“Hey, Where Can I Go for Help?”: Aboriginal People and “Good Medicine” at an Urban Aboriginal Health Agency

by

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF EDUCATION

in

The Faculty of Graduate and Postdoctoral Studies

(Educational Leadership and Policy)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

June 2018

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“Hey, Where Can I Go for Help?”: Aboriginal People and “Good Medicine” at an Urban Aboriginal Health Agency

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the degree of Doctor of Education

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ABSTRACT

This dissertation examines the perspectives and experiences of urban Aboriginal people who utilize cultural, social and health services and staff who work at an urban Aboriginal agency located in Surrey, British Columbia (BC). Availability, accessibility, and acceptability of health services from the perspectives of urban Aboriginal people are emphasized to inform future policy and services offered to urban Aboriginal people by the BC provincial health care system. Archibald’s (2008) seven Indigenous Storywork principles of respect, responsibility, reciprocity, reverence, holism, inter-relatedness, and synergy form the foundation of the Indigenous methodology for this study. Kirkness and Barnhardt’s (1991) principle of relevance is added to the methodology. The traditional story and metaphor of Hamumu, (Butterfly) from my family in Kwakiutl territory, Kalugwis/Turnour Island also guides methodological and theoretical aspects of this thesis. Hamumu highlights transformation and the metamorphosis of urban Aboriginal people’s lives, including mine, through wholistic health services that address physical, emotional, mental, and spiritual well-being. The development of a Hamumu Theoretical Framework for this research is an outcome of a critical examination of colonial impacts upon urban Aboriginal people and the start of a self-determining conceptual health framework based on local Indigenous knowledge. Three sources of knowledge which shape the development of an Indigenous Good Medicine Theory include: (1) my personal story; (2) perspectives and health-related stories of 14 urban Aboriginal people; and (3) health and policy literature. The Indigenous Good Medicine Theory includes approaches that focus on culture, comfort, collaboration, and communication.
LAY SUMMARY

According to recent documents approximately 70% of Aboriginal people in Canada now live in urban centers. As an Aboriginal woman and residential school survivor, I am deeply concerned about the overwhelming health and social problems faced by urban Aboriginal people. These problems stem from cultural dislocation, feelings of powerlessness, discrimination, and economic hardship. In addition, the inner cities contain Aboriginal people who are disconnected from their traditional extended families, community kinship and cultures. However, urban Aboriginal organizations have begun to offer health and social services to address these issues. Urban Aboriginal people share their stories of accessibility, availability, and acceptability of health-related services at an urban Aboriginal agency and with provincial health services. An Indigenous Good Medicine Theory is a result of this research that suggests new ways for health care providers and the provincial health system to contribute to Aboriginal peoples’ health and well-being.
PREFACE

This work was approved by The University of British Columbia Behavioural Research Ethics board, Certificate number H09-03101, and by Fraser Health Authority Research Ethics Board on May 28, 2009. This dissertation is original, unpublished, independent work by the author, M. Wilson.
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ACKNOWLEDGEMENTS

There are so many people who supported me throughout this process whom I wish to express my heartfelt appreciation. I sincerely express my warmest regards and gratitude to my committee: Supervisor Dr. Jo-Ann Archibald, for the many hours and days of your kind and patient guidance and your kind ways of helping me achieve a deeper level of understanding, comprehension, cohesiveness and clarity in writing this thesis. Thank you, Jo-Ann for our student/teacher relationship your belief and continued encouragement to keep moving forward. To Dr. Heather Clarke, the second person on my committee, thank you for your empowering ways about transformation, that it is not only about transforming social structures and people, it is also the gentle reminder about being open to ourselves and our relationships with others. To, Dr. Michael Marker, the third person on my committee, thank you for your inspiring words of encouragement and belief in my abilities combined with your gentle approach of encouragement.

To the contributors of this study, Tlawitsis community, Kla-how-eya and Kekinow Elders, Clients, Administration and Staff, I am forever grateful for your willingness to share your gifts of stories, most of all your openness to entrusting me with your truth. To my Tlawitsis community, I forever hold in my heart, mind and spirit the greatest gift of belonging and having you as my greatest teacher despite life’s adversities, you are the foundation of whom I have become, a strong, resilient Tlawitsis woman. To Kla-how-eya and Kekinow Elders, Clients, Administration and caring health and social staff, you have shown me what it means to care, share and empower our people to bring out the best in wellness. I could not have completed this work without your continued advocacy of upholding and embracing traditional values, beliefs and principles throughout your daily lives. I have learned and grown in my heart, mind and spirit because of your gifts of contributions.

To the Fraser Health community, especially to those who work tirelessly for the First Nation communities to becoming healthier physically, emotionally, mentally and culturally. Your continued development of partnerships and collaboration to integrate health services for continued wellness.
To my EdD cohort, I started this journey with you all way back and while I am one of those who took longer and you’ve all gone your own ways, I want to thank each and everyone of you for the gifts you shared, encouraging me all the way, you remain my family.

Lastly but not least, to my Grandparent’s, Auda and Dada, Mary and Jim Crow for being the best teachers in my life. I am blessed with your gifts of love, knowledge and most of all the wonderful memories that keep me strong and grounded. Love you forever.
DEDICATION

I dedicate this dissertation to all residential school survivors, their Children, Grandchildren and future generations who may have to migrate to inner cities of Canada for whatever reason. I encourage you to look to your tribal community elders for ways of Good Medicine to carry with you in Body (Physical), Hearts (Emotional), Mind (Mental) and Cultural (Spiritual), to help you navigate the outside world of health and social systems.
CHAPTER ONE: HAMUMU, AND MY PERSONAL STORY

PART ONE: HAMUMU’S STORY
I am both a Tlawitsis\(^1\) and Kwakiutl\(^2\) First Nation person, woman, mother and health educator. My personal story in Part One demonstrates how my personal life experiences shaped my educational aspirations – and recognition of the “problem” that I examine in this dissertation. My story reflects the various impacts of colonization that numerous Aboriginal people have faced.

My story provides a personal and real application of these issues and serves as a historical, social, and cultural context for the major topic of my dissertation that addresses urban Aboriginal people’s experiences of accessing health services. My personal story reflects the larger story of Aboriginal people who have had to relocate to urban sites and serves to support Part Two, which introduces pertinent background information for this study. This dissertation begins with the story of my growing up in a traditional world and ways of being with my grandparents for the first five years of my life and every summer for the eleven years that I attended the residential school and boarding systems. I compare my Kalugwis (Turnour Island) personal context, which was a very supportive, cultural, nurturing environment of families and community members to my sentence to St. Michael’s Residential School. I endured emotional, psychological, sexual, and physical abuse at this residential school. The months spent in forced confinement experiencing harsh treatment from English supervisors reminded me of what a butterfly endures while going through dark, ugly stages until it eventually reaches the beautiful transformational stage of being a self-organizing system. Towards the end of my personal story, I share my experiences of moving to urban settings and becoming an Aboriginal nurse and then an Aboriginal health educator.

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\(^1\) Tlawitsis is the name of First Nation people who resided in the village of Kalugwis (Turnour Island) up until the mid 1960s when the community was forced to relocate due to cost of education and health services provided by the federal government. I am a Tlawitsis community member, which comes from my mother’s ancestry.

\(^2\) Kwakiutl is the name for First Nation people who reside in the village of Tsakis (Fort Rupert), or who are descendants of Kwakiutl ancestry. Tsakis (Fort Rupert) is located approximately 3 kilometers from Port Hardy, BC, Canada.
Throughout the dissertation, I use the Hamumu (Butterfly) as a metaphor of the research process to help make meaning of our complex provincial health care system and what acts as barriers to urban Aboriginal people accessing responsive health services. More importantly I examine the Aboriginal health services provided within an urban Aboriginal oriented health and social agency. These services from urban Aboriginal peoples’ perspectives and experiences are identified as ‘Good Medicine.’

The Hamumu story for Tlawitsis First Nation is significant in that it represents one of our original family crests. The story goes, during the time of the great flood when my Great Grandfather Numas, on mother’s side of the family, was sitting high on a mountain singing, a Hamumu landed on his head. This symbolized a blessing from our Creator. Hamumu fluttered ever so gracefully straight down into the village below. A transformation took place, Kalugwis, my community was created. The Hamumu is symbolic of strength, resilience, power and resistance, as delicate as Hamumu was, she was very strong and resilient throughout her metamorphosis.

Freire (1990) states that people act upon and transform their world and in so doing, move towards ever new possibilities of a fuller and richer life, individually and collectively. A good example of his theory comes to mind; a previous place of my employment offered a daily organizational training program called, “Personal Power Training”, for one week. The purposes were to discover for ourselves what takes power away from us as human beings; how to have personal power emerge in our lives – opening and creating moment by moment power; and how to restore our sense of power that may have been taken away through past negative experiences or people who may have taken complete control of our lives for a period of time. For me, the loss of who I was spiritually meant to be was taken away by the British residential school supervisors, nuns, dentists, and other authoritarian figures throughout my early years in life, including junior high and senior secondary schools in Abbotsford and Chilliwack, British Columbia (BC). The workshop was all about letting go and opening up space in our lives for healing and doing well.

This dissertation is motivated by my personal commitment to empower the First Nations to exercise more control over their experiences in accessing health services within alien inner
city environments. In addition, the hope is that when urban Indigenous health policies are enacted upon in terms of improving access to mainstream health services that action be taken to make these services and health practices more culturally responsive. This commitment directs my research and will serve as a validation of a strong sense of needing to be responsible in caring for others in a respectful manner as grandparents and elders in Kalugwis taught me (See Figures 1–3). In addition, my passion for empowering inner city Aboriginal people is that I am very aware that there are and will be many Aboriginal people moving to cities for education, employment, and other reasons. Knowing that there will be continued migration to cities has me concerned about their journey to and survival in inner cities’ environment. I have many bad memories of being treated differently, enduring emotional and psychological pain, which was an extension of my treatment at the residential school.

Figure 1. Village of Kalugwis, first established in 1792.³

³ Image retrieved from the Simon Fraser University (SFU) website (Bill Reid Centre) “Monumental Art and Architecture/Kwakwaka’wakw Architecture” Caption: “Cheslakees Village in Johnstone Strait. In 1792 Captain George Vancouver of the British Navy became one of the first whites to encounter the ‘Namgis. The scene was recorded by the expedition artist and was later engraved back in London by the renowned English genre artist John Landseer.” Retrieved from http://www.sfu.ca/brc/art_architecture/nw_coast_architecture/kwakwaka-wakw-architecture.html.
HOME OF THE TLAWITSIS FIRST NATION: LIVING IN KALUGWIS

The picture below (Figure 2) is symbolic of where I lived, how I lived and my way of being that included traditional and cultural practices. The gillnet boat in the foreground belongs to my grandfather who is pictured on the boat. My grandfather typically wore suspenders, plaid work shirt and his infamous hat. Our house is located to the far right with plum orchard, huge woodshed, our own wharf and a chicken coupe far right lower corner. Kalugwis from time immemorial has had beautiful white clam shell beaches known as middens (See Figure 3).

Figure 2. Kalugwis prior to the residential school.4

4 Personal photo.
Marsden (2005) emphasizes that a genealogy for Indigenous knowledge is rooted in specific lands, and enacted through our lived communities. Kalugwis was once a productive independent Tlawitsis community booming with Indigenous knowledge such as culture, language, dances, hereditary chiefs and noblewomen. The gillnet boat, TK, is pictured in the foreground in the photo above (See Figure 2) with Dada (grandpa), who was also known as Ha’masalatl, Jim Crow, working on his boat as always, this was his livelihood; this boat sustained us to thrive.

I was born in St. George’s Hospital, Y’alis (Alert Bay, BC). I was not discharged for a couple of weeks due to problems of family alcohol abuse. I was discharged into the care of extended loving grandparents who were an aunt and uncle to my mother. I was raised and grew up in Kalugwis (Turnour Island) until I was five years old, which was the time I was

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forcibly taken to St. Michael’s Residential School at Alert Bay, British Columbia. I was allowed to return to my village every summer for the eight years that I was in residential school. Following these eight years I was given permission to return to Kalugwis and live with my grandparents and attend grades seven and eight in our one-room school. I referred to my grandparents as Auda and Dada which most of the children in Kalugwis called their grandparents. In Kwakwala, Auda is granny and Dada is grandpa. I was the twenty-first child raised by my mother’s great aunt and uncle, whom we called our grandparents, as is traditionally customary for grandparents to raise their extended grandchildren. They had no children of their own. I was and continue to be surrounded by extended family. Some of my family members are closely related and others are not, it was just the way it was in our village and two other villages near to Kalugwis, where we had close connections and kinship with other families. The Royal Commission on Aboriginal Peoples ([RCAP], 1996) recognizes this sense of family in the wider Aboriginal community. According to RCAP, to Aboriginal people, family signifies the biological unit of parents and children living together in a household. But it also has a much broader meaning. Family also encompasses an extended network of grandparents, aunts, uncles and cousins. (Vol. 3, pp. 11–12)

The experience of growing up at Kalugwis surrounded by extended family and other caring people had very much to do with my all-round sense of family relationships and connectedness. My grandparents always reminded us that we are to take care of everything in life, meaning taking responsibility to take good care of not only ourselves but the plants, animals and sea-life that nourish our bodies to stay healthy. Consequently, I learned early in life through grandparent’s teachings about responsibility and respect for all living things. This included the fruit trees, chickens, cats, dogs, fish and shellfish. These teachings learned and lived early in life have influenced my sense of responsibility to me, immediate and extended families, co-workers, colleagues, and my communities both on and off reserve.

When I was very young my grandparents always spoke to us about treating each other with respect, sharing with one another and emphasizing how important it was not to call people down because we are all the same. Besides our grandparents speaking to us about these as values in life, we also learned these as lessons in Sunday school classes, church services and
summer Bible school, which we attended weekly with grandmother. Families would alternate opening their homes for evening services. I loved these evening home services especially when the aroma of coffee, salmon sandwiches and cakes wafted through the air distracting me from paying attention to the words and singing of Kwakwala hymns.

As children, we developed both respect and reverence towards our teachings at home, community and church services, especially reverence towards religious teachings and elders because it was taught that if we didn’t follow and live these church teachings that we wouldn’t go to this place called heaven; this was scary to me as a child. All these lived experiences at home and community embedded purposeful respect, responsibility, reverence and reciprocity within me. As a Tlawitsis member of Kalugwis I hold in my heart positive experiences, stories and memories rooted in my cultural, racial, and geographical location. I was raised in a nurturing environment, happy and inquisitive. As children growing up we were always mindful of how stepping out of line of any teachings would affect not only us as children, but our families, community and nation. When I did step out of line my grandparents would remind me of how others, including elders would be keeping their eyes and ears open to make sure that my behaviour reflected who I was raised to be, a respectful young Tlawitsis lady. These teachings and lived values of Ma’yaxala (Respect in Kwakwala) towards self, families (includes extended), Kalugwis (community) and Tlawitsis (Nation) are communicated throughout my dissertation.

These teachings are also illustrated within the Theoretical Framework, Methodology and Data Analysis chapters. I will conclude this early year’s section by re-stating that I was safely nurtured, and a happy, inquisitive, spontaneous little girl in my village with my kin-folk, extended families, and community.
LEAVING MY HOMELANDS

I was rudely plucked out of my first day of kindergarten in a one room classroom in Kalugwis when I was five and half years old. Two men with long beige overcoats took me by the hands instructed me to show them where I lived. Both Auda and Dada met me at our door looking puzzled, asking what I did, I replied, nothing in Kwakwala. The two very strange looking men spoke to my grandfather and explained that all Native children had to attend a school in Alert Bay. Kalugwis was a three-hour boat ride, on a nice day to Alert Bay, BC. I went as I was, told not to take extra clothes, no suitcase. My grandparents gave me a bag of plums from our orchard; they smelled so good. I left wondering why my grandparents would allow these strangers to take me away by myself and with no explanation.

I boarded a strange looking boat, not at all like my Dada’s gillnet boat on which I was used to travelling everywhere. My grandparents stood on our porch waving at me and I was waving madly at them. I was crying so hard that they became a blur to me, I wondered in sadness if they were crying and hurting as much as I was as we pulled away from the dock. I

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wondered for many years what I might have done to be taken away from my grandparents and away from my new kindergarten school. We stopped in two villages, New Vancouver Island and Village Island. I was familiar with these two villages as I would go berry-picking and beach combing with our family during summers and clam digging in the winters. I was relieved when I saw familiar elder faces, but it was all too brief before we were told to sit down and that we were leaving the village. These two men picked up seven children from these two villages.

ARRIVING AT ST. MICHAEL’S SCHOOL

We arrived at the biggest brick building I ever saw with so many windows and inside so many stairs for my little feet to take me up to where I would be sleeping for the next eight years, except for the summers when I was permitted to return to my grandparents (See Figures 4 and 5). There were rows and rows of little black and white-framed single beds neatly made up and the smell in the air reminded me of the dental room in the visiting medical mission boat called, Columbia. It smelled like Dettol or pine-sol disinfectant only stronger, some kind of strong pungent disinfectant. We were all marched downstairs to the shower rooms. A lady with a white dress made a noise as she was walking us, later I got to know that they starched their uniforms. She kept saying in a mad voice, “no talking, be quiet.”
Figure 5. Bedtime at residential school. Praying at bedside.\textsuperscript{7}

We arrived downstairs from the second floor that seemed so long and noisy because of the loud echo coming from the cement stairwells and huge pipes. Children were laughing and playing in the playroom, seeing and hearing the children made me feel a little bit better amongst all these unfamiliar noises, place and people. I felt so confused and scared. We soon arrived at the shower room, which had stalls with curtains. We were stripped of our own clothes (See Figure 6).

We had to sit in a chair with our feet in an aluminum bowl with whitish disinfectant. While my feet were being soaked in what smelled like strong gasoline solution, another lady came along with a pair of scissors. She literally just lopped off each braid and pulled some hair forward and then cut right straight across, just above my eyebrows. Having strangers strip me naked, take my clothes away that my granny made, giving me clothes to put on which were exactly the same as the other seven girls was a horrible experience. After cutting my braids off, we all looked alike, dressed in the same uniform. I guess this was their first

attempt at killing the Indianess inside each one of us by issuing us their type of clothes, cleaning and disinfecting us before we were fitted with government issue shoes.

**Figure 6.** Piled into open shower stalls on arrival.⁸

Next, we were off to the sewing/clothes room to be fitted for our year’s supply of clothes that included three bundles placed in a locker in the sewing room. Each set of clothing was bundled up in a towel tagged with our number, and mine was #5 when I was a junior girl, at the intermediate level my number was changed to #105. Furthermore, before this horrific experience, my hair was waist length and was neatly braided as my Auda always did it. My hair was cut to a length just below my ears and straight across the front above my eyebrows (See Figure 7).

Another lady came along with a big brown glass bottle that had DDT powder in it and oil in another bottle. The oil had a very strong smell, this was combined with DDT (which was incidentally banned from killing bugs in the forest) was drenched into my hair and scalp, and I was told to sit until they returned. Of course, we all sat there obediently and didn’t dare to say a word, just wondering what was next and what they were going to do with us. Would we be returning home anytime soon? Would my grandparents recognize me anymore? Would my Auda get mad at me for having my hair lopped off?

