes approaching one’s body with a sense of curiosity and a recognition of
its capabilities. In this way, her body is both seen Giiwabama and heard Giinohndawah. This is a powerful point of knowledge and, I would suggest, an area for future in-depth research to gather and share knowledge among Indigenous women, across generations, about how they understand and relate to their bodies and to the knowledge contained within their bodies (embodied knowledge) as an important piece of healing from the damage to Indigenous womanhood caused by colonization.

**Defragmentation: Relationship to self and the practice of wholeness**

The concept of defragmentation emerged for me in this research as I witnessed the ways in which women rejected stories that contributed towards a fragmented sense of self and moved towards a sense of wholeness or a practice of attending to their whole selves. But its roots stretch deeper and reach further back into my journey to this point here. I had first held the notion of defragmentation in my hands long before I met the first participant and began the work of gathering stories. I was reading *Sister Outsider* by Audre Lorde (2007), a Black lesbian feminist whose writings have long been a source of spiritual nourishment for me in managing my way through my postsecondary education. She wrote:

“...I find I am constantly being encouraged to pluck out some one aspect of myself and present this as the meaningful whole, eclipsing and denying the other parts of self. But this is a destructive and fragmenting way to live. My fullest concentration of energy is available to me only when I integrate all the parts of who I am, openly, allowing power from particular sources of my living to flow back and forth freely through all my different selves, without restriction of externally imposed definition.” (Lorde, 2007, p. 120)

As I read her words, I understood her refusal to divide herself into pieces – the resistance of fragmentation - as simultaneously constructing the process of defragmentation, of pushing back against the powers that ask us to deny (the
undesirable or “Other”) parts of ourselves so as not to rupture the daily hum of hegemony that helps to hold colonialism in place. Where fragmentation holds us to the margins, defragmentation restores our sense of wholeness – first within ourselves – and then with each other and all things around us (All Our Relations). This is what I witnessed in the stories and knowledge shared by the women in this research – a rejection of services, treatment and interactions that contributed towards fragmentation, and a movement towards and practice of attending to themselves as whole beings.

So what do the practices of defragmentation or movements towards wholeness look like in the day to day lives of the women who participated in this research? The stories of Marie and Fay illustrate the practices of re-connecting to self and Indigenous identity by remembering (“remembering who I am”) and by being in relation (helping others, mothering, being in relation to community, to culture and traditional teachings), while Donna’s story emphasizes the importance of telling our stories as a way of connecting or reconnecting to our sense of self and our knowledge. For Segaine and Susan, part of creating and engaging holistic and meaningful healthcare was rejecting a dichotomized (either/or) understanding of health and well-being. For example, the idea that one could only use Indigenous or western approaches to health and well-being, or that health was only about the absence of illness or the achievement of a cure as opposed to health as a practice, a way of being. In addition, their stories underscore the importance of knowing by doing and choice - being able to choose from and utilize multiple approaches to health care that lined up with what each woman knew about herself and her health and well-being through her lived experiences. Susan’s story also highlighted the importance of spirituality, particularly the role of dreaming in guiding
decision-making and practices in relation to health and well-being - something that several other women also identified as playing a role in their lives, as well as in the ceremonial practice of binding the homeopathic medication to her.

The practices of health and well-being described by women across the research circles and interviews centered on connections – to self, to voice, to choice and to relations and emphasized a sense of (w)holistic health and well-being inherent in Indigenous worldviews. This included practices of addressing emotional and mental health well-being (crying; laughing; journaling; education/learning; seeing a helper – e.g. healer, seer, traditional teacher, Elder, social worker, therapist, etc.), spiritual health (drumming, attending ceremony, attending church, praying, meditating, dreaming – as a way of connecting to Ancestors, spirit helpers and knowledge), physical health (running, yoga, volleyball, hockey, figure skating, boxing, martial arts, walking, swimming, cooking and sharing food), and sexual health (having sex; healing from sexual trauma).

The practice of being in relation was identified as foundationally important to health and well-being and embodied in relationships to women friends, other Native people, children, older people, animals, and land. For some, the ability to be in relation was mediated by technology, particularly in the form social media (i.e. Facebook) as a way of staying connected with family across significant geographical distances or busy urban lives. While the connectivity supported by social media sites like Facebook is on one hand a very positive phenomena, for others who had limited access to technology in the form of computers or smartphones, the increasing use of social media as a primary form of communication by community organizations, services, family and friends contributed towards an increased sense of isolation. This is poignant reminder for myself as a
researcher and helper in the community and for others seeking to promote services, programs, events or gatherings to account for the barriers to technology that face members in our community, particularly those living in poverty.