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⁸ Note that girls had the same set-up. Original photo, *Toronto Star* files. Retrieved via a Bing image search, Residential Schools in Western Canada: https://goo.gl/A8D9y1.
EXPERIENCES AT ST. MICHAEL’S RESIDENTIAL SCHOOL

Previously, I had not shared too much about my experiences at the residential school. It hasn’t been until the past few years that I have shared with my two adult children my experiences of how I was treated by staff and other children in the school. Most experiences were pretty scary, especially when I first arrived, just not knowing anything or anyone, about why this happened, how long I would be there, most of all if I would ever see my grandparents again. Usually when I get together with girls I attended school with, we talk and remind each other of our experiences, good, bad and funny, mostly bad. I can’t really recall having fun, although we must have because we did play outside and there were a couple of playhouses near the field. My favourite type of play was riding on a huge tree branch that hung over a shallow creek that ran alongside the girls’ side of the playing field. I would play there for hours with my friend Mary.

I apparently had two sisters and a brother attending the same building. I was raised by my grandparents from the time I was 18 months old so I did not know my brothers and sisters. When someone pointed out who my brothers and sisters were, there were rare times that we could speak to each other because of the various ages, therefore we were all on different levels: junior, intermediate or senior dorm. I vaguely remember speaking to a couple of my brothers over the fence that divided the girls and boys. The girls’ boundary extended towards the bottom of the road and alongside the village road, where we would be able to talk with the village kids. The village kids were the ones who lived on reserve in Alert Bay.

I attended grade one and two at the residential school. From grades three to six, I attended an Indian Day School, located on Namgis Reserve in Alert Bay. Both these buildings are located on the reserve today. The residential school is now empty. Apparently, it cannot be torn down because of asbestos hazards. After the residential school closed it was used as Namgis administration offices and classes for various programs and courses. I think it was put to good use for education and other programs that served the Namgis First Nation and other Nations that were forced out of their villages, like New Vancouver Island, Village Island and my first home at Turnour Island. A new reserve was formed up on the hill of Alert Bay; the members that live there to this day are people that once lived at other villages that are now closed by the Canadian state. There is an exception, about ten years ago New Vancouver Island was revitalized and restored. This village has a newly built Ceremonial Guxdzi (Bighouse). The Guxdzi are used for cultural events, potlatches, feasts, community events and traditional teaching of singing, drumming, language, storytelling (legends) and dancing.

THE EFFECTS OF THE RESIDENTIAL SCHOOL

I think what stands out for me the most is how I seemed to have lived or died in silence during my eight years at the residential school. There was and is no denying that I am a different person than I would have become had I not attended this institution. I had entered the residential school as a loved and loving child, inquisitive and spontaneous, without fear of repercussions. I received many praises for little accomplishments taught to me by grandparents, therefore, I had a lot of confidence in whatever I was taught, by them and extended families in our village. I recall this feeling of being loved, nurtured, cared for,
praised for little things I did well, or not afraid to be wrong. Children were taught by their families and communities that “it is ok if you don’t get it right away in the beginning, you’ll get it soon enough, just keep watching and listening.” All these good feelings were gradually changed and undone while I was under the care of these ladies in white crisp uniforms and the man who walked around in his black flowing robe and a stiff white round collar. I never knew what the supervisors wanted of me. I would hear statements like, “don’t be looking at me like that,” I never knew how to look, seems like I smiled at the wrong times. I started to feel so afraid all the time, always expecting to get into trouble or be punished for whatever reason. To this day, I have very exaggerated startle responses and startle very easily, it is as if someone is always watching over me and ready to tell me that I haven’t done it right, or always just afraid that whatever I do is not up to par with everyone else. It feels like everyone else is better and much happier!

The worst impact had to be the attack on my little heart, soul and mind when I entered those two huge front doors of the residential school. Unfamiliar sights, sounds, smells and people, strangers. To this day unhealthy feelings and perceptions produce a steady negative type of energy throughout my body, sometimes worse than others. I shared this with my adjudicators, supports and lawyer on the day of giving my testimony of experiences while in St. Michael’s residential school. All my sisters were financially compensated substantially more than I was, my session was wrapped up that day with the adjudicator looking straight at me who said, “You seemed to have gotten through this, because you are certainly well educated.” Little did she or anyone know that I am still negatively affected today: physically, emotionally, mentally and spiritually.

The most painful feelings I had and still experience whenever triggers appear are feelings of abandonment, not belonging, disconnection and never being good enough. It seems I have struggled to achieve whatever I have pursued in my life, it has never been easy, but I guess with the strict discipline and punishments in the past I have learned to complete pursuits, however, I always require more time to fully complete the task at hand. During the times that my children visited me while living away from our hometown, I always experienced a profound feeling of abandonment and loneliness when my children and grandchildren departed for their homes. I always cried and wondered if they will be all right.
I guess I worried a lot when they departed because I always felt that I could have been a better parent, and wished I could have taught both children the right ways to live. I wished I could have loved them more like someone who learned loving and nurturing ways. As mentioned earlier I was a loved child and loving, caring for all living things as taught from my grandparents but this was changed into resentment, hate, mistrust, meanness and deceit during my years away from home. My son resented me for many years, saying I wasn’t like other mothers who cared for their children, attended many events with their children, enrolled their children in extracurricular activities to learn social skills: what I knew about social skills was having to sleep in dormitories in silence, girls side – boys side, never allowed to speak to my brothers or sisters.

The school did their best to keep us separated by wooden fences, boundaries and punishment if we were caught speaking to a sibling.

**DISCONNECTION FROM CULTURE AND TRADITIONAL WAYS OF BEING**

Prior to being forced from my village and uprooted to live in a strange building with people I didn’t know, my grandparents always attended cultural events and I remember attending a few potlatches when I was little. I always remember being told, never take the last cupcake or sandwich, leave it for the elder next to you and give up your seat. Walk like a young lady, no running around, stay put while ceremonies are being performed, keep knees covered and don’t chew gum while at a potlatch and never when you are performing a dance. During the summer, I was able to stay connected to the elderly women in our community as they were busy with berry picking, clam digging, beach combing; making plum, blackberry, huckleberry and salal berry jam. Work ethics were very important during my time with grandparents. I was used to working hard as a young girl, especially helping Auda while Dada was away far up north salmon fishing usually until the end of August when he’d return home. My cousin and I took pride in opening the woodshed to show him that we beach-combed instead of using the wood he prepared for us while he was away for the summer.

**SUMMER HOLIDAYS: STRANGERS IN OUR OWN VILLAGE**

When I returned home for the summer holidays, I was happy, but at the same time feeling shy and fearful of what the other village kids thought of me because they all knew I attended
what they termed, the ‘big school.’ I remember arriving on my grandpa’s boat, the village kids, some relatives and friends my age just looking at me, I guess staring at what I was wearing and of course I must have really looked different to them. I had this strange haircut, a tunic issued to wear while going home, very different shoes, wearing glasses, which were round light pink framed government issued. We all were issued the same glasses in the residential school if needed of course. I remember all the village kids speaking Kwakwala and wondered if I should attempt to speak Kwakwala or did they know or had they learned to speak the borrowed English language. I remember hesitating to speak Kwakwala at times when I returned home because it seemed I was not as fluent anymore and I had to think of some words. I could totally understand this now as language is a part of who we are and our lived experiences. I certainly wasn’t living the life and ways of being as I did in earlier years prior to leaving my community. I attribute my preservation of Kwakwala (language) to being amongst the elderly women throughout summers as it was only during the summer that I was allowed to go home from the residential school.

It even seemed a bit strange being back in my own bed with my cedar bark woven clothes basket still sitting where I left it the day I was forcefully taken to this alien place. I never did understand how the residential school system selected who was going to attend the residential schools.

Neither did I understand or ever made aware of the reasons I was selected to attend both programs. It didn’t take too long to blend in with community kids that I had known all my life, but still it was a different feeling, as if I was different or were they different? I know I was becoming different. I was always teased about how slow I spoke as a child. It seemed that I was becoming even slower in speaking Kwakwala as each year went by that I attended the ‘big school.” Each time I went home to the village it seemed easier to return to the school. I believed with those feelings that I was getting used to someone telling me my every move, having a very structured life. It began to almost feel strange to be home.

**STRUGGLES TO SUCCEED WHILE AWAY FROM THE VILLAGE**

Due to the treatment and racism in the residential school, elementary, high school, and first year of college, I began to internalize racism. I always feared I wouldn’t complete my
programs. I have always had to work extra hard to finish anything in schools. Although I lived on the reserve and attended an Indian Day School, racism existed between those of us who were called ‘school kids’ and the ‘village kids’; in the residential school, racism existed between the ‘Northern kids’ and us who lived nearby in Alert Bay. When I returned home to my village, kids teased me about my clothes, haircut, and funny glasses and at times said, “go back to your school.”

Following my eight years in the residential school, I was returned to Kalugwis to complete grades seven and eight in the one-room classroom I was plucked out of on first day of kindergarten to attend the ‘big school.’ I had completed grade 8 successfully in Kalugwis. My completion of the highest grade in the one room day school was interpreted by grandparents as having completed required education. Following completion of grade 8 in Kalugwis, during one of our trips to Tlas’ust’o (Minstrel Island) where we checked our mail and got groceries monthly, my grandparents received a letter from the Indian agency office located in Alert Bay, British Columbia (BC).

The content of the letter in the usual brown government envelope, stated that I was to meet with other First Nations children who lived in villages outside of Alert Bay. The villages included Kalugwis, New Vancouver Island, Kingcome Inlet and Gilford Island. Shortly after returning to Alert Bay, I met these students at a ferry dock; we boarded a BC ferry to Kelsey Bay, BC where a bus was waiting for us. We all travelled in this bus to a place called, Vancouver. I had no idea where we were going, as a matter of fact, none of us had even heard of this place. When we arrived at the Vancouver Bus Depot, our names were called and we went with a stranger assigned to us. Go with who, where, I did not know! Arriving at this huge crowded unfamiliar place was pretty frightening: all the noise, traffic, people everywhere and then travelling for what seemed hours to Abbotsford, BC. I boarded with an English woman, Mrs. Appleby for two years, and then I was moved way out on a very rural farm in Chilliwack, BC out in ‘nowhere’ land for grades 11 and part of grade 12. I grew to like being out on Banford Road, the farm was huge, animals to care for, fruit and garden vegetables to attend, butter to churn, corn-fields to cultivate, there was always lots to do and a lot of time spent outdoors. There was a lot of racism in the schools even from teachers and on our bus-ride to schools!
Living with these people out on their farm homes felt strange, and scary. I especially felt fear and discomfort because they had the same British accents much like our residential supervisors, who didn’t treat us very well in many ways. I felt a lot of mistrust and unease on my part because I had been uprooted again and told by strangers where I was going to school, especially with no consultation with grandparents. However, I felt like we were given more freedom, meaning we were allowed choices of chores amongst us four students, downtown privileges with our two-dollar weekly allowance, called by our proper given names, and not just numbers, able to wear our own clothes, and the food was mainly fresh from the farm except we all missed our traditional foods. All this I identify as experiencing more freedom seemed so unreal to me compared to the residential school system where we all slept in one big dormitory in little white single metal beds within three feet of one another. The farm out in Chilliwack stretched for what seemed like miles of corn, which we picked and ate. It took me a few months to accept the bit of freedom we were given on this farm. After all, my residential school experiences of eight years had me conditioned to the residential rules, bell times for meals and biscuit time, perfect rows of tables and beds, chores for a month, it seemed like there was a punishment for every little thing, every little move out of line.

**EFFECTS ON MY YOUNG SPIRIT**

I always had a sense of shame and low self-esteem. I attributed this feeling to my low sense of self-worth and dependence that was fostered in the residential school. I have to say that although this sense stayed within me, I began to realize that I could do almost anything with extra hard work. I guess I just got used to the residential school, thinking and doing for me as if I didn’t have a mind of my own. It certainly felt that I had no mind of my own, “do this, do that, don’t do this, don’t do that, you will be punished if ....” and to the point where I froze not knowing whether to smile or answer, just for fear of punishment and being demeaned. But then on the other hand, I seemed to always want to challenge myself in life; I never could really figure this out, where it was coming from and why I did this. A counsellor once told me a few years ago, this was how I coped with life, keeping busy all the time.
BECOMING A NURSE

I reflected on the words of elder Gwanti’lakw (Mrs. May Smith) in Kalugwis about how she’d say that I was a good helper setting up a special table for the visiting public health nurse.

Furthermore, the elder would say I would make a wonderful public health nurse. I have always remembered those encouraging words and how she would instruct me to carefully wash my hands and put on a white apron before setting up this special table at her house with a white sheet, sterilized jars with cotton-balls, cotton tipped applicators, tongue depressors and cotton swabs. I felt a sense of inner pride for being entrusted to do this task. I felt special. I believe it was at this time that I developed a glimmer of hope that I could actually become a nurse one day. Along with this feeling of hope came that feeling, a build up of self-esteem and confidence that I could go to a nursing school, and do well. Many years later following high school when I lived in Y’alis (Alert Bay) I applied to a Canada Manpower program through the Department of Indian Affairs and got accepted. My motivation and desire to pursue nursing school was through the encouragement of Mrs. May Smith’s words of confidence that always resonated with me, whenever I thought about returning to school.

This motivation and desire to pursue nursing also came from the memories of hardships accessing health services when we needed them in Kalugwis. I remember a few times when we could have used a health professional to provide relief to medically ill children and adults, as well as family accidents through falls, drownings, house fires and many other minor accidents through activities of daily living. There were no telephones or any way of communication with the outside world. People travelled to Alert Bay by boat for the more serious accidents. The boat trip would usually take at least three hours. Usually the gillnet fish boats that had newer faster motors took sick people to the nearest hospital, St. George’s Hospital, in Alert Bay, BC. In looking back to my lived experiences in Kalugwis living with my grandparents, observing and learning about the application of traditional medicines deepened my interest in good health and wellness. When we travelled to our annual locations for example, Xaxam (Port Neville) and Dzawadi (Knight Inlet) to prepare fish and tlina (oolichans grease) my grandparents would share their teachings about what was
available during that season as medicine in terms of herbs, plants and roots. My grandparents taught me that as human beings we would never go hungry if we knew about the many plants, roots and plant bulbs naturally available. My grandpa used to say, even the grizzlies and other animals know how to survive in the forest and the river banks of Dzawadi.

My first year of a program for licensed practical nursing took place at Malaspina College in 1970, Nanaimo, BC. I had enrolled my husband then who was employed full-time as a logger to a welding program in the same college. We had one daughter who was two years old. The year away from our community was difficult but not as difficult as being forced into a residential school and boarding homes. This year away by ourselves as a little family with a limited monthly income, not knowing our neighbours, or the city environment and no resources familiar to us was difficult. I was the only Native student in the class. I would write my notes over once I got home, read them over, studied diligently because I mostly feared being asked a question and not knowing the answer.

Somewhere along the stages in my life I just had enough of life’s treatment and my not very good style of living or should say dying. I made a choice to leave home to attend registered Nursing school in Victoria, BC. I had worked as a licensed practical nurse for 19 years before I gained the courage and confidence to upgrade in courses required to successfully enrol at Camosun College’s Nursing School. Another reason for pursuing my bachelor’s nursing degree was the fact that when I worked in St. Georges Hospital as a licensed practical nurse, there were always a handful of Kwakwala speaking elders hospitalized. Whenever I arrived on shift they always expressed their desire for more Bakwam (First Nation) nurses to be working in the hospital because the elders and other Kwakwaka’wakw patients often expressed their frustration of not being understood or being misinterpreted. The elderly could not speak English or understood very little of it.

Credit needs to be given to the First Nation staff who worked in housekeeping, laundry and kitchen, as most could either speak or understand Kwakwala. Finally, there were the issues of discrimination, racism, disrespect and judgement towards First Nation people, especially the elderly and children who were helpless when there were no First Nation health,
education and social supports. There had been many complaints to First Nation staff about various forms of mistreatment, and this still happens in hospitals, clinics, schools, mainstream society and other institutions. So, these issues fueled my strong passion to stay with nursing and later complete a nursing degree that would enable me to practice nursing in First Nations communities.

In the Nursing School, there were two of us First Nation nursing students out of the whole class of 120 students. The other female First Nation nursing student was from Ahousat, BC. Most of the instructors I believed were very helpful, wanting us to succeed, on the other hand, there was a female instructor who appeared to amuse herself by humiliating two of us in different terms.

However, all female First Nations achieved our registered nursing diploma. In contrast, I will always remember and be thankful to this one nurse instructor whom I always thought was picking on me, always getting me to go an extra mile in the nursing lab. Little did I realize that this particular instructor was teaching me to improve my skills in critical thinking while making decisions in the nursing lab. I almost blew everything away in terms of my proposed career. I remember being in the narcotics medical room and just froze when the instructor spoke to me about administering narcotics in a red cupboard, double locked, that scared me. I froze and told her I couldn’t do it! I was devastated with the thought that I would overdose a patient! The instructor calmly looked at me and said, “you can do this, I know you can do this, sit in this room for about 20 minutes and think this through, I will be back,” and “No, Margaret I will not let you go home, you have come too far and have worked so hard, and you’re just about finished”. All it took was time to think procedures through, the principle and the rationale of doing practice skills. I explained to her why I needed more time to read, write and respond to class instructions. So, in the future I felt more comfortable responding to class questions and exams because she took the time to understand my learning style. I am ever so grateful for her caring, kindness and patience with me, she was certainly a leader in my eyes, a nurse leader that took the time to understand where I came from and my struggles meeting the teaching style used in this institution.
I met wonderful people in my life, instructors who taught me to believe in myself, who encouraged and talked me into attending the University of Victoria where I got my BScN in 1994. In 1998, I went onto to complete a two-year Diploma in Public Sector Management. I finally regained a good feeling (confidence) and believed (self-esteem) that I could complete and attend school to take up whatever I wanted and be successful like ‘others.’ In 2001, I completed my Masters in Education, Administration and Leadership to combine this with Nursing Education and here I am today working on my Doctorate in Education degree (EdD).

**IMPACTS ON THE PHYSICAL, EMOTIONAL, MENTAL, AND SPIRITUAL DIMENSIONS**

My sense of shame and low self-esteem was always there and still to this day continuously flows inside me like negative energy resulting from bad treatment that has an effect physically, emotionally, mentally and spiritually. I attributed this effect to my low sense of self-worth and dependence that was fostered in the residential school.

I faced so many trials and tribulations for about 40 years of which I had no idea how to deal with most of the time. I had been married twice, divorced twice and both times for wrong reasons, after all marriage is supposed to be about loving relationships and nowhere in my life did I receive love, nurturing and respect except from grandparents who raised me prior to residential school and during times I was home for holidays. Sometimes I just can’t believe how I got here and how I ever thought I could be in this EdD program, especially with the requirement of critical thinking skills. I think it is fair to say that I experienced culture shock whenever I went to a new educational program because every place was a different environment, different learning, different teaching styles, some instructors were ruthless, especially in Biology. I couldn’t keep up with one instructor, thank goodness for counsellors, tutors and libraries. I utilized everything that was offered to me as a resource to get through most programs. I am slower but proud to say I complete whatever I pursue.