Relationship to self and in particular, to one’s Indigenous identity, mediated through access to teachings and ceremony, connection to community (through social gatherings, access to Aboriginal-specific services and programs, community/volunteer work or formal/paid work), blood memory and dreaming was also incredibly important to a sense of well-being and wholeness. Several women also identified the importance of a protected home space where they could rest and feel safe, the creation and maintenance of which required a conscious practice around who was allowed to enter. Finally, a number of women discussed the importance of some form of (and often times the lack of opportunity to) practice of creativity as part of caring for their health and well-being. This included but was not limited to painting, dancing, singing, drumming, creating clothing, making films or writing stories.

**Walking in beauty: Reconciliation and the path forward**

I had the opportunity to attend a symposium in Ottawa in February of last year focusing on Aboriginal perspectives on mental health and addictions called “Walking in Beauty”. Walking in beauty is a reference to a Dine prayer and understanding of being in the world, in relation, in a good way. It was used at the symposium as a way to enter into discussions of truth and reconciliation in relation to healing ourselves and responding in meaningful ways to the struggles of mental health and addictions caused by residential schools. I listened carefully and gratefully to one of the guest speakers Grandmother Madeleine Kētēskwew Dion Stout, a Nehiyaw nurse, scholar and leader in
Aboriginal health. She spoke of the theme of walking in beauty, of the importance of seeing beauty within ourselves and each other, and recognizing ourselves as part of the beauty all around us. She then spoke to reconciliation, not as a state of repair that we would arrive at in Canada between Aboriginal and non-Aboriginal peoples, but rather reconciliation as a way of being, a way of being in relation to one another. This way of being requires us to attend to who we are, how we are and what we stand on; to attend to our histories, our relationships with one another and our collective responsibility to the future and those yet to come. This way of seeing and being was also brought forward in the research by Amy, whose powerful words rooted me immediately to my Ancestors and our collective responsibility to move forward in a good way, looking backward and forward as we go:

“...I think that the best way to move forward is to, is with the presence of mind not to inflict further trauma. If you can move forward, um, knowingly and consciously doing everything in your power to, um, prevent further trauma from happening, and coming to the table with good minds and good intentions, and, full knowledge of what's gone, of the history of what the situation is, then moving forward, um, yeah, in a good way, in a way that's culturally appropriate to the situation, to the people involved, and um, that's the only way to move forward now. So...uh...you have to look at the issues together, and to be fully present and mindful in order to make sure that you don’t repeat history, you know, that all those.....that all those people didn’t die for nothing... all that pain wasn’t suffered for nothing...”

The painful and racist discourses of woundedness described in Chapter 5, are held in place by dichotomous thinking that focuses on a state of being (good/bad, healthy/ill) and does not readily account for the process of being. In this kind of thinking, reconciliation as a state seems to require a collective forgetting such that Indigenous peoples finally “get over” the “history” of colonialism in Canada, and non-Indigenous peoples can finally be relieved of feelings of guilt, anger, frustration or confusion. In contrast, reconciliation as a process, a way of being, requires a collective remembering
so that we do not repeat histories of colonization and so that we can collectively rupture and transform its contemporary manifestations. I would assert that this concept of reconciliation, as described by Grandmother Madeleine Kētēskwew Dion-Stout, not only provides a healing pathway forward for Indigenous and non-Indigenous peoples, but for Indigenous peoples among ourselves in addressing issues of lateral violence and the collateral damage of colonization that linger in our communities in such forms as homophobia, sexism and racism.

Pulling forward the work of Desjarlais (2012), Hart (2009) and my own conceptualization of defragmentation, reconciliation as a way of being compels us to see and hear one another, and to recognize each other as inherently whole and always in the process of both being and becoming. It also requires us to hold consciousness of our relationship to those who have gone before us and those who are yet to come. Where defragmentation addresses a rejection of fragmentation and a movement towards and sense of wholeness within urban Indigenous women, and a revitalization and recognition of Indigenous ways of knowing and being as inherently whole, reconciliation addresses a new (old) way of being in relation with one another that also recognizes and centralizes wholeness.

The giveaway: What does this research bring? What does it offer?