For the past 35 years I have lived in various urban environments, as if searching for the “right place,” at times feeling displaced due to the affects of the residential school system. Kirkness (1991) explains, “Every Aboriginal person is affected even today by residential schools despite the fact that they no longer exist...Many generations of children were denied
the association with their nuclear family, with their extended family’s culture, their values, their language, their customs, and their spirituality” (p. 101). Despite experiencing subconscious beliefs of doubt, powerlessness and helplessness, I have become strong willed, hopeful and have been gifted with spurts of confidence that I could overcome adversities. I am very resilient, I have been able to survive in various environments and continue to overcome challenges slowly but surely. My way of facing adversities in life are the gentle reminders of my grandparents and a handful of caring, understanding people to accept life, mistakes will be made, it’s not the end of the world and most of all no one will accomplish my goals except me. I feel that I have succeeded through challenging myself to overcome obstacles of fear, and this included speaking for myself, my needs and asking for what I want. My initial journey of healing consisted of gaining an in-depth understanding of the historical context of colonization throughout my schooling into post-secondary years. I share my personal story of experiencing colonization through the residential school and subsequent high school education to exemplify its intergenerational impact. My story reflects the experiences of generations of Aboriginal people.

I am happy to say I have reconnected with my culture, heritage, and friends. I continue to work on getting closer to my immediate family. We all live in different communities and rarely see one another: four sisters and an older brother. Rarely do we get a chance to visit one another. I believe in our own ways we each do our best to keep connected. On rare occasions, funerals especially, we could be seen altogether, sad, but these seem to be the only times we see each other.

In terms of family, we love each other in our own ways. We do lack family relationships and there appears to be a lack of closeness as well. Once my younger sister and I were in a Port Hardy cafe having brunch. I couldn’t help but observe and hear the family on the table next to us, 14 people having lunch together. There was a lot of laughter, exchanges of joking with one another, stories and their feelings of shared happiness. My sister said, “I wish our family would get together like that, eat together and just laugh around.” I replied, I hope one day we will get together. It is such a nice feeling to have all sisters and family members together. But as previously mentioned the only time this happens is at funerals. I look at them all and smile; this is who I belong to, this family. I guess you could say that our family
ties were successfully broken in St. Michaels’s Residential School where we all attended as siblings. We were so out of touch. There was nothing to hold us together because the ‘big school’ kept us apart in every way: fences, dormitories, eating separately, walking to school, not being allowed to speak with your relatives. I was robbed of the ability to love and even show love for my own children, other than buying so much stuff for them. I do love them dearly and especially my grandchildren. I lacked so much love that I always want to be there for them, to show love, so they can love themselves and others.

I have learned from others about continuing to work on myself to regain my sense of trust, this remains to be the hardest to overcome. To this day I work mainly as an advocate for others who have lost their voices along this journey of ours from the past. I am nearing the end of pursuing my lifelong dream to be educated and will continue giving back to community members so they can move forwards in their lives. A way of giving back is through this doctoral dissertation that focuses on an area that needs much consideration: urban Aboriginal people’s health services.

**PART TWO: INTRODUCTION TO THE STUDY**

The persistence of social conditions in this country – which is judged by many to be the best place in the world to live – constitutes an embarrassment to Canadians regarding the health challenges experienced by Aboriginal people (Royal Commission on Aboriginal Peoples, 1996). The forces of colonial domination have created huge disparities and gaps in the health of Aboriginal people and deliberately have undermined the cultural values of Indigenous people (Barman, 1986; Kirkness, 1991). Negative stereotypes about Aboriginal people are deeply rooted in Canadian society, and much of what Aboriginal people experience in the health care system is an extension of this systemic racism (Health Council

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10 “Health, the fundamental human condition…. the health of any human population is a product of a complex web of physiological, psychological, spiritual, historical, sociological, cultural, economic, and environmental factors. In Canada, one of the most telling examples of how these factors interact can be found in the health of the country’s Aboriginal people. Long considered to be the most disadvantaged group in an otherwise affluent society, Aboriginal people today paradoxically experience the kinds of health problems most closely associated with poverty, problems linked to their historical position within the Canadian social system” (Waldram, Herring & Kue Young, 2006, p. 3).

11 The term, Aboriginal, includes First Nations, Inuit and Métis people, and acknowledges their various languages, cultures and traditions (CIHI 2004; Health Canada 2003a).
of Canada, 2012). Social and historical inequities and disparities that contribute to risk factors are well documented in relation to health status in Aboriginal communities (Adelson, 2005). These data are presented in Chapter Two.

Amongst those that are currently experiencing and suffering those health challenges are the inner-city dwelling Aboriginal people across Canada, from eastern Canada to western British Columbia. In order to understand the inner-city context for Aboriginal people, population data as it applies to Aboriginal people nationally, provincially, and locally in the Vancouver area is presented next.

**URBAN ABORIGINAL POPULATION**

In 2011, 56% of Aboriginal people lived in an urban centre, an increase from 49% in 1996. Relationships with urban landlords, searching for employment in urban economies, making spaces for Aboriginal cultures and languages in cities, interacting with neighbours from different cultures, and building urban Aboriginal programs and institutions is as much a part of Aboriginal realities as are land claims, conflicts over logging, hunting and treaty rights, and rural economic development (Newhouse & Peters, 2003). The growing Aboriginal populations living in Canada’s urban centres have increased dramatically since the 2006 Census. The Aboriginal peoples’ health care needs and issues continue to grow at a rapid rate. The sections that follow present 2011 Canadian Census data about the increasing population growth of First Nations, Métis, and Inuit people in Canada, many of whom have or will move to urban centres. This section about population data concludes with some issues about the urban Aboriginal population and the British Columbia context.

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12 The 2011 Canadian Census data for Aboriginal people in urban settings were the most recent data when this thesis was submitted for external examination.
CANADA’S ABORIGINAL POPULATION

According to Census Canada 2011, National Household Survey, 2011 reported that the total Aboriginal identity population in Canada is 1,400,685 representing 4.3 percent of the total Canadian population. Canada is comprised of First Nations,\textsuperscript{13} Métis,\textsuperscript{14} and Inuit\textsuperscript{15}

The five census metropolitan areas (CMAs) with the largest number of Aboriginal people include Winnipeg, Manitoba (78,420); Edmonton, Alberta (61,765); Vancouver, British Columbia (52,375); Toronto, Ontario (37,000); and Calgary, Alberta (33,370). The Aboriginal population increased by 232,385 or 20.1% between 2006 and 2011 compared with 5.2% increase for non-Aboriginals.

Living arrangement data of Aboriginal children aged 14 and under in Canada indicate that they lived in a variety of arrangements: 50% of Aboriginal children lived with both parents, either biological or adoptive, compared with 76% of the non-Aboriginal children; 34.4% of Aboriginal children lived in a lone parent family compared with 17.4% of non-Aboriginal children. Of the children in care, 48% were Aboriginal. Nearly 4% of Aboriginal children were foster children compared to 0.3% of non-Aboriginals.

CANADA’S FIRST NATION (FN) POPULATION

In 2011, 851,560 people identified as a First Nation person, representing 60.8% of the total Aboriginal population and 2.6% of the total Canadian population. Many FN people lived in Ontario and the western provinces, but they made up the largest share of the total population of the Northwest Territories, Yukon, Manitoba and Saskatchewan. In 2011, 637,660 FNs people reported being Registered Indians, representing 74.9% of all FNs people, 45.5% of

\textsuperscript{13} First Nations are registered or status Indian according to rules set out in the Indian Act and they are recorded in an Indian register maintained by Indian and Northern affairs Canada (CIHI, 2004).

\textsuperscript{14} The majority (84.9\%) of Métis people who identified themselves as Métis lived in either the western provinces or in Ontario. The largest population was in Alberta (96,865) where 21.4\% of all Métis in Canada lived. The next largest was in Ontario (86,015), where they represented 19.0\% of all Métis.

\textsuperscript{15} Inuit – Canada is home to 51,000 Inuit (Statistics Canada, Aboriginal Origin for population, for Canada, Provinces and Territories, (Statistics Canada 2006) a number that is expected to increase to 68,400 by 2017 (Statistics Canada, Canada’s Aboriginal Population in 2017, the Daily, June 28th, 2005). Inuit live in 53 arctic communities.
the total Aboriginal population and 1.9% of the total Canadian population. One-quarter of FN people (213,900) were not Registered Indians, representing 15.3% of the total Aboriginal population and less than 1% of the total Canadian population. First Nation people represent a large and diverse population. There are 60 FN languages. There are 600 First Nation Bands in Canada. The province with the largest FN population is Ontario with 201,000 or 23.6% of all FN people in Canada (Statistics Canada, 2016). The next largest is BC, with 155,020 or 18.2% of the total FN population (Statistics Canada, 2016).

CANADA’S MÉTIS POPULATION

Over two-thirds of Métis in Canada live in an urban area as indicated in Statistics Canada. In the 2011 Census, 637,660 identified themselves as a Métis person, which is 32.3% of the total Aboriginal population, or 1.4% of the total Canadian population. The largest segment of the Métis population live in Alberta, 96,865 or 21.4%; followed by Ontario, 86,015 or 19%; Manitoba, 78,830 or 17.4%; British Columbia, 69,475 or 15.4%; Saskatchewan, 52,450 or 11.6%; and Quebec, 41,000 or 9.1% (Statistics Canada, 2011, National Health Survey, 2011).

CANADA’S INUIT POPULATION

Inuit people represent 59,445 or 0.2% of Canada’s total population, which is 4.2% of the Aboriginal population. According to the 2011 Census almost three-quarters (73.1%) of Inuit in Canada, or 43,460 people, live in Inuit Nunangat. Inuit Nunangat stretches from Labrador to the Northwest Territories and comprises four regions: Nunatsiavut, Nunavik, Nunavut and the Inuvialuit region of the Northwest Territories. About 16,000 Inuit live outside Inuit Nunangat. Nunatsiavut, in northern Labrador has a population of 2,325 Inuit, or 89.1% of the total Inuit population in Canada. Inuit represent 89.1% of the total population of Nunatsiavut.

Nunavik, in northern Quebec, was home to 10,750 Inuit, or 18.1% of the total Inuit population. Inuit living in Nunavik accounted for 89.1% of the total population of this region. There were 27,070 Inuit who lived in Nunavut, which has the largest land mass and biggest Inuit population within Inuit Nunangat. Inuit living in Nunavut accounted for nearly half (45.5%) of the total Inuit population in Canada. Within Nunavut, Inuit represented
85.4% of the total population of the territory. The Inuvialuit region, in the Northwest Territories, had a population of 3,310 Inuit, or 5.6% of the total Inuit population. Inuit living in the Inuvialuit region accounted 57.6% of the total population of this region (National Health Survey, 2011).

**Canada’s Urban Aboriginal Population**

Increasingly, there are more Aboriginal people moving into Canadian cities (Statistics Canada, 2011). It is this Canadian urban Aboriginal population that I will focus on in this dissertation, particularly in Surrey, British Columbia. The term urban Aboriginal people refers primarily to First Nation, but also Inuit and Métis individuals currently residing in urban areas. According to the 2011 Census data off-reserve Aboriginal people constitute the fastest growing segment of Canadian society. In 2011, 18,485 or 23% persons identified as Aboriginal living in Metro Vancouver. Vancouver constitutes the largest Indigenous community in the province with 52,375 Aboriginal people (Statistics Canada, 2011).

**British Columbia’s Aboriginal Population**

According to Census Canada 2011, the total Aboriginal identity population in British Columbia (BC) is 232,290 or 17% of the national Aboriginal identity population, which is 5% of the total general population of this province. One in six Aboriginal people in Canada live in British Columbia. Almost one in four Aboriginal people resided in Vancouver although they represented only 2% of the total population living there. BC was home to 155,020 First Nations people, 69,470 Métis and 1,570 Inuit, with the rest reporting other Aboriginal identities (3,745) or more than one Aboriginal identity (2,480). From 2006 to 2011, the FNs population in BC increased by 20%, while the Métis population rose by 17%, and the Inuit population nearly doubled. Of those who identified as FNs people in 2011, almost three-quarters (73% or 112,405) reported being a treaty Indian or a Registered Indian as defined by the Indian Act of Canada. One third (33% or 51,045) of the FNs people lived on a reserve. Just under half (45%) of Aboriginal people in BC were under the age of 25, compared with 27% of the non-Aboriginal population.

British Columbia faces a challenge in ensuring that all parts of society and all populations can access health services and enjoy good health. While the health status of Aboriginal
people has improved significantly in several respects over the past few decades, the Aboriginal population in BC continues to experience poorer health and a disproportionate rate of chronic diseases and injuries compared to other residents of British Columbia.

**THE NEED FOR THIS STUDY: URBAN ABORIGINAL PEOPLE’S REALITIES**

The effects of colonization and neo-colonialism continue to impact the health\(^\text{16}\) of Indigenous people across Canada. I will use the third definition of health provided by Sartorius (2006) who asserts that “health is a state of balance, an equilibrium that an individual has established within her/himself and between her/himself and her/his social and physical environment” (p. 662). The emphasis on wholistic health will become evident in later thesis chapters.

Providing health and social services to distinct populations of First Nations, Métis, and Inuit has many hurdles including cultural barriers to accessing primary health services\(^\text{17}\) especially for those living in urban centres. Aboriginal people living in urban centres often face overwhelming social and health problems that are rooted in cultural dislocation and powerlessness, discrimination and economic hardship leading to emotional vulnerability to the isolation and alienation they find in the city (Native Friendship Centres Report, n.d. p. 9). Sometimes these issues of poverty, racism, and isolation may result in addiction to illegal substances and mental illness, often leading to a loss of social cohesion (Alexander, 1986).

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\(^{16}\) “Today, three types of definition of health seem to be possible and are used. The first is that health is the absence of any disease or impairment. The second is that health is a state that allows the individual to adequately cope with all demands of daily life (implying also the absence of disease and impairment). The third definition states that health is a state of balance, an equilibrium that an individual has established within himself and between himself and his social and physical environment.” https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2080455/

\(^{17}\) Primary health services are regarded as the first point of contact that an individual or community has with a health care facility. The World Health Organization (WHO) declared at the Alma-Ata conference in 1978 that primary health (ph) should be the means to achieve health for all by the year 2000. Canada embraced the goal through a focus on health promotion, as reflected in reports by Epp (1986), and the Canadian Public Health Association ([CPHA]1986). Nursing shares this vision; at the provincial, national, and international levels it has encouraged nurses to make (ph) a reality. Primary health is both a philosophy of health care and an approach to providing health care resources. Its basic elements are essential health care, socially acceptable and affordable methods and technology, accessibility, public participation, and intersectoral collaboration (Beddome, Clarke and Whyte, 1993).
This loss of cohesion is heightened when Aboriginal people are separated from their home territory, family, community and culture.

Notwithstanding the many healthy urban Aboriginal peoples, the inner core of Canadian cities contains a component of marginalized Aboriginal people who are disconnected from their traditional extended families, communities, cultures and nations. With higher than average growth in population over the last 15 years, the supply of housing and cultural supports for Aboriginal residents in Metro Vancouver falls short. In 2011 the estimated total population of Aboriginal people living in Metro Vancouver was approximately 50,000. The annual growth rate of the urban Aboriginal population in Canada has remained steady at 4.8% between 2001 and 2011; the current housing need is only going to increase.

Interestingly though, only 23% of Metro Vancouver Aboriginal residents live in the City of Vancouver (Urban Aboriginal Health and Wellness Report 2015–2020). The report notes further, though Aboriginal people only comprise 2% of Metro Vancouver’s total population, 31% of homeless individuals identify as Aboriginal.

More recently the Vancouver Aboriginal strategy indicates there are 18,477 people living in downtown Eastside Vancouver. The Downtown Eastside (City of Vancouver, 2011) is often labelled “Canada’s poorest postal code”, the average income in the neighbourhood is $12,000 per year (Culhane, 2009 p.160). More information is provided below about the Downtown Eastside of Vancouver because many of the female participants in this study either live in this area or have lived there and have accessed health services at the research site of this study.

**DOWNTOWN EASTSIDE VANCOUVER**

Downtown Eastside (DTES) has a much higher proportion of Aboriginal people than the city as a whole (City of Vancouver, November 7, 2013). DTES is also called “Q’umq’um al ‘ay,” is one of Vancouver’s oldest neighbourhoods and the historic heart of the city. DTES is considered by the Coast Salish communities as unceded land of the Coast Salish Nations, which means that they did not relinquish their land through treaty or other legal means. It has a mixed predominantly low-income population living in some neighbourhoods rich in history and strongly connected to its founding Aboriginal communities including Musqueam.
and Squamish First Nations. Japanese, Chinese and other cultured groups have early ties to the DTES neighbourhood (2013, p. 2).

The uniqueness of the DTES stems from the early settlements from Victory Square to Gastown to Strathcona. The total population of the DTES between 2001 and 2011, grew slightly faster than the rest of the city as a whole, though the rate of growth has slowed since 2006 (City of Vancouver, 2013, p. 6). The gender split in the DTES remained stable, approximately 60% male and 40% female. In 2006, just over half of the DTES residents were over 45 years of age. There is a high percentage of children (2%) and youth (8%) constituting about half the citywide percentage.

The basic income-assistance rate for a single, unemployed person designated “employable” was $325 per month as a shelter allowance from the provincial income assistance program. Rent for a small basement apartment in the low-income neighbourhood of East Vancouver begins around $600.00 per month. Hotels with single room occupancy and rooming houses – often in poor repair and lacking locked doors and private bathrooms in the DTES are available at welfare - shelter rates. Federal, provincial, and municipal social-policy decisions determine income- assistance rates, minimum wage levels, and accessibility of affordable housing, factors that shape the living-conditions for many Aboriginal people, particularly those who live off-reserve and in urban areas. The well-documented relationship between absolute and relative poverty and poor health make these government policies important determinants of Aboriginal and non-Aboriginal health in Canada (Culhane, 2009, p. 164).

Welfare office catchment areas are organized according to Canada Post mail forward station areas (FSA’s) that is a client’s first three digits code. Most of the DTES falls with V6A that extends from Carroll Street to Clark Drive and from Burrard Inlet to Great Northern way. The shelter component for a single employable person on low-income assistance (temporary assistance) is $375 and $235 for all other expenses. The DTES has the highest single occupancy resident (SOR) in the city; these places lack space to store and prepare food. The DTES has the highest concentration of free and charitable food in Vancouver.
SURREY’S ABORIGINAL POPULATION

Surrey has the largest population of Aboriginal children and youth in Metro Vancouver. There are 4,115 Aboriginal children and youth in Surrey, compared to 2,600 in Vancouver. There is a high number of Aboriginal foster children living in Surrey. A disproportionate number of Aboriginal adults in Surrey lack a high-school degree. However, most Aboriginal adults in Surrey do have a post-secondary education. The Aboriginal community in Surrey has one of the highest child and youth poverty rates in the region. These children and families face significant challenges and barriers (First Call, Surrey, May 18th 2016). During my employment with Fraser Health I regularly made visits to Kla-how-eya Aboriginal Center where I was told stories about the different treatment of urban Aboriginal people who lived in Surrey. Furthermore, young mothers shared their stories about apprehension and their reluctance to attend pre-natal classes or visit doctors during their pregnancy for fear of having their children apprehended. Surrey Memorial Hospital had the highest apprehension rate of Aboriginal infants.

I was interested in finding out more about how and why the urban Aboriginal people of Surrey seemed to be targeted in negative ways affecting their overall well-being. My choice of Surrey as the location for this study included my curiosity as to why there was such an increase in First Nations people locating to this city, as well as working there. More importantly, I was and am interested in learning about the health and social services located in Surrey, specifically services for the Indigenous population. I also heard that many Indigenous people would rather go to hospital emergency departments than go to provincial health clinics and services. Furthermore, I often wondered what services the urban Indigenous people were utilizing, if they were utilizing services and why they were avoiding receiving mainstream health and social services. Reflecting on my negative experiences of racism and discrimination I felt compelled to learn from urban Indigenous people’s stories and hoped that I could somehow contribute to their health services.

THE CENTRAL PROBLEM

Newbold (1998) states that, while Aboriginal people residing in urban areas may have access to a greater number of health care services, including access to traditional healers
through Native friendship centres, health services may not be utilized to their full benefit (p. 62). Primary health care services incorporating disease prevention and health promotion approaches are also not easily accessed (Shestowsky, 1995, p. 24). Access to health services refers to the ability of individuals or groups to obtain services they seek, and is widely regarded as an important determinant of health. According to Browne & Dion Stout (2012), health inequity refers to differences in health or access to care that result from structural arrangements that are remediable, and therefore unjust (p. 8). Equitable access does not mean that everyone receives the same number of services but fair and just distribution of resources, where the service provided is based on need. The services available for the research site do not match the services provided within the city of Vancouver, BC. In addition, there are approximately just 1000 more people living in Vancouver than Surrey, BC., and there is always a shortage of funding and resources to meet the urban Aboriginal people’s health needs. The fact remains that there are continuing disparities between Aboriginal and non-Aboriginal Canadians in their ability to access and utilize primary health care services. The reasons for these health disparities are complex, relating to a number of different factors, which have less to do with health and more to do with historical, socio-political and economic factors (Romanow, 2002; Smye, 2004). My personal story provided a historical context of negative impacts of social and educational policies that separated and re-located Aboriginal families and communities. Cultural dis-connection occurred. Moving to urban environments has often meant that Aboriginal people do not receive culturally responsive health care (Royal Commission on Aboriginal Peoples, 1996). To address these disparities, some urban Aboriginal organizations have attempted to improve the availability, accessibility, and acceptability of Aboriginal health services for urban Aboriginal people.

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18 Health Disparities are, first and foremost, those indicators of a relative disproportionate burden of disease on a particular population (Adelson, 2005).
ABORIGINAL-ORIENTED SOCIAL, CULTURAL, AND HEALTH SERVICES AGENCY

In urban settings, some Aboriginal organizations such as Aboriginal Friendship Centres or new agencies are expanding their services to include health and social services, or have been established for that purpose, such as Vancouver Native Health Society. What is not known is how Aboriginal agencies/organizations are providing culturally relevant health services and what Aboriginal people think about such services.

The research setting for this thesis is an urban Aboriginal oriented agency, known as Kla-how-eya, located in the lower mainland of British Columbia, which is the only agency that provides primary health and social services to over 11,000 Aboriginal people in Surrey, British Columbia and neighbouring communities. The commitment and vision of this urban Aboriginal agency provides an Aboriginal framework in guiding the implementation of social, cultural and primary health care services and programs. Their mission and values incorporate a wholistic approach of collaboratively working together to build relationships to enhance understandings of client’s Aboriginal health experiences. Health in this agency is seen in relation to family, community and cohesion versus mainstream health interventions that are often developed outside of a historical and cultural framework (Mitchell & Maracle, 2005).

For research purposes, what is needed is an understanding of how Kla-how-eya as an Aboriginal agency provides health services to urban Aboriginal people (availability); how they get access to its services (accessibility); and if they are satisfied (acceptability) with its cultural, social and health services. My research will emphasize health services, but it will also consider health in relation to the agency’s cultural and social services because of the wholistic nature of Aboriginal knowledge and culture.

RESEARCH PURPOSE, QUESTIONS, AND METHODOLOGY

The purpose of the dissertation is to more fully understand the experiences of urban Aboriginal people who utilize cultural, social and health services at an urban Aboriginal-

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19 I received permission from the 2016 executive director to use the name of the Aboriginal agency, Kla-how-eya. In 2011, its name was changed from Kla-how-eya to Fraser Regional Aboriginal Friendship Centre.
oriented agency, with an emphasis on health. Considerations for making the mainstream primary health care system more culturally responsive to urban Aboriginal people will also be examined. The following research questions guided this study:

1. What are the experiences of urban Aboriginal people in using health services at an urban Aboriginal cultural agency and elsewhere?
2. What hinders urban Aboriginal people’s use of provincial health services?
3. How can an urban Aboriginal cultural agency facilitate availability, accessibility, and acceptability of health services for urban Aboriginal people living in the Lower Mainland of British Columbia?

To address the research purpose and questions, methods included in-depth interviews and a sharing circle (focus group) with Aboriginal people using the health and cultural services, staff members, and board members. In addition, contextual information was gathered through stories shared by professionals who serviced the agency and several social and health polices. The participants’ stories, experiences and perspectives were gathered and analyzed by drawing on the “R” values outlined in Archibald (2008), and Kirkness and Barnhardt (1991): reverence, respect, responsibility, relevance, and reciprocity. Furthermore, the participants’ stories were also analyzed within a wholistic historical-socio-political context with adaptations using the Aboriginal Medicine Wheel approach. McCormick (1994) is one of many Indigenous scholars who utilize the Medicine Wheel, saying that “it is perhaps the best representation of an Aboriginal worldview related to healing. The medicine wheel describes the separate dimensions of the self – physical, emotional, mental [intellectual] and spiritual [cultural] – as equal parts of a larger whole. The medicine wheel represents the balance that exists between all things” (p. 33). I use the aforementioned wholistic health realms to contribute to an understanding of why Aboriginal people prefer to access cultural-based primary care services provided in an Aboriginal-oriented agency.

**Organization of the Dissertation**
The present chapter has introduced my personal context, my story, the research topic, population data about Aboriginal people, the research questions, and methodology. My
personal story is shared in the first part of this chapter to provide a real example of the intergenerational impact of colonial policies that have negatively affected many Aboriginal people. The remainder of the dissertation is organized so that Chapters Two and Three provide literature related to policy and theoretical approaches to lay a foundation for the methodological framework in Chapter Four, subsequent analysis in Chapter Five, and conclusions for Chapter Six. A fuller explanation of each chapter follows.

Chapter Two examines literature that addresses the impact of colonization on the lives and well-being of Aboriginal people with an emphasis on legislation and policy. Issues of Aboriginal urbanization are introduced as impacts of these colonial systemic structures. Aboriginal people have not been passive recipients of colonialism. The literature review demonstrates the expanding Indigenous knowledge movement for education and health that has introduced Indigenous health frameworks and concepts such as cultural safety and Aboriginal control of health. The research site, which is an example of the Indigenous Knowledge (IK) movement is introduced in this chapter. Cajete (2000) describes IK as the expression of the vibrant relationships between the people, their ecosystems, and the other living beings and spirits that share the lands … disturbing these interrelationships creates disharmony; balance is restored by applying appropriate actions and knowledge. Thus, knowing about the complex nature of Indigenous knowledge is an important context that relates to the totality required to maintain multi-dimensional balance and harmony for the participants in my study.

Chapter Three presents an Aboriginal health policy context in Part One and I introduce Hamumu as the theoretical framework in Part Two. The Aboriginal health policy context focuses on Aboriginal people living in the Fraser Health Region of British Columbia. Historical, cultural, social, demographic, and health data are presented as well as the role of Aboriginal people/communities/organizations in making health policy changes. In Part Two, the Hamumu Theoretical Framework incorporates Archibald’s (2008) Indigenous storywork principles of respect, responsibility, reverence, reciprocity, holism, inter-relatedness, and synergy and an additional principle of relevance from Kirkness and Barnhardt (1991).
Chapter Four provides a description of and rationale for the research approaches and methods that guided this study. Of most importance, an Indigenous approach was utilized in the design of this research. First Nations people have historically had negative experiences with non-indigenous researchers; therefore, there was a need to address this study in a culturally relevant way that includes ceremony and cultural protocols (Absolon, 2011; Smith, 1999; Wilson, 2008). Furthermore, Archibald’s Indigenous storywork principles and the Hamumu Theoretical Framework also served as methodological guidelines to honour the stories of participants in their own words and for establishing a research relationship based on trust and ethical responsibility between myself and the participants.

In Chapter Five, I first present the co-founders’ memories of establishing Kla-how-eya. Second, I share the clients’ stories of their positive experiences in receiving health services at Kla-how-eya. Third, I present a wholistic analysis and findings of the interviews and subsequent sharing circle with the urban Indigenous clients, Kla-how-eya care providers/staff, and members of Kla-how-eya’s administration. The Hamumu Indigenous Wholistic Health framework is used for this analysis that includes four health dimensions of physical, emotional, mental and spiritual realms.

Chapter Six, presents a summary of the research study. I discuss the findings in relation to the study’s three major research questions and the notions of available, accessible, and acceptable health care. The 4 C’s of an Indigenous Good Medicine Theory are presented. Inspired by Hamumu, this theory evolved from the participant’s stories, the literature, and my personal experiences to develop the concept of good responsive healthcare for urban Indigenous people. In addition, some policy implications, the significance and the limitations of the research study are discussed.
CHAPTER TWO: ABORIGINAL HEALTH—HISTORICAL AND CURRENT PERSPECTIVES

In this chapter, I first examine the literature about the historical and current contexts influencing urban Aboriginal people’s access and use of health services in British Columbia and, secondly, I introduce the research site. Colonialism, hegemony, and social change were forced upon First Nations people, where culture had to be practiced in secret to escape being imprisoned (RCAP, 1996). Practicing culture in this way reminds me of Hamumu entering its cocoon stage.

However, we know that Hamumu will transform into something beautiful, which gives hope for Aboriginal people’s culture.

Examining continuities from the past to the present help to explain how often government health policies and programs consistently fail to take seriously the experiences, the self-determined positions and decision-making involvement of Aboriginal populations (Culhane, 2009). I will attempt to articulate in this chapter and subsequent chapters, my evolving understanding of the historical and structural context which is critical for understanding the complexities of availability, accessibility, and acceptability of health services for urban Aboriginal people.

I begin by drawing on the works of Aboriginal and non-Aboriginal scholars who have written about the impact of colonization on the lives and well-being of Aboriginal people. I illustrate how colonial policy, which emphasized assimilation and re-location of Aboriginal people created cultural, health and social issues for urban Aboriginal people. Issues about primary health care and urbanization for Aboriginal people are then discussed. Despite the intergenerational impact of colonization, many Aboriginal people have resisted, shown resilience, and have revitalized their Indigenous knowledge (IK). Indigenous-based health

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20 I borrow from Browne, the term structural to refer to those fundamental structures in society – the state, the Canadian government’s social and economic status, local and global political economies, globalization and racialization, and dominant institutions including health, legal, educational and government systems – that define, determine and reproduce unequal power relations, racialization, class, and patriarchy as a basis for social relations (Browne, 2001).
values and approaches are then discussed. The chapter concludes with the introduction of the research site, which exemplifies a culturally responsive approach for health services for urban Aboriginal people.

**HISTORICAL CONTEXT OF COLONIALISM**

I highlight selected government policies to indicate the extent to which they controlled, manipulated and constrained Aboriginal people’s gendered, social, political, cultural, spiritual and economic relations within and outside Aboriginal people’s communities. A full discussion of these legislated discrepancies can be found in the Royal Commission on Aboriginal Peoples (1996c) and in other key readings (e.g., Boyer, 2009; Browne, 2003; Culhane 2009; Smye, 2004; Waldram, Herring, & Kue Young, 2006). I will discuss some of the policy issues from these sources in this chapter. Under colonialism, Indigenous peoples have struggled against dominant Western policies and laws. Indigenous attempts to reclaim land, language, knowledge and sovereignty through law and policies have usually involved contested accounts of the past by colonizers and colonized (Smith, 1999).

Since the time of first contact with Europeans, First Nations clans and groups across British Columbia have endured profound changes to their territories that continue to affect individuals, families and communities to the current day (King, 2013). The systemic subjugation of Aboriginal people has its origins in the colonial Canadian legislation that was embedded in the 1876 Indian Act. When the Indian Act first passed in 1876, it was designed to facilitate the administration of programs to Indians, as well as to their assimilation into mainstream Canadian society (Waldram et al., 2006).

The government introduced a series of policies aimed at deliberately relocating geographically remote, island-dwelling, Aboriginal communities. These policies were designed to reduce the administrative costs of delivering government services to these groups and were given legislative power under the Indian Act. The Royal Commission on Aboriginal People (RCAP, 1996) explains that the overarching goal of this resettlement scheme was to centralise Aboriginal people in urban centres for the purpose of reducing the

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21 Colonialism: Control by one power over a dependent area or people, also a policy advocating or based on such control (the Mirriam-Webster Dictionary, 1997).
costs of the administration and delivery of services such as health, education and welfare (RCAP, 1996).

Furthermore, the *Indian Act* provided the legal framework for the relationship between First Nations people and the Canadian government (Boyer, 2009). Aboriginal people lost their independence through enforced legislation, which set out regulations that affected virtually all aspects of their lives (Laroque, 1997). Many Indigenous scholars say this attempt to obliterate the existence of Indigenous people in Canada and elsewhere, reflects the lack of relevance, and respect for Indigenous knowledge, culture and worldview, particularly in educational institutes (Cajete, 1998; Graveline, 1991; Kirkness, 1991; Leroy Little Bear, 2000; Stonechild, 2006). This destructive process has been described as “ontological imperialism” (Livinas, 1961) and “cognitive imperialism” (Battiste, 1986).

The influence of colonization has had a lasting impact on almost every aspect of the social, economic, and cultural life of British Columbia’s First Nation communities. The relocation policy mentioned above is one that is not discussed much in the literature. However, it has certainly had intergenerational effects upon numerous First Nations. I return to a personal example.

For the Tlawitsis people who lived in Kalugwis including myself, the early 1950s from my recollection, seems to be the beginning of what I remember as the gradual displacement of our village. By the early 1970s, the last remaining members had left the island to new locations throughout Western Canada and beyond. This final emigration marked the beginning of a period of sustained social, cultural and physical disconnection that continues to affect our Tlawitsis people who moved to other areas of Vancouver Island, mainly Campbell River and Alert Bay. Other Tlawitsis people have moved to the Vancouver region.

The second most horrible memory was when I thought I was returning to my homeland, Kalugwis, for the summer months after I was boarded out to a family who owned a farm at Sardis, Chilliwack, BC. When I arrived in Alert Bay, BC I was brought to my sister-in-law’s home, only to find out that my grandparents and other Kalugwis village members had relocated to Y’alis, Alert Bay. I asked Auda why we were now living in this one room plywood wall shack, she replied, “The government moved us to here because we would
have more things.” From that day forward, I began to realize the changes that our village elders predicted, was beginning to happen. The displacement of whole communities by the federal government continues to shape my life and my children’s’ lives. Sending me off to the residential school, then sending me off to the BC mainland to attend high school and then relocating Auda and Dada to a place that wasn’t their home has continued to be a painful journey. Since the final exodus of families from Kalugwis, Tlawitsis members have become territorially alienated from their ancestral homeland, experiencing varying levels of social, isolation and cultural disconnection that have also continued to impact their health in every aspect.

**ABORIGINAL HEALTH ISSUES WITH PRIMARY HEALTH CARE**

The World Health Organization (WHO) declared at the Alma-Ata conference in 1978 that primary health care (PHC) should be the means to achieve health for all by the year 2000. Canada embraced the goal through a focus on health promotion, as reflected in reports by Epp (1986), and the Canadian Public Health Association ([CPHA]1986). This action created a paradigm shift from a focus on direct care to include health promotion and community development, consistent with a primary health care approach (Beddome, Clarke & Whyte, 1993). Aboriginal health outcomes are determined by a range of social and economic factors, many of which lie outside the direct control of the health care sector. However, health care system capacity and effectiveness are also important determinants of Aboriginal health. The development of community-level primary health care systems has become a priority for Aboriginal communities. (Smylie, Williams & Cooper, 2006).

Access to adequate, culturally appropriate primary health care is still an issue in many Aboriginal communities (Favel & Jock, 2004). Concerned about the health care system’s inadequacy to meet the needs of Aboriginal Canadians, particularly of those in urban areas, the Canadian Nurses’ Association (CNA) initiated a project to determine Aboriginal health-related concerns. The aim of the project was to determine how the expressed needs of urban-dwelling Aboriginal people could be met through a health care system based on primary health care (Shestowsky, 1995). Structural and attitudinal barriers to primary health care access were identified as the greatest problems facing Aboriginal people in urban centres.
Learning about basic services, their availability and ways to gain access to them were the most difficult problems or barriers faced by Aboriginal people.

A major part of breaking down barriers to health care access in Aboriginal populations is to make off-reserve primary health care services more familiar and non-threatening. A second factor is to tailor the service so it reflects, or at least is understanding of cultural norms.

Aboriginal people working in front line health delivery have tangible positive effects on Indigenous patients who access health services. I myself have witnessed the effects of this numerous times in hospital settings, health centres, community health and at educational institutions. I recall many times being referred to as the Indian Nurse, “is the Indian nurse here”? I guess I was perceived as understanding the needs of Aboriginal patients better because we shared cultural beliefs and values. On the other hand, I have worked with many non-Aboriginal nurses who were knowledgeable about Aboriginal cultures, which I admired greatly, especially when I was just newly employed. I recall one nurse who gave me an orientation to the Aboriginal community that she had worked with for many years. She was adopted by the community as one of its members.

It has been reported that urban Aboriginal people could be expected to achieve positive health outcomes based on their close proximity to mainstream primary health care services. The available data indicate that this is often not the case. “Research indicates that Aboriginal people may not be benefiting from mainstream services owing to the emphasis on biomedical models of health that conflict with more culturally-based, ethno-medical models” (Ivanitz, 2002, pp. 49- 57). Aboriginal people living within the urban-based communities continue to experience health inequities and barriers to accessing primary health care services.

Mainstream health programs are most often disease-specific, focusing primarily on the physical aspect of individual rather than emotional, cultural, mental, and spiritual (wholistic) aspects of health (Mitchell & Maracle, 2005). We must come to understand that conventional clinical approaches may not fit well with traditional Aboriginal values or with the realities of contemporary settlement or urban life (Adelson, 2005). Kirmayer, Tait, & Simpson (2009) suggest that there is a need to redress past wrongs, protect human rights,
and respect the aspirations of Aboriginal peoples both as individuals and as members of distinct nations, which are all crucial for the health, well-being, and moral order of Canadian society as a whole (p. 28).