The theoretical model introduced in Chapter 3 has framed and guided this research along with the wisdom and generosity of the CAC and my thesis committee. This model places urban Indigenous women’s voices at its core, illustrating my assertion that urban Indigenous women should hold leadership roles in developing, guiding, transforming and evaluating the systems that impact and respond to their
health. It is a conscious movement towards the revitalization of Indigenous women’s roles as health leaders (Anderson, 2009), that simultaneously recognizes the interconnectedness between the health of our women and that of our families and communities (Dion-Stout et al., 2001). Utilizing this theoretical model, I propose recommendations for moving forward in improving the health and well-being of urban Indigenous women as part of my giveaway (sharing) for this research.

As a social work student, Indigenous peoples were largely absent from the content of class discussions and course readings and Indigenous ways of knowing and being even more so. Where content about Indigenous peoples was presented, it was overwhelmingly in the version of a single story of a deeply troubled service population in need of social work attention; a familiar, inadequate and pathologizing story of woundedness. This research tells a different story, it offers a different way of knowing Indigenous women beyond the single story of woundedness. It is “talking back” (hooks, 1989; Smith, 1999) to racist and stereotypical discourses, rejecting the fragmentation they cause and attending to and centering on defragmentation, wholeness, reconciliation and the path forward. It offers, from an Indigenous perspective, a different way of thinking about health and well-being, about social work and helping, and about research.

**Implications for social work**

Echoing the work of Baskin in her 2011 book *Strong Helpers’ Teachings*, the knowledge gathered from this research can be used to contribute towards a shift in social work education in what she describes as “an opportunity for [social work students] to see Indigenous peoples as strong and active contributors to ways of
helping rather than as constant victims and mere recipients of social services” (p. 16).

The knowledge and experiences shared by the women in their stories demonstrate remarkable tenacity, strength, resilience, beauty, wisdom, courage, humility and kindness. They bring forward Indigenous perspectives of helping and healing.

The importance of bringing forward Indigenous women’s knowledge in social work education cannot be understated. Indigenous women (and Indigenous peoples generally) are grossly overrepresented in nearly every major service sector in which social workers find themselves working or in contact with: child welfare, social services, justice, housing and homelessness, education, health, mental health and violence prevention and intervention. Regardless of which area a social worker may choose to specialize in, the likelihood that they will come in contact with Indigenous service users is quite high (whether they recognize them as Indigenous or not). In order to understand and respond to the needs of Indigenous clients, social workers must have a foundational understanding of the historical and contemporary context of colonization in Canada that shapes the social, economic, political and geographical realities of all people residing on Turtle Island, but specifically serves to severely marginalize Indigenous peoples on our traditional lands. Social work’s core professional values of social justice and anti-oppression assign social workers a responsibility to not only analyze issues of marginalization, but to develop and implement anti-oppressive practices in response. With regard to Indigenous peoples in Canada, this responsibility is underlined by the historically negative involvement of social workers in the lives of Indigenous families in the mass removal of children to residential school, foster care and cross-cultural adoption.
For social work students and practitioners in Canada, the knowledge bundle of this research contributes towards a deeper understanding of historical and contemporary issues that shape and impact the health and well-being of urban Indigenous women, their families and communities. Sharing the experiences and wisdom of the women who participated in the study will also contribute towards creating the critical consciousness required to disrupt colonial practices within social work, and to transform relationships between social workers and Indigenous peoples. More broadly, this knowledge emphasizes the need for social workers to attend to not only the historicity of the individuals we serve, but to our own history as a profession and how this manifests in our pedagogies, policies and practices. Social work as a profession profoundly needs to critically and continuously examine the ways in which history lives in and through our present, and why and how particular accounts of histories are amplified while others are barely whispered. In Canada, the horror of attempted cultural genocide of Indigenous peoples is largely erased in our education systems. Social work education urgently requires increased Indigenous content – not only to serve towards decolonizing social work practice with Indigenous peoples, but to honour and provide meaningful curriculum to the increasing scores of Indigenous social work students and educators.