Mainstream health and mental health interventions directed towards Aboriginal populations are often developed outside of a historical, socio-economic, political, psycho-social and cultural framework. Health and wellness will be realized among Indigenous individuals, families and communities when “self,” or niya, is liberated and challenged with shifting from a mainstream to a wholistic paradigm based locally and experienced organically. I use the Cree word by Dion-Stout (2015), a Cree speaker, a survivor of residential schooling, and who was a registered nurse for over 46 years. In her recent article, “Ascribed health and wellness, Atikowisi miýw-āyāwin, to achieved health and wellness, Kaskitamasowin miýw-āyāwin: Shifting the paradigm,” she uses the Cree language to describe her experiences, realities and aspirations because she believes language provides a ready and relevant window into society and Indigenous health.

Furthermore, Dion-Stout (2015) leans heavily on her Indigenous language in the hopes of opening vistas into the Cree culture and to provide insights into what shapes Indigenous health and wellness (p. 143). Moreover, she notes that “the struggle toward health, social, and health care equity has to respect the spirit of every individual and must find expression in the living contexts, or eyihta, particular to Indigenous peoples” (p. 144).

**Issues of Aboriginal Urbanization**

The impact of having to locate themselves to an alien environment has left many urban Aboriginal individuals struggling. Many urban Aboriginal people suffer from disadvantages similar to other immigrants within the Vancouver region, but as previously mentioned Aboriginal people also struggle against difficult conditions and overwhelming problems that are rooted in colonialism – cultural dislocation, powerlessness, social and economic hardship leading to emotional vulnerability to discrimination, racialization, isolation and total feelings of alienation in an environment that is strange in every way from their traditional territories. Frequent migration back and forth from cities to home communities
and from city to city may diminish the well-being of urban Aboriginal populations (Norris & Clatworthy, 2003).

Residential instability is associated with weakening family and social cohesion in communities, as a consequence individuals and families living in these areas exhibit greater social problems which in turn lead to even greater levels of social disintegration. Therefore, a major challenge for Aboriginal peoples living in cities is to maintain social cohesion through collective activities and community strategies that reinforce Aboriginal cultural identity and to develop urban institutions that reflect Aboriginal values, or ways of knowing (Kirmayer & Guthries, 2009).

Aboriginal people who live off-reserve frequently need to interact with the formal health care system in relation to their self-care and informal care giving roles. Sibbald (2002) argues that Aboriginal people have “little voice in articulating appropriate approaches to care, the incorporation of culture into the healing process, or approaches to teaching health-care practices that are consistent with Aboriginal ways of knowing” (p. 169). I believe that urban Aboriginal people have even less voice than First Nations who live on reserves who at least have some decision-making power in relation to health services that they provide to their members. The lack of involvement of urban Aboriginal people in developing relevant health services has resulted in health education and services that do not meet the needs of urban Aboriginal people. Wilson (1999) writes

that historical approaches to provision of health education and the use of Western planning frameworks and theories developed by non-Indigenous peoples have been largely unsuccessful for several reasons: the lack of conceptual frameworks of cultural differences; the absence of using traditional knowledge from the perspectives of Indigenous people and communities at the grass root level in linking knowledge to action to create change; and the lack of understanding by health educators, health planners, health care providers of the significance of health issues for Indigenous communities. (p. 12)

Clearly there is a need for addressing Indigenous knowledge for health care.
THE ROLE OF INDIGENOUS KNOWLEDGE FOR HEALTH

The recognition and intellectual activation of Indigenous knowledge today is an act of empowerment by Indigenous people (Battiste, 2002, p. 4). To reinforce Battiste’s point, many Indigenous scholars are articulating Indigenous ways of knowing that can be used to shape education and adapted for health education (Archibald, 2008; Battiste, 2000; Brown, 2005; Cajete, 2000; Castellano, 2004; Marsden, 2005; and Wilson, 2008). There is a shared understanding among many Indigenous peoples that education and well-being (health) is really about helping an individual find “his or her face, which means finding out who you are, where you come from, and your unique character ...Indigenous education is, in its truest form, about learning relationships in context” (Cajete, 2000, p. 183). Cajete also makes a specific point about the important relationship between cultural knowledge and medicinal knowledge. He says that Eurocentric researchers may know the name of an herbal cure and understand how it is used, but without the ceremony and ritual songs, chants, prayers, and relationships, they cannot achieve the same healing effect.

Brown (2005) developed a wholistic learning model for adults based on the Medicine Wheel philosophy, which he states is a traditional Indigenous model of human development that promotes wellness and good health. His Indigenous knowledge curriculum framework used the wholistic realms of the mental/intellectual, spiritual, physical, and emotional, with an emphasis on the emotional. Brown believed that one’s emotional competencies were denied in educational systems that Indigenous people experienced. He also added a fifth realm, the volitional to his wholistic Indigenous knowledge approach, which introduces an empowerment aspect to one’s actions and contributes to identity and good health.

Indigenous scholars, particularly those in the education and health fields are using forms of Indigenous knowledge to shape culturally responsive approaches that have relevance to my dissertation research, which will be discussed more fully in the next chapter.

INDIGENOUS HEALTH FRAMEWORKS

The development of an Indigenous health framework is one that demonstrates respect, sensitivity and engagement with the individuals and communities in providing culturally safe health care. Smith, (1999) suggests providing frameworks for hearing (acknowledging)
silence and listening to the voices of the silenced, to create spaces for dialogue across
difference (p. 103). While there appear to be several health education and health promotion
models and frameworks being used in the planning, implementation and evaluation of health
promotion and prevention programs, none appear to centralize culture as a critical force in
the prevention of disease and the promotion of health (Airhihenbuwa, 1995, p. 26).

Indigenous scholars criticized the limitations of Western science and actively advanced
methodologies that embraced Indigenous historical, social, political, economic, spiritual and
cultural realities (Absolon & Willet, 2004; Duran & Duran, 1995; Leroy Little Bear, 2000;
Thomas, 1993).

However, in the last 15 years, change began to happen with First Nations becoming more
involved in offering health programs and services that were culturally relevant and
responsive. After reviewing a few health research frameworks/conceptual models for
cultural relevance, the one model I resonated with is the Nuu-Chah-Nulth Nursing
Framework (See Figure 8). The Nuu-Chah-Nulth Tribal Council (NTC) symbology, depicts
a respectful partnership between the client and nurse. The partnership emphasizes respect,
which is at the core of NTC cultural beliefs and values, in addition, respect is very much at
the core of most Indigenous people’s cultural values, beliefs and teachings. One hand joined
by two arms shows that each partner has a responsibility and the two partners work together
to be responsible for self and others. The arm muscles depict the strength that each partner
brings to the relationship. The picture represents the natural rhythm and balance we create
with each other and with the environment as we work to improve and maintain a better state
of health (NTC, 2009). The Nuu-Cha- Nulth framework presents a balanced relationship
where neither person has power over another, which is very different from the medical
model discussed earlier.
Many scholars began to look at health and well-being from a comprehensive and wholistic perspective (Airhihenbuwa, 1995; Archibald, 2008; Cruikshank, 2005; Henderson, 2000; Wepa, 2007). Their frame of reference for good health was presented by Indigenous worldviews.

Furthermore, Indigenous perspectives of good health and healthy ways of being were interconnected to elements of Indigenous knowledge, spirituality and relationships. Indigenous concepts of health were and are wholistic in nature, locating individuals within the extended family and community contexts emphasizing interdependence and recognizing cultural and spiritual determinants of health. For example, Kwakwakawakw who harvested plants for medicine prayed to the plants before taking them, and elders still speak of the need to take only what is needed and to offer something back to the plants who have given some of their medicine (Kelm, 1998).

**WHOLISTIC HEALTH FRAMEWORKS**

Like Archibald’s principle of wholism (from an educational perspective) Marsden (2005) asserts that wholistic (or holistic) theory, as it relates to health and ways of living, was the most encompassing and relevant theory for her study. Following Marsden’s point of view,
that in an era of health reform, with emergent wholism and increasing dissatisfaction with entrenched health care systems, communities including Aboriginal communities are beginning to practice medical pluralism. Recent examples of the growing recognition of Aboriginal health practices can be found in the statements made in the Tripartite First Nations Health Plan. The Health Plan agreement was signed June 11, 2008, and reflects the vision of the federal and provincial governments and First Nations to work in partnerships in the development and implementation of new ways of delivering health programs and services (Tripartite First Nations Health Plan, 2008): a cultural wholistic approach to health.

A wholistic approach to health involves more than a seamless connection of services. This perception of health views the individual in the context of his or her family and community. This wholistic approach is an entire paradigm shift that is distinct from the Western medical model of health (Dialogue on the Tripartite First Nations Health Plan, 2008). According to Alfred (1999), good Indigenous leadership ensures that government is rooted in tradition and is consistent with the cultural values of the community (p. 22). It is with Alfred’s conception of Indigenous leadership in mind that my research respectfully acknowledges the cultural beliefs, and value systems of the First Nations, Métis and Inuit.

Furthermore, it is important to acknowledge the life experiences of the First Nations, Métis and Inuit (urban or otherwise), carefully listening to Indigenous stories that express experiences and perspectives of the impact social exclusion has on their decision whether or not to access mainstream health care services. The definition of social exclusion is relevant to my research:

Social exclusion can manifest itself in the form of racism and discrimination in Aboriginal people’s daily lives. Social exclusion can also result in social, psychological and spiritual aspects of ill health. It contributes to and perpetuates negative stereotypes, which in turn create barriers that prevent many Aboriginal people from accessing services. (Congress of Aboriginal Peoples, 2007, p. 8)

Aboriginal people who migrate to urban settings that are foreign to their values and beliefs often experience social exclusion and difficulties in accessing primary health services, often feeling alienated and alone without familiar supports. It is important for not only myself as a
health care professional to demonstrate genuineness and value each person’s uniqueness and respect them for who they are, but for all professionals who work within the Western medical model. Health professionals who work with Aboriginal people need to be respectful and open to learning about their cultural history and traditional ways, and open to understanding their cultural holistic worldview and practices. The health professional also needs to recognize the connection or inter-relatedness between Indigenous traditional knowledge, place-based knowledge, and well-being.

Waldram et al. (2006) indicate that, “there were many types of healers and medical practitioners among the Aboriginal people of Canada, there existed among Aboriginal peoples a ‘popular’ sector of medicine wherein certain knowledge regarding the maintenance of health and the treatment of illness or trauma was extant” (p. 133).

Airhihenbuwa (1995) asserts the belief that a state of balance exists between the individual and the environment and it is a concept that is true for all traditional healing modalities worldwide. Airhihenbuwa’s point is that, when people lose access and connection to their land, their health is threatened. Health becomes compromised due to loss of spiritual well-being and cultural identity (p. 51).

**ABORIGINAL CONTROL OF ABORIGINAL HEALTH FOR WELLNESS**

Healing is a means of recovery of the spirit, which Freire (1980) identifies as freeing ourselves. Brown (2004), states healing is necessary to reclaim affective competency within a wholistic context of Medicine Wheel teachings. Furthermore, healing is a necessary part of the drive for self-determination and self-management. Culture and issues of oppression are inter-related entities. Knowledge and understanding of the impact of oppression on culture is paramount in future planning within Aboriginal societies (Brown, 2004). Critical reflection of the past is an important pre-requisite to developing meaningful transformative strategies (Freire, 1997; Smith, 1999).

The Royal Commission on Aboriginal Peoples ([RCAP] 1996) has played a major role in providing an action plan to address the needs of Aboriginal people. RCAP saw “whole health” and healing as fundamentally important. To restore health and well-being, RCAP recognized that Aboriginal people required greater control over their social and economic
futures (1996). One example of this type of control, the Greater Vancouver Urban Aboriginal Strategy (UAS) recognizes that local communities are best placed to develop solutions that meet their unique opportunities and challenges (UAS, 2003). The ultimate goal of this strategy is improved delivery of mainstream health services, transferring control of health programs, services and funding from Health Canada to the Aboriginal communities. The transference of control is about including community input and decision making that includes communities to decide what should count as good, safe health care; resource allocation for good, safe health care; the ability to develop healthy accountability structures for Aboriginal people, as well as the validity and legitimacy of Aboriginal cultural preferences. Aboriginal people often do not utilize health services that are culturally unsafe which includes “any actions which diminish, demean or disempower the cultural identity and well-being of an individual” (Polaschek, 1998, p. 453).

CULTURAL SAFETY: ADDRESSING POWER INEQUITIES

Mainstream health programs are most often disease-specific, focusing primarily on the physical aspect of individual rather than emotional, cultural, mental, and spiritual (wholistic) aspects of health (Mitchell & Maracle, 2005). We must come to understand that conventional clinical approaches may not fit well with traditional Indigenous values or with the realities of contemporary settlement or urban life (Adelson, 2005). A recognition and understanding of power inequities and the role of cultural safety also needs to occur.

Ramsden (1993), a Maori nurse-leader in New Zealand, developed the concept of cultural safety within a nursing education context in response to colonizing processes that historically disregarded the illness and health belief systems of the Maori people, and instead privileged those of the dominant white culture in the construction of the health care system. “Cultural safety is, therefore, not about cultural practices; rather, it involves the recognition of the social, economic, and political position of certain groups within society, such as the Maori people in New Zealand or Aboriginal people in Canada” (Smye, 2006)

Viewing access to health care through the lens of cultural safety suggests that until unequal power relations in health care are acknowledged and addressed, the barriers to health care for minority people will remain (Ramsden, 1993). Ramsden (2000) also argues, “it is not
time but nurses’ ability to recognize the wider context of racializing experiences and responding to power differentials that contributes to trusting relations” (p. 10). Smye (2006) reports on the findings of the “Integrating Culture into Practice” Workshop, a Vancouver Island-Wide First Nations Nursing Conference which underlined the importance of fostering critical and social consciousness in nursing (and other health professionals) in relation to providing health care with Aboriginal Peoples (p. 17). From Smye’s point of view, cultural safety, is an important aspect of effective provision of primary health, and she reminds us that individual’s health problems are located within the domains of historical and structural disadvantage that shape them, and requires us to unmask the ways in which racism and unequal power relations have resulted in marginalization and poverty with its associated illnesses (2004, p. 268).

Browne (2007) also believes that power inequities may shape how some patients relate to provider or health care workers in a passive, quiet way, stating that this behaviour stems from people being told how to live, how to speak, and what language to speak for many years. I can attest to this point because in the past I had always second-guessed myself when often I was correct, but due to fears embedded from residential school experiences I sometimes felt passive and powerless in making choices for fear of being wrong.

**WORKING TOGETHER AS AN URBAN ABORIGINAL COMMUNITY**

Kirmayer and colleagues suggest that there is a “need to rethink the applicability of different models of [health] intervention from the perspective of local community values and aspirations” (Culhane, 2009, p. 163). The socio-economic pressures facing urban Aboriginal people require new ways of working together as a community. Urban Aboriginal populations find they are often isolated or scattered from their own cultural nation; therefore, they may identify with many Aboriginal nations or tribes rather than a single unique one that is their own. For example, one key conclusion drawn from interview studies in two different Aboriginal Anishnabe communities was that the incidence of diabetes brought “the community together,” renewed their recognition about the importance of “spirituality, culture, values, traditions,” and consequently generated “hope for healing” through “cultural belonging” (Sunday, Eyles, & Upshur, 2001, p. 16). Similarly, it may be the case for me attending the West Coast Nights held at the Vancouver Native Friendship
Centre when I lived in the eastern region of the Fraser Valley, in British Columbia. It was important for me to connect with other Aboriginal people and nations to share traditional food, dance, song, and drumming, as well it was important to be in a place where I felt comfortable, experienced a sense of belonging, and celebrated together regardless of diverse Aboriginal cultural backgrounds. We were brought together as a community of Aboriginal people living away from our traditional territories with the desire to be connected with Aboriginal people with distinct cultures, language and cultural identities.

The Vancouver Aboriginal Friendship Centre Society (VAFCS) and others like it started to open across Canada in the mid-1950s. Since then, approximately 118 Friendship Centres provide support for the rapidly growing urban Aboriginal population in Canada. The importance of cultural identity is demonstrated by the fact that the VAFCS has implemented weekly Family Night and West Coast Nights. Tuesday night is Family Night and was started as an open house for the Métis community of Vancouver to celebrate their heritage. Since then it has become a Powwow Night that regularly has 100 dancers and singers in the big gym. Wednesday night is West Coast Night. Each week is hosted by one of the West Coast First Nations. Upwards to 250 people attend and standing room only is a common occurrence. VAFCS’ goal is to promote respect and understanding to all those who are interested in Aboriginal culture. I have visited VAFCS several times and it is clear that it is providing a supportive environment, a sense of safety, trust and inclusivity of all Aboriginal cultures. The other vibrant urban Aboriginal Friendship Society in the Greater Vancouver area is the Fraser Region Aboriginal Friendship Centre (formerly known as the Surrey Aboriginal Cultural Society (SACS) and Kla-how-eya Aboriginal Centre), the site of my research. Some background information about this Aboriginal organization is presented in this chapter to exemplify how it addresses culturally relevant and responsive health programs and services.

ABORIGINAL-ORIENTED SOCIAL, CULTURAL, AND HEALTH SERVICE AGENCY
The Surrey Aboriginal Cultural Society (SACS) was registered on May 31, 1996, as a non-profit charitable organization in response to an Aboriginal grassroots’ vision that formed a

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cultural centre for the resurgence of Aboriginal culture, language and teachings. It was also known as Kla-how-eya, which means a greeting, “Welcome” or “How are you?” in the Chinook language. Its goals and objectives were to provide the Aboriginal community with a meeting place to enhance their cultural, economic, and social well-being. The clients utilizing these services have been a diverse socio-economic urban Aboriginal population, mainly non-status First Nation, Métis and a handful of Inuit (former administrator, personal communication, July 19, 2009). Kla-how-eya could be considered an operational example of the policy recommendations of RCAP (1996) noted earlier. I will use Kla-how-eya as the name for this agency for much of the dissertation because research participants used this name throughout their discussions with me. I received permission from Kla-how-eya administration to use its real name in this thesis.

This grass roots organization provided social programs and services for Aboriginal people living in the Surrey region. Over the years, Kla-how-eya has supported Indigenous people taking care of individuals and families in a different (cultural) way, giving different treatment, and caring for all aspects of clients’ physical, emotional, mental and cultural/spiritual needs. Kla-how-eya was also part of the Fraser Region Indigenous communities that came together to create a Fraser Health Aboriginal Health Logo (See Figure 9). The Fraser Health Aboriginal Health logo was later developed with input from members of the Aboriginal communities living within Fraser Region, creating an Aboriginal identifier displayed on the cover of Fraser Health Aboriginal Health Plan, during my time of employment. This Working Group’s vision was to design a visually identity that conveys a culturally-inclusive and caring organization.