Indigenous knowledge(s), particularly in relation to notions of health, well-being and helping, have much to offer social work (Baskin, 2011), and in fact are being taken up and centered in some social work programs across Canada (e.g. Wilfrid Laurier University’s “MSW Aboriginal Field of Study” program; required Indigenous-focused courses in Ryerson University’s BSW and MSW programs; and the University of Victoria’s Indigenous specialization options within its BSW and MSW programs). At the
same time, given the egregious history of theft and destruction of Indigenous knowledge(s) described earlier in this thesis, a fear of appropriation is not unfounded (Baskin, 2011). Neither fear nor appropriation constitute a reason to cease from moving forward towards transforming the relationship between social work and Indigenous peoples, towards transforming social work knowledge to better reflect and respond to the lives and ways of knowing and being of Indigenous peoples and to better meet the needs of increasing number of Indigenous social work students, educators and practitioners.

I am grateful to have had the opportunity to teach social work courses for several years now across three different universities; in each course (whether an Indigenous-specific or general social work course) I have utilized an Indigenous approach to teaching and learning. This included using circle as the primary means of sharing knowledge (collectively), bringing in and using my bundle and medicines in the classroom, and opening and closing with a traditional prayer. The idea of using an Indigenous pedagogical approach is not about trying to indoctrinate students into an Indigenous worldview, or a simple reactive response to the dominance of western approaches to pedagogy. Nor do I assume or assert that my Indigenous approach to teaching will necessarily reflect or resonate with each Indigenous student who enters the classroom since we are likely to come from different traditions, histories and practices. Rather, I use this approach because it not only allows me to be in the classroom as a whole person, but invites each student to also bring their whole self in. It challenges the dominance of western ways of knowing in academic spaces and offers an alternative way of gathering to share knowledge, learn and grow.
This way of teaching and learning acknowledges each person in the circle as having something to give and something to receive, it recognizes and centres the importance of history and our collective responsibilities to the past and to the future. It centres storytelling as an important means of sharing knowledge and recognizes knowledge beyond what lies in our head, but also in our heart, our bodies and our spirits. Like the stories of the women, this approach to healing recognizes each person as whole and invites each of us in the circle to attend to our ways of being with ourselves and our ways of being with each other. It invites attending individually and collectively to the ways in which we know (epistemology), how this shapes our views of, for example, ourselves, each other and what it means to be a social worker, and how this impacts our thoughts, actions and relationships – with ourselves and with each other. This kind of consciousness is not only helpful for creating a supportive and productive learning environment, it also models a way of being a helper and being in relation to those we are seeking to work alongside in the community – it supports us to see ourselves and each other whole, as both being and becoming, and like the women in this research, in the process of defragmentation. It is a critical piece of reconciliation – a way of being in relation to each other described by Grandmother Madeleine Kētēskwew Dion Stout above.

Questions for consideration: Social work and the path forward

As I reflect on the ways in which I teach and how social work education more broadly might learn from Indigenous ways of knowing and being without wading into the dangerous grounds of appropriation, I think about the ways in which Indigenous practices around the care of knowledge are helpful in envisioning and navigating a way
forward. For example, returning to the opening questions of “Who are you and where do you come from?” – as described at the outset of the thesis, these questions provide necessary information that help each party locate the other, gauge the knowledge they are sharing and establish a way of being in relation. Another Indigenous knowledge practice that I have tried to demonstrate within my writing is naming who my teachers are and where my teachings come from. How might it be for social work as a whole to answer these questions? Who are you? Where do you come from? Who are your teachers? These questions serve as a reminder of the importance of historicity, social location and epistemology. They invite social work not only to account for and make visible the ideas the profession holds about itself, its history and its approach to knowing, but also the histories, identities and epistemologies that are left out or unspoken. What might it mean for social work to consider Indigenous ways of knowing as a teacher? How might this transform the relationship between Indigenous peoples and the profession and contribute towards rupturing the hegemony of western ways of knowing in the profession?

Given the significant attention paid to the impact of child welfare in this research, it is important to speak directly to the urgent attention required in transforming the practice of child welfare organizations and their workers. Social workers, as the primary players in child welfare, are directly implicated as responsible parties to the process of change whether at the micro (frontline), mezzo (organizational) or macro (policy and research funding) level. Child welfare has profoundly failed Indigenous children, families and communities, a failure marked by a legacy of rupturing Indigenous ways of knowing and being and inserting western ways of knowing and being in relation to child development,
family structures, parenting practices and health and well-being. Entering into relationships of reconciliation requires a shift in the ‘thinking’ (epistemology, theory) that has allowed the ‘doing’ of child welfare as it has existed and presently exists. I would argue that this shift must address where the “problems” of child welfare concerns emanate forth from, as well as accounting for Indigenous ways of knowing and doing in understanding and responding to child welfare concerns in Indigenous communities.