Figure 9. Fraser Health Aboriginal Health Logo

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24 Used with permission from Leslie Bonshor, previous Executive Director, Aboriginal Health, on behalf of Fraser Health.
The Fraser Health Authority provided the funding to Kla-how-eya for staffing and services: Aboriginal Health Liaison Nurses and Community Engagement Coordinators. Kla-how-eya has also partnered with the B.C. Ministry of Child and Family Development and Kwantlen University College Nursing practicum to assist in community health prevention. As well, Kla-how-eya had established a number of touch points with the City of Surrey, Surrey School District and community stakeholders where they were making efforts to improve the educational and health status of Aboriginal people living in the area (Agency Proposal Narrative, June 27, 2008).

Besides promoting the health and economic well being of Aboriginal people, Kla-how-eya also promoted the resurgence of Aboriginal culture, language and teachings, particularly those of local residency. Kla-how-eya provided health-related social and health services at the time I conducted interviews, from 2009-2011. Starting in 1996, Surrey Aboriginal Cultural Society (SACS) had grown to have seven different departments. At the time of my interviews, I recall Kla-how-eya having the following services with a great focus on children and families: Early childhood programs – infant development; pre-post natal programs; monthly immunizations per health nurse for half-day; cultural programs; after-school tutoring; rental and employment services; Ministry of Children and Families development programs for the 60 apprehended Aboriginal children requiring supervised visits; nurse practitioner; visiting mental health worker; and cultural worker. All services at that time totaled 70 programs. Monthly encounters included, 1000 walk-ins [clients] and 2000 telephone encounters. Partnerships, funders and supporters included the following: United Way, Success by 6, Diverse City, Fraser Health Authority, BC Housing, Government of Canada, Community Resources Society, Community Action Program for Children, Public health Agency, City of Surrey and the Aboriginal Head Start Association of British Columbia (BC).

In 2015, Kla-how-eya or the Surrey Aboriginal Cultural Society (SACS) became the Fraser Region Aboriginal Friendship Centre Association (FRAFCA), BC’s newest Aboriginal Friendship Centre, committed to improving the quality of life to urban Aboriginal people of the Fraser Valley. FRAFCA continues to emphasize Aboriginal culture, language and
traditions through social, employment, educational, and early years programs for Aboriginal people of all ages. FRAFCA serves the following communities: Delta, Langley, Surrey, and White Rock. FRAFCA serviced 5800 clients in 2016.\(^{25}\)

On September 6, 2013, a new health clinic opened using the name, Kla-how-eya Healing Place, that offers “culturally safe, holistic primary care health services to urban Aboriginal people without a regular family doctor or nurse practitioner.”\(^{26}\) Its current location is within the Guildford Public Health Unit, in Surrey, apparently offering patients handy access to other public health services.

**CONCLUSION**

When First Nations, and Métis leave their homelands, many re-locate themselves to Vancouver (Metro Vancouver, 2015). It is well documented, reported and understood that Indigenous health is one of the most important health issues facing our country (RCAP, 1996). Access to wholistic health and health care for urban Aboriginal peoples is paramount as discussed in the section about *wholism*, a much-utilized Indigenous philosophical concept that refers to the interrelatedness between the physical (body and behaviour/action), emotional, mental/intellectual and spiritual/cultural realms to form a whole healthy person.

While each Indigenous group has developed their own cultural content for the wholistic circle symbol, as I have with the Hamumu Indigenous Wholistic Health Framework (to be discussed in Chapters 3, 5 and 6), a common goal is to attain and maintain mutual balance and harmony among animals, people, elements of nature, and the Spirit World. The challenge is how do urban Indigenous populations maintain their cultural beliefs, ways of being and knowing which is believed to be crucial to their well-being and ways when located within inner city environments? At the same time, I am encouraged by the fairly recent establishment of the First Nations Health Council, Aboriginal Health Services, development of additional Aboriginal Friendship Centres, urban Aboriginal social, cultural, and health service centres/providers that are working in partnerships with provincial health

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\(^{25}\) Personal telephone communication, executive director, September 19\(^{th}\) 2017

\(^{26}\) See: [http://www.fraserhealth.ca/health-info/health-topics/aboriginal-health](http://www.fraserhealth.ca/health-info/health-topics/aboriginal-health)
services to meet the physical, emotional, mental/intellectual and spiritual/cultural health needs of a diverse urban Aboriginal population.

Mokuau and Fong (1994) suggest that the responsiveness of health services may be measured according to three criteria: availability, accessibility, and acceptability. Heather Clarke, professional health practitioner and scholar interprets these three criteria respectively: How do we find health care services? (availability). Can we get into these places that provide these services? (accessibility). Will the services meet unique needs as identified by urban Aboriginal people? (acceptability). The literature selected for this chapter mainly identified how colonialism and the current misunderstanding of Canadian society continues to have a huge impact on the current health and social wellness of urban Indigenous people who have located to inner cities.

What is missing is scholarship about urban Aboriginal people’s experiences with using such services, as well as perspectives about Aboriginal staff and leaders who provide culturally relevant and responsive health services. The purpose of my study is to examine a well referenced, well attended Aboriginal agency to determine from participants’ perspectives and storytelling why this particular health and social agency services is preferred over provincial health services.

My hope is that the ‘voiced’ perspectives and personal life experience stories of urban Aboriginal people will like Hamumu, act as transformative actions for positive change and development. Urban Aboriginal people’s stories could “take on their own life” and “become the teacher” to provide understandings about urban Aboriginal health policy, programs, and practices (Archibald, 2008, p. 1). Just as Hamumu (butterfly) has the capacity to travel to other locations to become a form of Indigenous knowledge, my research about urban Aboriginal people’s health experiences will privilege their stories that emphasize liberation and freedom. My research will contribute to the re-emergence of urban Aboriginal people’s knowledge and understanding of Indigenous history as they move forward. Furthermore, my

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27 Personal communication, July 3, 2009.
research will inform the future development of Indigenized health frameworks that will be relevant to health, social and education program service delivery.
CHAPTER THREE: POLICY AND THE HAMUMU THEORETICAL FRAMEWORK

PART ONE: ABORIGINAL HEALTH CONTEXT

This chapter includes two major parts, with the first part focusing on the health policy context of Aboriginal people living in the British Columbia Fraser Health Region, which is the geographical location of my research. Part One has three sections to provide an overview of the historical, cultural and social context of policy development in the provision and delivery of Aboriginal health services. The first section introduces population, demographic, and health data about Fraser Health Authority’s Aboriginal Communities. Section two explores issues and impacts related to colonial and dominant (government) health policies.

Section three examines the struggles and possibilities for changing Aboriginal health policies and practices. To close the gap in health outcomes between Aboriginal people and other British Colombians, the status quo must be challenged through the pursuit of policies that acknowledge collective Aboriginal participation in defining responsive health care that is culturally focused to meet the needs of urban Aboriginal people. In order to meet this culturally responsive health challenge, other paradigm shifts are needed such as theory that is also culturally responsive or based on Indigenous knowledge.

Part Two introduces the Hamumu Theoretical Framework that I developed as an example of Indigenous theory and serves as a guide to this study. This framework is an exemplar of Indigenous knowledge, which is both culturally specific and adaptable to other Indigenous cultures. More will be said about this point in the theoretical section below. The interrelated nature of Indigenous knowledge will be continued in chapter four, where the Hamumu Theoretical Framework will also serve as an Indigenous methodology.
SECTION ONE: ABORIGINAL COMMUNITIES IN THE FRASER HEALTH AUTHORITY.

In British Columbia, health services are delivered through regional health authorities. The Fraser Health Authority (FHA) is mandated by the BC Ministry of Health to deliver health care to populations that reside within the Fraser region, between Burnaby and Boston Bar, BC. These agencies have regulatory responsibilities for the maintenance of safe levels of public health amongst the population within each of their catchments. Their Boards and senior officers each control hundreds of millions of dollars and employ thousands of health care workers. The Fraser Health Authority came into existence December 2001. Prior to the formation of the FHA, for Aboriginal people, the Fraser Valley Aboriginal Health Council provided policy direction for nine years until the formation of FHA. The Fraser Health Authority was created as part of a province-wide restructuring of health authorities, under the leadership of former Premier Gordon Campbell. It merged three former health regions: Simon Fraser Health Region, South Fraser Health Region and the Fraser Valley Health Region. FHA now provides policy direction with full participation of community members. A Fraser Salish Regional Caucus now provides Aboriginal community health policy and program input. FHA provides health care services to more than 1.48 million residents, from Burnaby to Boston Bar. This is BC’s largest health authority by population. Between 2014 and 2019 the expected population increase is estimated at 163,000 people for a total of 1.86 million. Fraser Health Authority has three Health Service Delivery Areas (HSDA, 2012): (1) Fraser Health South, with 738,107 people; (2) Fraser Health North, with 623,357 people; and (3) Fraser Health East, with 288,598 people. Fraser Health Authority represents 22 municipalities.

Building a population profile of Aboriginal people in the Fraser Health region is complex and difficult because a variety of data comes from many sources. In some instances, data

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28 Also, Fraser Health, FH, will be used.
29 In December, 2011, a new Partnership Accord was signed where each Coast Salish Region had their own representatives resulting in an Aboriginal health steering committee made up senior representatives from Fraser Health, Fraser Salish and First Nation Health council that formed what is now known as the Fraser Salish Regional Caucus. The purpose of the Accord was to achieve greater service integration through sharing decisions on planning, management, service delivery and evaluation of culturally appropriate, safe and effective practices.
30 See https://www.fraserhealth.ca/media/FraserHealthStrategicOperationalPlan2014-2017.pdf
refers to all Aboriginal people, while other data has been collected exclusively about First Nations status individuals. However, the current estimate of Aboriginal people (First Nation, 56%; and Métis, 40%) of Fraser Health puts the total number at three per cent or 52,000 self-reported as Aboriginal, of the total Fraser Health residents (FH Aboriginal Profile 2006). There are 32 Indian bands, with the majority of individuals living in urban settings.

It is important to note that the actual Aboriginal population is reputed to be higher than reported here. There are a variety of reasons for this, including in federal legislation, inconsistent answers to the ancestry question in census questionnaires, and incomplete enumeration of some reserves. Three main tribal groupings are part of Fraser Health: (1) Coast Salish lands extend from Burnaby to Hope and South to the US border; (2) St’at’imc is located near Lillooet in the Interior; and (3) Klaka’pamux is in the Thompson Fraser canyon, extending from Hope to Boston Bar. Of the three main tribal groupings within Fraser Health, the Coast Salish account for the majority of the First Nations population. Although Coast Salish is not the traditional First Nations name for the people occupying this region, this term is used to encompass a number of First Nations Peoples such as the Klahoose, Homalco, Sliammon, Sechelt, Squamish, Hal’qumeylem, Ostlq’emeylem, Hul’qumi’num and Pentlatch Strait. Many of the First Nations in the first tribal grouping noted above are encompassed by the Stó:lō Nation and are known as Stó:lō.

Of the 199 First Nation communities in British Columbia, 35 are located in the Fraser Health region constituting 17% of the total First Nation communities/bands in the province (see Figure 10). All but three of the First Nations communities are served by Fraser Health. Status First Nations people make up about 50% of Fraser Health’s Aboriginal population.

The enumerated population of these First Nations community’s totals 4,590 or 12% that reside on reserves. Aboriginal people living off-reserve, constitute 88% or 33,515 people (FH Aboriginal Profile, 2010). Other tribal groupings are important to health planning in the FHA, specifically non-status First Nations, Metis, Inuit and First Nations people from other regions who are physically located within this region. The Aboriginal communities are quite

scattered and some are located in very remote parts of Fraser Health region. Fraser Salish Nations and First Nation Health Council are the responsible health governances for the 35 First Nation communities in the FH region (Aboriginal Health Profile, 2010). FH has the lowest number of Aboriginal people living on-reserve among the five health authorities.

**Figure 10.** First Nations Bands in Fraser Health.

Three Bands physically located in Fraser Health—Samahquam, Skatin and Douglas—are served by Vancouver Coastal Health Authority because washed out bridges result in their only access being through Pemberton.

**Aboriginal demographics of the Fraser Health**

Before considering the health status of the Fraser Health’s Aboriginal population, it’s important to consider some more statistics. In many instances, these point to issues relating to the determinants of health (DoH) as well as factors to health service planning. Aboriginal people continue to experience social, economic and historical disparities. Despite recent improvements in many indicators, the report shows that status First Nations still have lower:

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• life expectancy

• higher infant and child mortality rates

• higher rate of injury and health due to motor-vehicle collision, falls and accidental poisoning, suicides and alcohol-related mortality. (Joint Report from PHO of BC and the FNHA, 2015)

Age

The Status Indian population in both the province as a whole, and Fraser Health, is younger and has a higher birth rate compared to all other BC and Fraser Health residents. Points of note include:

• The largest population group is 1-14 years, in which males slightly outnumber females.

• Among adults, the largest population group is made up of people between the ages of 30 and 44. Females outnumber males in the 30-44-year bracket.

• Seniors, age 65 years or older were estimated as the smallest group among Status Indians age 75 and over than those who are between 65 – 74 years.

Education

Basic literacy and higher education are key determinants of health and well being. Education affects employment opportunities and is directly correlated with income, higher education usually leads to higher paying jobs, more job options and greater employment. Some facts illustrate circumstances facing Aboriginal people in the area:

• Individuals living on reserve have lower levels of education than the provincial average

• In Fraser Health less than one-half who enrol in grade 8 graduate with a high school diploma within six years.

• In New Westminster and Burnaby school districts, only one-third of Aboriginal children achieve a high school diploma, 14% of the Aboriginal population aged 15 years and over have some university education.
• Aboriginal population within Fraser Region aged 25 – 64 have some university education.

• Halq’eme’ylem is now a provincially approved second language option for Fraser Valley students in grades 5 - 12

• Communities in the eastern part of Fraser Health generally have a lower proportion of residents with less than grade 9 education as well as having a lower proportion of residents with university education than their counterparts in the western areas of Fraser Health.

Income and unemployment

Aboriginal people with paid employment earn less than the provincial average; this may be due in part to the part-time or part-year work among Aboriginal people. Not surprisingly, with lower levels of education among Aboriginal people in the eastern part of Fraser Health, a parallel pattern emerged during the 2006 census relating to unemployment. At that time, the communities in the eastern part of Fraser Health had higher unemployment rates for both the Aboriginal people and the total non-Aboriginal population of Fraser East (22% and 5.3% respectively). For example, nearly a quarter of the Aboriginal residents in Hope, Chilliwack and the Agassiz/Harrison areas were unemployed. One-parent families (52%) had income at or below low-income cut-offs.

The higher unemployment rates are reflected in the lower average incomes for the Aboriginal population (2011 Census).

• Aboriginal male 15 years and over earned on average $25,680 annually while a male in the general population earned $32,581.

• Aboriginal females on average earn less than their male counterparts.

• Only 6% of the total BC Aboriginal population earns more than $40,000.

• Of the on-reserve Aboriginal people over the age of 15, 22% are unemployed, four times higher than non-Aboriginal people.

• Aboriginal people on average earn less than others.
Aboriginal Health Statistics in Fraser Health

Extensive health statistics are available for Status Indians in Fraser Health. Statistics include four distinct regions: Simon Fraser/Coquitlam, South Fraser Valley, Fraser Valley, and Burnaby (Aboriginal Health Profile, 2010; PHO Report, 2013, O’Connor, E. 2015). Life expectancy, mortality rates, and hospital rates will be discussed in this section as they relate to the Fraser Heath region as a whole.

Life expectancy

Life expectancy as reported in, FN health and Well-Being (November 2015) has long been regarded as a reliable indicator of the overall health of a population. Life expectancy tends to be higher for females, for the wealthy, and for married couples. The target identified in the Transformative Change Accord: First Nations Health Plan (TCA: FNHP) is a 35% reduction in the gap in life expectancy between Status Indians and other BC residents by 2015. Life expectancy of Status Indians has improved since the Transformative Change Accord (TCA) baseline year (2001–2005). The average life expectancy for Status Indians in the most recent period, 2013, is 75.9 years, compared to 81.6 years for other residents. This is an increase of 1.6 years from the baseline of 74.3 (2001–2005) among Status Indians (SI), which was larger than the 1.0-year increase for other residents during the same period. The 2015 report indicates that if life expectancy continues to increase life expectancy for Status Indians will be 76.2 years. Despite this progress, life expectancy for Status Indians is currently projected to fall short of the TCA target (77.1 years). It is noted in this 2015 report that while a comprehensive discussion of causes and explanations of trends are beyond the scope of the report, it is noted that some listed indicators impact the trajectory of others; for example, one way to further increase life expectancy is to improve infant mortality rates.

Mortality Rates

Age-standardized mortality rate (ASMR) measures the number of deaths due to all causes, expressed as a rate per 10,000 population. This measure allows for comparison in death

33 The First Nations Health and Well-being is a Joint Report from the PHO of BC and the FNHA, an interim update that provides progress made to close the gaps between FN and other British Columbians, in accordance with the targets and indicators set out in the TCA: FNHP (2006), furthermore, in accordance with commitments in the initial 2005 TCA.
rates between Status Indians and other BC residents by adjusting for differences in population age distribution. The Transformative Change Accord: First Nation Health Plan (TCA: FNHP) target is a 35% reduction in the gap in mortality rates between Status Indians and other BC residents by 2015. ASMR for Status Indians has fluctuated over time but continues to decrease. It has improved since the baseline year (2005) and since the last update year (2010). In 2013, the AMSR for Status Indians was 72.1 per 10,000 population, compared to 43.7 per 10,000 for other residents. While there has been an increase in the raw count of Status Indian deaths from 2005 to 2013, the ASMR for Status Indians decreased by deaths per 10,000 population (from 87.9 deaths per 10,000 population among Status Indians in 2005, to 72.1 per 10,000 in 2013). This decrease in rate was larger than the 8.6 per 10,000 population reduction in ASMR for other residents over the same period (PHO & FNHC, 2015, p. 7).³⁴

Fraser Health had the lowest Status Indian mortality rate across all health authorities in BC (64.8 deaths per 10,000 population) while Vancouver Coastal had the highest (78.7 deaths per 10,000 population). Fraser Health’s other residents’ rate of 53.6 deaths per 10,000 population was 11.2 deaths per 10,000 lower than Fraser Health Status Indians’ mortality rate.

**Hospitalization rates**

According to the Provincial Health Officer’s Report 2006/2007 (PHO’s) 83% of Status Indians visited a doctor or other practitioners yearly compared to 87% of other British Columbians. Status Indians were hospitalized at a rate 1.6 more times than that of other British Columbians. The most common admissions were for digestive system diseases, pregnancy, childbirth, injuries and poisoning (PHO’s Report, 2006/2007, p.180). Status Indians had higher rates of hospitalization in all categories (ibid, p.180). Aboriginal Health reports use and report on different health indicators. There are no current data on recent hospitalization or discharge rates.

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³⁴ See https://www.fraserhealth.ca/media/Aboriginal%20Profile_2010.pdf
SECTION TWO: ISSUES WITH COLONIAL AND DOMINANT HEALTH POLICIES

The existing data and statistics point to some of the challenges faced by Aboriginal communities and there appears to be little political will to have a diversity policy that will recognize the uniqueness of Aboriginal communities and their unique health needs. Community members continue to ask, “How many more statistics and data do they (governments) need, before change happens in terms of funding and change to development of programs and service delivery?”

Health Status is the physical, emotional, mental and spiritual well being of a population, which can be assessed objectively using measures such as births and deaths or subjectively through community health surveys. Most of the Aboriginal health statistics collected by government are related to Aboriginal persons who are registered with Indian and Northern Affairs Canada (INAC) or who live on reserve. There is very little statistical data about the health of Non-Status First Nations, Métis and Aboriginal people living in urban areas.

In spite of numerous reports and initiatives undertaken by the federal, provincial and regional health authorities to address the significant health needs of Aboriginal people in Canada:

The fact remains that there are deep and continuing disparities between Aboriginal and non-Aboriginal Canadians both in their overall health and in their ability to access health care services. The reasons for this are complex and relate to a number of different factors, many of which have less to do with health and more to do with social conditions (PHO & FNHC, 2015)

Challenges to Receiving Health Services

While the health needs of Aboriginal communities are great, many Aboriginal community members do not receive timely health services, which is largely due to the remoteness and scattered nature of some communities. A lack of service coordination and/or the complexity of jurisdictional issues such as whether or not an individual resides on-reserve or off-reserve is another factor. A major challenge to Fraser Health is the complexity of funding for Status First Nations. Formerly Health Canada through First Nations and Inuit Health provided the majority of the First Nation on-reserves with health transfer agreements, while other First
Nation communities are in integrated services agreements. Each type of agreement has their benefits and drawbacks. When I worked for the Fraser Health Authority and Vancouver Island Health, I noticed that if a First Nation Band was in an integrated agreement, the Band and community received more integrated programs and services, with mainstream health providing many outreach health services and resources. Whilst those communities that were on a transferred services agreement, didn’t receive as much support, funding or extra resources to meet their community needs.

There is a lack of understanding of different services entitled to Status FN, Non-Status FN, Métis and Inuit people and as well the various health services available for Status FN, living on and off reserve. The largest gap is the lack of knowledge and understanding of legislated colonization and social control aspects that the Indian Act has placed on Aboriginal people that remains today, although albeit subtle.

**Colonial Dominant Policies**

Indigenous people have experienced 500 years of colonization and the effects of ethno-cultural stress on health status. Loss of Aboriginal identity, language, self-esteem and nurturing ways are some of the multiple, multi-generational losses which have contributed to the erosion of Aboriginal self-reliance and collective responsibility for health. Canada’s history of colonization and the attempted assimilation of Aboriginal peoples are similar to many other countries, including Australia and New Zealand (Airhihenbuwa, 1995; Smith, 1999).

Prior to European cultures the Aboriginal people had social and political systems. As a result of contact with the European cultures many changes within these social and political systems of Aboriginal people occurred (Alfred, 1999; Duran & Duran, 1995; Henderson, 2000). Three major historical events helped to destroy the cultural foundation of Canada’s Aboriginal peoples, epidemics that took the life of large percentages of members of then self-sufficient communities, disabling those remaining (Segall & Chappell, 2000); development of reserves of limited size and resources as places for the people to reside and removal of children from the influences of family and community to first industrial and then residential schools (Aboriginal Healing Foundation, 2005; Truth and Reconciliation
Commission of Canada [TRC], 2015), in most instances, which were too far away to encourage on-going contact with family, community and culture.

Many Aboriginal Nations are in a state of crisis. This state of crisis can, in part, be directly linked to various historical and contemporary social and public policies and programs. The policies and their associated programs, like the impact of residential schools and the reserve system have contributed significantly to Aboriginal social and political marginalization and oppression (RCAP 1996, TRC 2015).

**Residential schools**

In Canada, Sections 113 to 122 of the Indian Act (Aboriginal Healing Foundation, 2005) legally removed the rights of Aboriginal parents to their children, giving the government total control over the children’s lives (King, 1996; Middleton-Moz, 1989; Miller, 1996), including my life from the time I was five years old to the age of 15. Beginning in 1861 and as recently as the 1990s, Indigenous children were removed from their families (Legacy of Hope Foundation, 2003; TRC 2015) to be trained in residential schools, often long distances from their homes, forbidden to speak their languages or to practice their cultural ways. The residential school experience seriously disrupted family units, communities and nations and to date continues to have serious inter-generational effects, touching every aspect of community life today (TRC, 2015).

Clearly residential schooling was effectively used as a colonizing weapon intent on destroying the social, economic, political, cultural and spiritual ways of being for all Aboriginal people in Canada. The schools “were designed to destroy every last remnant of alternative ways of knowing and living, to obliterate collective identities and memories and to impose a new order” (Smith, 1999, p. 69).

Residential schooling has affected every Aboriginal family in Canada and continues to have a lasting impact on the daily lives and well being of Aboriginal people. Smith (1999) writes about cultural identities being fragmented by the forces of colonization: “People now live in a world which is fragmented with multiple and shifting identities, that the oppressed and the colonized are severely implicated in their own oppressions that they are no more nor less authentic than anyone else” (p. 97). The rapidly changing Canadian Aboriginal context
requires a multi-layered approach to bring healing to over a century of oppressive practices forced upon Aboriginal people, particularly those who have been forced to relocate to the inner cities of the BC Mainland.

SECTION THREE: STRUGGLES AND POSSIBILITIES FOR CHANGING ABORIGINAL HEALTH POLICIES

Across Canada there have been many different policies developed regarding Aboriginal health. Each province and territory is vastly different not only in their Aboriginal population but in health needs, government, geographic distribution and economic opportunities. This diversity has lead to many different policies being developed or not developed in the many areas of health, e.g., research, primary care, health promotion and prevention, mental health and addiction, traditional medicine and Aboriginal culturally focused health.

The current policies, roles and responsibilities are characterized by enormous inequities between the federal, provincial governments and Aboriginal peoples. Needless to say, in comparison to Aboriginal people, the federal and provincial governments and their structures dominate with respect to the human and system resources that are applied to carrying out their policies, planning and program roles and exercising their service responsibilities (BC First Nation Leadership Council, 2005).

The responsibility for legislation, policy, planning and control is assumed by different departments and ministries of governments. Barriers are created, and contradictions are entrenched by officials who are unaware of the effect that their mandates have on the mandate of others. It is left to First Nations to make the “stove-piped programs and funding arrangements” work within the reality of their communities and expending limited resources on finding ways to synchronize the activities that are funded under one arrangement with the projects that are supported through another department of the government.

Currently, the requirements of the governments for Aboriginal peoples’ accountability are mostly defined in funding agreements and decisions made by governments. British Columbia’s Aboriginal people do not consider these requirements to be reciprocal in any way. Sawyer (1989) maintains, mainstream society continues to operate from positions of privilege, while Aboriginal people continue to internalize contradiction while questioning
government decisions (p. 5). Aboriginal people continually have to report how resources are spent in order that government officials can justify their work to Ministers who, in turn, justify their actions to Parliament. Government operates often from a micro accountability position. It requires many reports and relies heavily on statistics and paper.

**Policies driven by culture**

Aboriginal organizations tend to rely on relationship accountability; people rely on whom they know and where they originate from and origin of family roots (Wilson, 2008). Aboriginal organizations see great value in small accomplishments and make sure these are recognized, versus governments that tend not to recognize accomplishments unless it’s their manipulated outcomes. Policy within Aboriginal organizations is driven by culture. It stems from a belief system that all people’s culture, teachings and worldviews are valued (Bishop, 1985; Bhabha, 1994; Smith, 1999), unlike government policy that is primarily centred on limiting legal implications for the organization and staff and ensuring a standard. Government policy seeks to limit, Aboriginal policy seeks to expand the roles, functions and capacity of people to meet identified needs.

**Aboriginal health worldview versus mainstream health policies**

Likely government policy would seek to limit the conditions under which a homecare aide could do his/her work in an effort to reduce risk and legal implications. Aboriginal policy would look at taking risks to meet individual’s needs. Aboriginal policy is open to partnerships and finding the program, service etc. that best meets the need, which requires creativity, and uses combinations of funding to develop programs.35 While Indigenous people may have similar goals as non-Indigenous people, planning health services would be guided by Indigenous communities’ cultural beliefs, values and traditions.

Foucault’s concept of ‘governmentality’ can be seen happening in the following policy differences. Foucault (1979) looks at people and the power afforded to the elite (mainstream society) and the forces that result in policies that affect the Aboriginal people. For example, if we look at what a pandemic outbreak might look like, it would require having an Aboriginal specific communication plan and education opportunities that consider the

35 Personal communication, Nursing Pandemic Outbreak planning, 2011.
unique experiences of Aboriginal people and their impact on a pandemic response. In the event of a pandemic outbreak, provincial Medical Health Officers (MHO’s) and the BC Centre of Disease control hold the right to declare an emergency and impose any necessary restrictions to the public, not First Nations and Inuit Health (FNIH) MHO’s. An example might be the restriction of public gatherings and school closures to prevent the spread of disease, the establishment of mass immunization sites or travel restrictions. Who declares this emergency I think is not the issue. The issue is for Aboriginal people who have suffered from previous laws restricting spiritual practice and the requirement to have travel permits. What would be the consequences if they were unable to hold funerals or gather for ceremony for those who pass on? Would they abide the ban? Our reality is that the consequences of communicable disease, influenza and small pox are still current memory for our communities and further disruption to our grieving processes holds consequences.

There is a national committee of physicians who will set the protocol and ethical standards for immunization and treatment triage. In the event of a pandemic outbreak, there will not be enough vaccine prepared to vaccinate everyone. The priority may be health professionals, first responders and those of child-bearing and working age: not the frail, elderly or children, a different value perhaps than one that Aboriginal people would have prioritized. Also for triaging treatment, physicians may have to make decisions about who gets treatment first, again the elderly and frail may not be the priority. How we communicate these things to Aboriginal people in a respectful way is crucial. There is a lack of financial resources for coordination of federal and provincial and Aboriginal plans and zero funding for insuring that urban Aboriginal people receive the same communication considerations as those living on reserve. The following question is one that needs more discussion and action: How would we address mass casualties and reduced access to staff and maintain our decisions within a culturally focused framework?

**Aboriginal health policies**

In 2005-2006 significant federal and provincial policies were developed to provide a framework and guide for improving the health of Aboriginal people at Fraser Health. These policy documents include the Transformative Change Accord (2005), and a National Blueprint on Aboriginal Health (2005) that builds upon and supports the First Nations
Health Blueprint for British Columbia (2005) and other relevant reports. In addition, the Aboriginal Health Transition Fund was announced by the Federal Government in 2006. The goal for these policy documents collectively was to close the gap in Aboriginal health outcomes by improving access to Aboriginal focused health care services and programs and to increase the numbers of Aboriginal health professionals. More recently, these goals have been identified as health indicators in more recent documents: Tripartite Committee on First Nations Health and Well-Being, Interim Update, 2015; First Nations Health Annual Report, 2015 – 2016; Surrey Urban Indigenous Social Innovation Strategy- All Our Relations Report 2017. Each report summarized that while improvement in health indicators exists there still needs to be work done to meet the goals of closing the gap in health disparities between Aboriginal people and the non-Aboriginal population.

The policy accomplishment of the collective levels of First Nations, provincial, and federal governments required collaborative action and relationship building between the provincial and federal governments, six provincial health authorities and Aboriginal people which include, First Nations, Inuit and Métis. Roles and responsibilities were to respectfully establish jurisdictional and fiduciary relationships and responsibilities. The provincial and federal governments recognized that First Nations needed to be involved in the design and delivery of health programs and services to First Nation people. Progress in this area includes each Health Authority hiring Indigenous people as executive project managers and Aboriginal community engagement coordinators. Each Health Authority has also established Aboriginal Health Improvement Committees that include Indigenous community members from the applicable service delivery area.

Another health-related policy area for First Nations is the environment, which is vital in determining health and well-being. Our environment includes the land, air, water, food, and other resources that need to be cared for and considered to sustain healthy children, families and communities. The Environmental Health Officers (EHOs), working in Environmental Public Health Services, have transferred from Health Canada to the First Nations Health Authority. This area of Health Canada was generally well received prior to the transfer, as many of the staff had long working relationships with First Nations leadership and
communities. The Environmental Health Program provides services to all First Nations across BC.

Some of the guiding principles of the Environmental Health Services are to:

- Build on relationships with First Nations;
- Continue to work with individual Nations based on their needs and concerns;
- Collaborate with public health workers, local and provincial health authorities, and other municipal, provincial and federal departments and agencies when delivering programs in First Nations communities; and
- Strive for on-reserve services comparable to those available off-reserve \(^{36}\)

Each of the provincial Health Authorities are responsible for identifying population health needs; planning appropriate programs and services; ensuring programs and services are properly funded and managed; and meeting performance objectives. During my employment with Fraser Health Authority each employee was required to complete a performance evaluation annually. I also noticed much improvement in collaborative decision making, allocation of resources and funding, and coordinated partnerships and sharing of resources within FHA.

*Royal Commission on Aboriginal People (RCAP)*

The Royal Commission on Aboriginal Peoples ([RCAP]1996) was the first ambitious attempt to reconcile the relationship between Aboriginal and non-Aboriginal peoples in Canada. It was launched in response to the Oka crisis of 1990. That summer, a bitter land-claim dispute led to a military siege of the Mohawk community of Kanesatake and galvanized many long-standing Aboriginal grievances across Canada. Established in 1991, RCAP was mandated to conduct hearings across the country and offer recommendations on how to improve Canada’s relationships with its original peoples. Released in 1996, its five-volume Final Report included over 3500 pages and offered over 400 recommendations thematically organized into categories of renewed relationships, treaties, governance, lands

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\(^{36}\) See [http://www.fnha.ca/what-we-do/environmental-health](http://www.fnha.ca/what-we-do/environmental-health)
and resources, economic development, family, health and healing, housing, education, arts, and heritage.

RCAP’s Final Report is a particularly rich resource. It invites Canadians to participate in a national dialogue on possible pathways to reconciliation. It offered hundreds of relevant recommendations, too numerous to be reviewed here, but their main message was the need for a new relationship between Canada and Aboriginal peoples. “Four guiding principles for the new relationship were proposed: mutual recognition, mutual respect, sharing, and mutual responsibility. Aboriginal nations would be recognized as the third order of government in Canada alongside the federal and provincial or territorial branches. Recognition of Aboriginal peoples’ inherent right to self-determination would be the only pathway to Aboriginal reconciliation with Canada.”

In 2006, the Assembly of First Nations (AFN) issued a ten-year report card that looked at the RCAP Final Report’s recommendations. This report card gave Canada a failing grade in over half (37 of 65) of the categories of recommendations. Almost a decade later, another national commission focused on Aboriginal peoples and their experiences in Indian residential schools reiterated some of RCAP’s recommendations.

**Truth and Reconciliation Commission of Canada (TRC)**

The Truth and Reconciliation Commission of Canada (2015) was created as a result of the largest class action about Indian residential schools in Canadian history. More than 150,000 Aboriginal children were taken from their homes, sometimes by force with the assistance of the Royal Canadian Mounted Police, to attend the schools. The TRC was established to reveal the truth about the residential school system, and to identify pathways to reconciliation for its survivors and for all Canadians. When former students of Indian residential schools decided to settle out of court with the federal government and four national churches, the launch of a TRC was part of the terms of settlement (p. 23).

The former students wanted to ensure their stories were not lost by settling out of court. Aboriginal people from across Canada participated in the TRC’s activities that recorded

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their stories and testimonies. For example, many of the First Nations people who live in outlying villages from where I live in Alert Bay, BC told their stories of their mostly negative experiences staying at St. Michael’s residential school located at Alert Bay, which were similar to those stories that I shared in Chapter One.

The final report of the Truth and Reconciliation Commission (2015) notes that the Royal Commission on Aboriginal Peoples (1996) identified the key issues to be addressed in righting the relationship between Aboriginal and non-Aboriginal peoples in Canada. Although RCAP did not identify a specific role for the churches in addressing a reconciliation process, such participation clearly is captured by the spirit of RCAP’s recommendations. Furthermore, the TRC reinforced that RCAP’s guiding principles of mutual recognition, mutual respect, sharing, and mutual responsibility are critical to any reconciliation process. An important component of the TRC’s call to actions (recommendations) included the recognition and use of Indigenous knowledge, culture, and language in education, health, social services, justice, and many other sectors to create positive change and impact for improving Aboriginal people’s well-being. In response, I decided to develop and use an Indigenous theoretical framework for my study that contributes to changing health policies and practices within the provincial healthcare system.

**PART TWO: INDIGENOUS THEORETICAL FRAMEWORK**

In this section, I begin by exploring the meaning of Indigenous knowledge(s), articulated by scholars and I connect these meanings to my early years of living Indigenous knowledge. I remember a mainly traditional harmonious life, where I lived the teachings, beliefs and values in stories told by elders and learned through hours of observing, experimenting, working and playing outdoors in the forest, on Kalugwis beach and spending a lot of time on our gillnet boat fishing, clam digging, berry picking, and going on potlatch ceremonial trips. My early years provided an important foundation of Indigenous knowledge that is an important component of my theoretical framework that will be introduced in this chapter. I then introduce the Hamumu Theoretical Framework that has guided my research.

Dr. Daes (1994/2012) in her report on the protection of Indigenous peoples, points out that Indigenous knowledge is “a complete knowledge system with its own concepts of
epistemology, philosophy, and scientific and logical validity” (para. 8). My personal IK descriptions shared throughout this thesis exemplify this complete system of knowledge, without the academic terminology. Daes further concludes that diverse elements of any Indigenous knowledge system “can only be fully learned or understood by means of pedagogy traditionally employed by these peoples themselves, including apprenticeship, ceremonies and places” (1994, par. 9). A similar view held by Cajete indicates that Indigenous thought classifies ecological phenomena based on characteristics observed through experience; such classifications rely on a high degree of intuitive thought. Eurocentric science, in contrast, “relies more on properties that are inferred from necessary relations in the structure of the objects classified” (Cajete, 1986, p. 124). As my grandparents always said, “watch, listen and learn.”

I therefore characterize my Indigenous knowledge as rooted in a place, based on traditional environmental (ecological) learning, teachings and practices, accessed from previous generations which ensures the continuation of Tlawitsis culture. My experience and the knowledge of Tlawitsis elders reinforces this point by Battiste and Henderson (2005), “That the knowledge systems of Indigenous peoples are more consciously empirical than those of Western scientific thought—especially at the individual level where a person is actually learning first hand. Everyone must be a scientist to subsist by direct personal efforts in whatever they do” (p. 45).