Gitxsan social work scholar and Indigenous child and family advocate Cindy Blackstock, writing in collaboration with Nico Trocmé (2005), advocates for the utilization of community development approaches to child welfare that emphasize the links between community resiliency and child resiliency. These kinds of approaches necessarily acknowledge and address structural issues such as poverty and housing. The authors pose two very powerful questions:

“To what degree are parents held responsible for systemic and structural community-based challenges over which they have little or no influence? To what degree is child protection social work itself prepared to meaningfully support sustainable community development approaches to reduce the drivers of maltreatment?” (p. 30)

A community-based approach to child welfare effectively pushes back against individualistic and pathologizing models of care that locate the challenges faced by a family in contact with child welfare as residing within the parent(s) themselves. I would suggest that it requires a deeper critical analysis of not only the structural issues shaping the lives of an Indigenous family but of the histories that led to the creation of those issues in the first place, and to the creation of social work itself. The consciousness enacted through such critical analysis is integral to creating knowledge and practice in child welfare that does not replicate the past trauma experienced by
Indigenous families in contact with child welfare, but in fact, accounts for and responds to the individual and collective impact of that trauma. This kind of critical consciousness makes visible the power of policy makers and social workers to direct the focus of practice and to locate “problems” faced by families and to identify the origins of these problems. It inherently shifts the responsibility for systemic and structural issues from the individual to the collective.

Creating or shifting consciousness is not enough. Real transformation requires actually doing something different. How might child welfare practice informed by Indigenous ways of knowing and being and specifically the concepts of wholeness and reconciliation result in different relationships and outcomes? Indigenous-informed child welfare practice rooted in relationality, interconnectedness, reciprocity and attention to our collective connections and responsibilities to both the past and the future would require, on the part of social work, a willingness to divest itself of its place as ‘expert’ in relation to child welfare and Indigenous child welfare specifically. Entering into relationships of reconciliation would require recognition and demonstrated valuing of Indigenous knowledge(s) in a multi-pronged manner (e.g. from legislation, to practice guidelines, to assessment models, training and workplace policies). This would foundationally require a relationship between child welfare agencies and Indigenous communities in which Indigenous peoples, in particular Indigenous mothers who represent a steady target of child welfare historically and contemporarily, are not only included, but have recognizable decision-making power in shaping the development, implementation and evaluation of policies, practices, training and education for child welfare social workers.
Implications for mainstream health care systems, services and knowledge production

The contributions of this knowledge bundle to health care systems, services and knowledge production are two-pronged. Firstly, the research offers an understanding of Indigenous women as knowledgeable, capable, strong, resilient and whole in the face of what Dion-Stout and Kipling describe as the “longstanding tendency within the mainstream research and policy communities to portray Aboriginal women as victims and to pathologize their lives” (p. 24, as cited in Dion-Stout et al., 2001). The women’s stories underscore the importance of structural and systemic level change in highlighting the ways in which not only racism, but also an incongruence in worldviews, serve as barriers to accessing or receiving meaningful and effective treatment. The concept of defragmentation resists the dehumanization embedded in racism, and centres Indigenous women in the context of their personal and collective histories, their ways of knowing and being, and as whole people who are both being and becoming. How might seeing Indigenous women through the lens of defragmentation shift the practices of health funders, policy makers and service provider? Defragmentation accounts not only for the impact of colonization, but also recognizes and seeks to revitalize the complex and sophisticated ways of knowing and being that have existed among Indigenous peoples on Turtle Island long before contact. As such, it necessarily compels mainstream health systems (including the education of health service providers and policy makers) to account for the impact of colonization and acknowledge Indigenous ways of knowing and being as necessary components in developing meaningful, safe and effective health policies, programs and services for urban Indigenous women, their families and communities.
Secondly, the concept of defragmentation can equally be applied to health systems, services and knowledge production to help make visible the context, history, and ways of knowing and being that inform health care in Canada, and to reframe it as both a state of being and becoming. The idea of visibility and transparency in unpacking what histories, contexts and epistemologies inform our major institutions is meant to encourage consciousness of not only what mainstream health care systems in Canada have done and are presently doing in relation to Indigenous peoples (and other marginalized peoples), but to also be clear about what else it can do moving forward. It confronts mainstream health care in asking not only how the well-worn single story of pathology has come to represent Indigenous women (Dion-Stout et al., 2001), but what continued colonial function this story helps to hold in place. Addressing these questions is a necessary starting point in establishing relationships of reconciliation and decolonizing mainstream healthcare to create services in programs that help rather than harm or hinder the health of urban Indigenous women.

As I consider the implications I am identifying here in relation to my theoretical framework, I revisit the work of Browne et al. (2005) who recommend a model of cultural safety to in order to shift from focusing on the cultural traits or differences of Indigenous peoples as the supposed site of difficulty in healthcare and health outcomes, to examining the culture of healthcare itself. This requires an examination of how the culture of healthcare - including funding practices, policies, frontline service delivery and research - sustain health inequities and reinforce the social marginalization rooted in historical and ongoing acts of colonialism.
I wonder about the use of the term “culture of healthcare” and what it infers, or more importantly what it obscures. Does a framing of “culture of healthcare” invite a more superficial focus on modifying behaviours and practices of health care workers without necessarily having to address the epistemological framework that underpins the entire system? While unpacking the ways in which health care systems and those who work within them are implicated in and can work to transform the marginalization of Indigenous peoples, I would assert that a necessary part of moving forward in a relationship of reconciliation and with a goal of decolonizing healthcare is to fundamentally address and dismantle the epistemological hegemony of western ways of knowing in healthcare (Williams, 2001).

O’Neil, Reading and Leader (1998) highlight the role of mainstream health knowledge production as an active participant in the continued marginalization of Indigenous peoples:

“In Canada, and elsewhere, epidemiological portraits of Aboriginal sickness and misery act as powerful social instruments for the construction of Aboriginal identity. Epidemiological knowledge constructs an understanding of Aboriginal society that reinforces unequal power relationships; in other words, an image of sick, disorganized communities can be used to justify paternalism.” (p. 230)

Transforming what is “known” about Indigenous health also means attending and addressing how we understand knowledge (our epistemology) and how we gather that knowledge (our approaches to research). Research that is grounded in Indigenous epistemologies and Indigenous approaches to gathering and caring for knowledge contributes towards a defragmented view of Indigenous health and a relationship of reconciliation between Indigenous peoples and the health systems we navigate in attending to our health.
I am advocating not only for revitalization of Indigenous knowledge practices in relation to health research, but the active engagement of Indigenous epistemologies in healthcare beyond tokenistic measures, engagement that must be driven by Indigenous peoples. In the case of urban Indigenous women in Toronto, this would include meaningful participation (including decision-making power) in the development of Indigenized health policies, programs and services, and given the concerns shared in Chapter 6, the opportunity to inform not only funding directions but funding practices. This could include forming an advisory council of Indigenous women to inform priorities for health funding, policy and programming to better support and promote the health and well-being of Indigenous women, their families and the broader Indigenous community of Toronto. I further would advocate for the engagement of Indigenous women by health service sites such as hospitals and community health centres to improve access to and quality of care they receive.

As described in Chapter 3, facilitating meaningful engagement of Indigenous women in transforming health policy, programs, services and research requires the allocation of sufficient resources and support by relevant municipal, provincial, territorial, and federal agencies, and Indigenous organizations alike. It requires recognition of and response to the barriers to participation typically faced by Indigenous women, including the allocation of resources to assist with childcare, transportation, the provision of food (during meetings and workshops) and access to ongoing opportunities to enhance knowledge and skills. This responds to and identifies some potential pathways in moving forward with the recommendations of Dion-Stout et al. (2001) who called for “a re-orientation of existing models, approaches and practices, along with measures
designed to make the health system more accessible and supportive of Aboriginal women and their families" (p. 29).

**Conclusion**

This research set out to understand what impacts on the health and well-being of urban Indigenous women in the city of Toronto. Twenty-three women participated in research circles and interviews in which they were asked to share their knowledge about what helps them to be healthy and well, what gets in the way of their health and well-being, and what they envision as needed to support their health and well-being and that of Indigenous girls and women generally in Toronto.

Participants identified a number of challenges to caring for their health and well-being including racism in health services, fear of or trauma from child welfare involvement, and lack of or limited access to health services due to poverty, geography, or juggling multiple responsibilities (including the care of children, other adults, or both). Indigenous women face the challenges of fragmentation caused by colonization, while also holding a wealth of knowledge and practices in attending to their health and well-being as whole people – the knowledge bundle of defragmentation. This knowledge bundle is not only important for the healing, health and well-being of urban Indigenous women, but for the healing and transformation of the systems and service providers implicated in their health and well-being (including, for example, social work and healthcare providers).

Responding to the severe health disparities faced by Indigenous women and Indigenous peoples more broadly, requires more than anti-racism or learning about the history of colonization. It requires a fundamental recognition and incorporation of
Indigenous ways of knowing and being that existed long before European contact.

Decolonizing health and social services towards improving and supporting the health and well-being of urban Indigenous women requires that Indigenous peoples and Indigenous ways of knowing and being be both seen Giiwabama and heard Giinohndawah. The recognition and centring of Indigenous ways of knowing and being brings forward teachings and practices of wholeness – such as defragmentation and reconciliation – which are helpful to improving the health and well-being of not only Indigenous peoples, but all peoples living on Turtle Island. Colonialization ruptured Indigenous ways of knowing and being, birthing the single, pathologizing story of Indigenous people as woundedness, a story readily held in place by racism. I suggest that it is Indigenous ways of knowing and being that hold the power to rupture the single story by insisting upon and practicing from a grounding in wholeness, relationality, reciprocity and interconnectedness.

**The path forward: The CAC and ongoing engagement**

Like the thesis committee, internal and external appraisers, the CAC has also had the opportunity to review and provide feedback and vetting of this thesis. This reflects a valuing of their representation and knowledge as community representatives and my accountability in writing about this research as extending beyond the walls of academia. The knowledge sharing from this research will continue to be guided by the CAC, to help identify how to share back knowledge in the most meaningful ways with our women, our community (including community organizations), with health policy makers and funders, and with those working or training in the health and social service professions.
CHAPTER 8: CLOSING

This bundle is full of stories... stories of change – some stories about change that has already happened and some stories that are seeds of the change to come; this bundle carries stories of both pain and grief, and of joy and beauty – they are not separate but necessarily intertwined. They are also not separate from me or from my own journey. It has been nearly seven years since I started down my path in the PhD program; this has surely and fully been a life stage for me in which I grew more substantially into myself as a woman. As a mother in this time I have seen my girl child into her young womanhood and my baby into her girlhood. I have seen both of my grandmothers move from this world into the next. I have learned to breathe deeply without crying, to cry without shame, to humbly ask for help and to learn what it means to be and stay in my body. I am learning to trust more and more in my voice. I had to grow up and grow into my ability to gather and share the stories held in here in this bundle. My journey of learning about research, of learning to gather, care for and share knowledge in a good way has also been a journey of rebirth. As I picked up the responsibilities that came with my traditional name (to gather old knowledge and carry it forward), I had to journey with myself and know myself in a new way in order to be prepared to seek out, ask for and carry knowledge. In describing rebirth, Simpson (2011) states that “[o]ur mothers have always known that our rebirth, like any birth, is a powerful but painful process – a pain that fades in the background as the birthing ceremony comes to an end. Bringing the old into the new is our way forward” (p. 148-149).
The women who shared their stories, generously, kindly, have witnessed, experienced and survived tremendous challenges and trauma – for many this included significant loss, separation, dislocation and disconnection. Many have faced a multitude of violence – at the hands of the state, of strangers, of family members or partners. The violence of colonization – of the theft, deception and destruction upon which it built itself under the auspices of discovery, opportunity and civility – continues to ripple in the structural harm to our peoples through the institutions of education, justice, healthcare and social welfare, in political and economic marginalization and exclusion, and in the physical, emotional, spiritual and mental costs of daily living in a fundamentally racist society. Still, these women share stories and knowledge of power, choice, transformation, voice, of resilience, resourcefulness and resistance.

Some of their stories were beautiful, others deeply painful, and even in the painful stories lay the beauty of each woman in having lived through the struggles of her life, in seeking her own healing and sharing her knowledge and experience with tremendous generosity and trust. Their stories demonstrate the strength and agency of Indigenous women to persist and insist on healing, to insist on more than partial ideas about who an Indigenous woman is – to interrupt, disrupt and upturn colonialism’s tired single story. Their voices, their visions, their very being was healing for me to witness. They are powerful medicine unto themselves, medicine that they shared so generously for all of us to hear and to be safely held in this bundle for those who are yet to come. Their words honour their Ancestors and All Our Relations, they reflect the strength of surviving, of remembering, of resisting erasure and insisting on a present and a future of possibility, opportunity and hope. May we walk in beauty.
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