My grandfather is a perfect example of their point because he learned by experiencing the following: being a hunter, commercial fisherman, boat navigator and harvester of cedar bark for weaving. He possessed practical knowledge of good tides and bad tides for travelling, knew when to fish and how to fish with no or minimal technology. Battiste & Henderson (2005) also state, “Since every individual is engaged in a lifelong personal search for ecological understanding, the standard of truth in Indigenous knowledge systems is personal experience” (p. 43). My grandfather couldn’t read but learned the tide book and observed the moon to know about tides. Today most fishing boats have high technology to assist the fishers in finding hot spots for commercial fishing. My grandfather would travel for three days to reach Northern fishing grounds, which were foggy most of the summer. My grandfather was able to navigate to these far away areas with only a small square wooden
box with a compass. The remainder of his knowledge system depended on the collective beliefs in our village, practical teachings and experiences passed on from generation to generation.

Our Tlawitsis knowledge system was a total way of life that included similar principles to Archibald’s (2008) such as respect, reciprocity, responsibility, reverence, relevance, wholeness, inter-relatedness and synergy, especially the observed rules governing the resources for our health and well-being. These principles share a common purpose, one that is consistent with the knowledge (s) in which they are anchored: the development and maintenance of positive relationships, which to me has been as important throughout my traditional life, nursing career and more so for interaction and communication with research study participants.

Other scholars have used these principles in their own works (Archibald, 2008; Kirkness & Barnhardt, 1991; Wilson, 2008). Wilson (2008) states that this relational way of being was at the heart of what it means to be Indigenous (p. 80). For example, my use of an Indigenous wholistic health framework using the health dimensions reflects relationality. My framework is built on interconnections, and interrelatedness, inspired by the way that I lived my life with my grandparents. Life was more than relationships to human relationships, we had relationships to our culture, spiritual relationships, and especially relationships to the landscape that we respected and cared for in a reciprocal fashion. It’s like the saying goes, “Take care of the land, and the land will take care of you.” We are all only a part of the circle. Just as the principles are interrelated, so are the wholistic health realms that I use to illustrate the interconnectedness and interdependence of the physical, emotional, mental and spiritual. Synergistically, all health realms are balanced unless we do not practice the principles of responsibility, respect, relevance, reverence, and reciprocity. Archibald (2008) uses these principles in her Indigenous storywork. I use them to build upon and encompass a sense of community relations and responsibilities as taught by my grandparents.

Our health and well-being were very dependent on using these principles (theory) for sustaining our natural resources, otherwise I really believe we wouldn’t be here today. I have full respect for all my different ways of learning (all knowledges) through stories,
observations, and living a life of experiential learning. My Indigenous ways of being and knowing, in reality are my sources of putting theory into practice. One of my main family crests that we use to signify our ancestry is the Hamumu (butterfly), amongst other family crests that we as a family are allowed to use as a design on our button blanks and other ceremonial regalia.

HAMUMU THEORETICAL FRAMEWORK

My theoretical framework uses a specific form of Indigenous knowledge, the Hamumu (butterfly) that metaphorically represents a continual process of metamorphosis, paralleling the lives of urban Aboriginal people living away from their homeland. I feel that it is worth repeating this story that was included in Chapter One. During the time of the great flood when Numas, my Great Grandfather from Kalugwis was sitting high up on a mountain singing, a Hamumu landed on his head. This was the blessing from our Creator. Hamumu fluttered straight down into the village below and a transformation took place, Kalugwis was created. The Hamumu is symbolic of strength, resilience, power and resistance. Hamumu is one of the greatest transformers and survivors.

I use the traditional metaphor of Hamumu as a guide throughout my thesis because Hamumu highlights transformation and the metamorphosis of my life and perhaps others towards a healing journey. Hamumu also symbolizes the forced metamorphosis Indigenous people have endured over many years of colonization efforts. Much of our heritage was forced into a cocoon stage; however traditional cultural practices as a form of Indigenous knowledge continue to emerge much as Hamumu does. This is an ongoing process as we become conscientized, we shift and experience changes but remain who we are as Indigenous people. The metamorphosis of the butterfly represents the different phases that we go through as we struggle to know and understand our history as we move forward.

The Hamumu Theoretical Framework is primarily informed by Tlawitsis teachings, values and principles which includes Hamumu’s journey through life, and Archibald’s (2008) Indigenous storywork principles. The use of Tlawitsis theoretical principles, values, and culture are exemplified throughout this thesis to show how a specific cultural/community example can be used as an exemplar for theory and methodology.
The elders taught Archibald about the seven principles related to using First Nations stories, storytelling, and making meaning from and with stories for educational purposes, a term she coined, Indigenous storywork: respect, responsibility, reciprocity, reverence, holism, interrelatedness, and synergy. I have added the principle of relevance, which comes from Kirkness & Barnhardt (1991). These eight principles are located within the body of Hamumu and subsequent theoretical framework to give it strength and life. The Hamumu (butterfly) image is shown as an outline or body that encompasses the eight principles and is shaped or shapes environment and Indigenous family/community/nation (See Figure 11).

**Figure 11.** Hamumu Theoretical Framework

At this point, I acknowledge and discuss four foundational principles that were developed by Cree scholar Kirkness and non-Indigenous ally Barnhardt (1991) in their research concerning post-secondary students’ experiences: respect, responsibility, reciprocity, and relevance, known as the 4Rs. These principles also guided Archibald (2008). I include a short description of their meaning to Kirkness and Barnhardt to acknowledge the source of

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38 Archibald in 2008 uses “holism”; therefore, when I quote her usage, the “w” will not be included.
these principles. Respect is the need to honor the cultural integrity of First Nations students, including their values and traditions. The second principle of responsibility, speaks to the ability of individuals and collectives to take responsibility for their own lives. At the heart of this principle is the empowerment of First Nations people in realizing control over their daily lives. The third principle, reciprocity, is evidenced in relationships that create possibilities for new types of reciprocal education, as opposed to assimilationist approaches. The fourth principle, relevance, speaks to the relevance of learning within First Nations perspectives and experiences, for students to “build upon their customary forms of consciousness and representation as they expand their understanding of the world in which they live” (p. 8). Kirkness and Barnhardt (1991) argue that these principles are anchored in Indigenous worldviews/knowledge systems and are distinct in their application.

Archibald (2008) was taught seven Indigenous storywork principles (noted above) by Coast Salish and Stó:lō elders, principles relating to using Indigenous traditional and life experience stories and storytelling for educational purposes. An Indigenous philosophical concept of holism refers to the interrelatedness between the intellectual, spiritual, (metaphysical values and beliefs and the Creator), emotional, and physical (body and behavior/action) realms to form a whole healthy person. Holism extends to and is mutually influenced by one’s family, community, band, and nation (p. 11). A fuller description of these principles is included in the next chapter.

I agree with Archibald’s (2008) point that Indigenous stories form a core part of Indigenous cultures and shape our cultural identities. Elders who shared their stories with me gave me the power to think, feel and remain strong and to be a ‘good person.’ Like Trickster in Archibald’s Indigenous storywork, I have survived incredibly challenging experiences and have learned from these difficulties to live a better life and to move forward. Throughout my research, I apply the Indigenous storywork principles in renewing, revitalizing and building new relationships between health care service providers, service delivery systems and urban Aboriginal people looking for responsive health and social services. The Hamumu adds the transformative dimension or possibility regarding the wholistic health and well-being of urban Aboriginal people.
Cajete (2000) elaborates further on the wholistic aspect of Indigenous knowledge, which is similar to Archibald’s (2008) views on holism. He explains how Indigenous peoples view harmony as a dynamic and multidimensional balancing of interrelationships in their ecologies (respect). Disturbing these interrelationships creates disharmony; balance is restored by applying appropriate (relevant) actions and knowledge (responsibility) (Cajete, 2000, p. 43). I believe that these actions also illustrate wholism, interrelatedness and synergy. Our people had experiential knowledge of their environment and their relationship between animals, plants, human, spirits, and natural forces of the earth’s elements. Everything was interrelated; one could not live or survive without the other. I have heard the following statement over time and echoed by many people: “we can not exist without the natural elements, but nature can exist without us.” The Hamumu Theoretical Framework addresses relationships with the environment, as well as addressing conditions to nurture the resurgence and empowerment of urban Aboriginal people and considering influences upon children, families, communities, and nations.

CONCLUSION
My understanding of the impact of colonization on my life, community and culture and now recognizing the need to deal with power struggles between and among Aboriginal people, governments, health agencies, health educators and social services is critical for improving urban Aboriginal health services. Gaining and exercising self-determination is even more important, we must be determined to define and direct our own cultural formations and initiate cultural changes to make space for culturally safe health transformation and revitalization in ourselves and communities. Taking responsibility for our culture and our environment, our community problems, the social pathologies, and better health through Indigenized health education and health services are ultimately our (Indigenous people’s) responsibility. This self-determining concept builds on the theories developed by Brown (2004), Smith (2005), and Freire (1990, 1997) that oppressed people must participate in freeing themselves, instead of outsiders making these decisions.

The ongoing and negative impact of culturally non-responsive-colonial government policy upon generations of Aboriginal people is evidenced through the various health determinant data presented in the first part of this chapter. The impact of colonial policies still impacts
many Indigenous people today, impacting on their physical, emotional, mental, and spiritual well-being. Aboriginal people are gaining more responsibility and control over their own health services and continue to do so. A good example of this, is BC’s First Nations Health Plan: Supporting the Health and Wellness of First Nations in BC. Both federal and provincial governments and First Nations leadership signed the Tripartite First Nations Health Plan, 2007. The core of that change was to give First Nations a major role in the design and delivery of health care for their own people while ensuring increased partnerships, coordination and integration with the provincial health care system (BC Tripartite FNHP, 2009).

There is a growing urgency and recognition amongst Aboriginal populations to re-affirm and move towards the development of traditional-based health services and programs that are more responsible and responsive to the wholeistic health needs of Aboriginal people and their communities. At the same time, it must be acknowledged that Western medicine has a place in treating Aboriginal illness. The major issues relate to not acknowledging or involving Aboriginal people in developing and implementing health policy and programs. Major national studies such as the Royal Commission on Aboriginal Peoples (1996) and the report of the Truth and Reconciliation Commission of Canada (2015) continue to make policy and research recommendations that prioritize this self-determining and Indigenous knowledge movement. The development of the Hamumu Theoretical Framework for this research is an outcome and example of a critical examination of colonial impacts and the start of a self-determining conceptual framework based on local Indigenous voices of experience, perspectives and Indigenous knowledge.
CHAPTER FOUR: INDIGENOUS METHODOLOGY

Indigenous peoples’ interests, knowledge and experiences must be at the centre of research methodologies and construction of knowledge about Indigenous peoples.

—Lester Irabinna Rigney, 1999 (emphasis added).

Rigney’s quote about Indigenous interests, knowledge, and experience being at the forefront of Indigenous research means that Indigenous voices must be privileged. Just as Hamumu requires certain elements and environment to nurture its re-emergence, the main aim of Indigenous methodologies is to ensure that research on Indigenous issues is carried out in a respectful, ethical, correct, sympathetic, useful and beneficial fashion, as seen from Indigenous peoples’ perspectives. My research focuses on and privileges the voices, perspectives, and experiences of urban Aboriginal people who access and use both mainstream and Aboriginal oriented health services in the city of Surrey, British Columbia. Aboriginal people’s health issues were presented in previous chapters. Now it is time to set a research context to ‘hear’ and read about their perspectives on health services. In this chapter, I present my research methodology in two major parts. Part One includes a description of Indigenous storywork principles (Archibald 2008) and other principles and shows how they are used to carry out my methodology. Part Two presents the interview and sharing circle methods that are used.

Many Indigenous scholars draw upon principles from Indigenous knowledge(s) to explain, describe and/or guide the conceptualization and implementation of their work, (Absolon, 2011; Archibald, 2008; Battiste & Youngblood Henderson, 2000; Ermine, 1995; Wilson, 2008). I too, draw upon Indigenous ways of knowing and being to guide my research, through the works of Indigenous scholars and from my own experiences. The principles that guide this research study are anchored in overarching beliefs of many Indigenous nations including my own nation, Kalugwis, that form a strong foundation for who I am today. Just as my grandparents passed on their ways of knowledge, I too pass this knowledge along to my children, thereby continuing our intergenerational ways of cultural revitalization. My study uses Indigenous principles of respect, responsibility, reciprocity, reverence, relevance, wholism, inter-relatedness and synergy by locating them within relationships as a way to
understand and embark on this revitalization through the provision of ‘good medicine’ to urban Aboriginal people (Archibald, 2009; Kirkness & Barnhardt, 1991). These principles set the context for continuity and change.

Today, discourse on Aboriginal education and health often speaks about the need to decolonize our perspectives and experiences by critiquing the impacts of Western education and health on Indigenous cultures (Battiste 2000; Royal Commission on Aboriginal peoples 1996b; Smith, 1999). In taking a different perspective, Graham Smith, (1999), a scholar of Maori ancestry, challenges us to examine the political struggles inherent in the educational sites where Western and Indigenous education meet. He emphasizes an Indigenous consciousness-raising process that does not dwell on the colonizers but focuses on how Indigenous thought and action becomes transformative, thereby serving to improve Indigenous living conditions (p. 11). I agree that Smith’s points are relevant for the health field.

Although more Indigenous scholars are taking up the challenge posed by Graham Smith, many areas of practice have not seen systemic change or spaces opening up for transformation to occur. Evelyn Steinhauer (2002), exemplifies this point. She says that her formal education conditioned her to believe that Indigenous ways of knowing are only important to Indigenous people, that “we could never use that knowledge on a formal basis, therefore I never took a keen interest in the topic until now.” (p. 70). She goes on to say:

> It is exciting to know that finally our voices are being heard and that Indigenous scholars are now talking about and using Indigenous knowledge in their research. I think it is through such dialogue and discussion that Indigenous research methodologies will one day become common practice, for it is time to give voice and legitimize the knowledge of our people. (p. 70)

Some Indigenous scholars, such as Wilson (2008) introduce Indigenous-based concepts such as research as ceremony. An Indigenous ceremony often includes spirituality, emphasizes family and community history and responsibilities, and is a way of passing on and strengthening culture, knowledge, language, values, and beliefs. I use my culture as an example of the importance of ceremony. In our Kwakwaka’wakw culture there are
important sacred protocols to put into place prior to a potlatch to ensure that everything and everyone involved is in tune with the cultural event. Following the protocols of the ceremony everyone that is participating is prepared spiritually, mentally, emotionally and physically so that they are all able to be in a raised state of consciousness. Even children are taught to respect the ceremonies and speakers so that nothing interrupts the sacred songs and dance. Next, I discuss the relationship between qualitative and Indigenous methodologies because my research is also qualitative in nature and uses qualitative methods.

**QUALITATIVE AND INDIGENOUS RESEARCH**

Creswell (1998) offers his definition of qualitative research focusing on the methodological nature, the complexity of the end product and its nature of the naturalistic inquiry:

> Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The research builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in natural setting. (p. 15)

Qualitative research is an important tool for Indigenous communities because it is the tool that seems most able to weave and unravel competing story lines (Bishop, 1996); to create spaces for decolonizing and to provide frameworks for hearing silence and listening to the voices of the silenced (Smith, 1999).

I can totally relate to the use of qualitative research in this Indigenous research project as a tool for listening and acknowledging ‘voices’ of interest, as well as knowledge and experiences that have long been silenced. Because my ‘voice’ was silenced during my experiences at a residential school, Indian day schools and boarding homes, I began to think that there was only one way and right way to live or think. I am now particularly attuned to this silence. I am also attuned to Indigenous traditions that could guide research. Indigenous research is like traditional ways of learning that uses observation, participation, and experiential methods. Rigney (1997) says, “Indigenous peoples think and interpret the world and its realities in differing ways to non-indigenous peoples because of their experiences, histories, cultures and values” (pp. 54–55). This type of research/learning approach is used by many Indigenous people because we are very much a ‘looking’ and hands-on people.
Research and learning are continuous throughout our lives, it is through our personal experiences that we learn. To me there is no difference between research and learning because research is learning, and learning is research. I was told many times throughout my life by older people teaching me, “to pay attention so you can learn”; then we were made to try out what we had just observed. Being a participant-observer throughout my personal life allows me to take a more action-oriented approach to this research as reinforced by Smith (1999), and to emphasize face-to-face relationships, personal interaction between storyteller and listeners and people, keeping the spirit of the story alive by telling it to others and by interacting through and with the story articulated by Archibald (2008). The relationship building that this sharing and participation entail is an important aspect of ethical Indigenous research that is discussed in a later section. The next part discusses Indigenous principles that shape my methodology.

**PART ONE: INDIGENOUS STORYWORK & OTHER PRINCIPLES**

The Indigenous methodology that is used in this study is based on Archibald’s (2008) seven Indigenous storywork principles: respect, responsibility, reciprocity, reverence, holism, inter-relatedness, and synergy. The Indigenous storywork approach is one that I am personally and more recently professionally drawn to because stories are a good fit for me as they are important to my heart, mind, body and spirit in terms of teachings received from my grandparents who raised me with traditional teachings. I add the principle of relevance (Kirkness & Barnhardt, 1991) to the Indigenous storywork framework. The eight principles form a framework for understanding the stories told by the participants of this study. In the sections that follow, I elaborate on each of the eight principles and indicate their application to my research.

**PRINCIPLE ONE: RESPECT FOR ABORIGINAL CULTURAL INTEGRITY**

Principle One requires consultation and free informed consent from the research participants and Indigenous community members. In practice Archibald (2008) suggests this principle means that participants have a right to withdraw anytime and that as part of this right, participants are consulted throughout the research process. During the research process, everyone is treated equally; it doesn’t matter where they come from or who they are, everyone is respected equally. No one is better than the other person. Everyone is respected
for his/her background and history, everyone belongs somewhere. These important ideas guide my interactions with the research participants.

Urban Aboriginal people who have migrated to urban settings are often foreign to the different values, beliefs and the ways of living of the mainstream society. Quite often First Nation and Métis experience social exclusion and difficulties in accessing primary health care services within the inner-city environment. Furthermore, Indigenous people who have moved into cities are often left feeling alienated and alone without familiar supports such as their families, resources and culture. Therefore, there exists a need to demonstrate genuineness and to value each migrated person’s uniqueness in the research process. First Nation, Inuit and Métis people living within the inner cities may have once lived in their homelands in familiar, safe, supportive, and cultural environments. The once rural or reserve First Nation and Métis people lived and survived in safe places that also provided supportive kinship, language, songs, and traditional foods that resulted in feeling comfortable about being just who they were.

There is a huge need to demonstrate responsive respect and openness to learning about diverse cultural histories and Aboriginal nations’ traditional way of being and living. First Nation and Métis ‘voices’ have been silenced by colonialism through residential schools, foster homes, education, health and prison systems. It is paramount that interviewers, such as myself, know and show respect for the interviewee’s historical, social and economic background and political contexts in order to fully understand the person’s lived experiences, wholistically. I consider and discuss these contextual matters throughout the research.

Archibald (2008) starts with the principle of respect for cultural knowledge embedded in the stories and respect for the people who own or share stories as an ethical guide. A respectful practice is to acknowledge the storyteller, in other words to acknowledge where the story comes from, its source, and to ensure that the stories are used responsibly, in a proper way.

If the research process doesn’t happen in a “proper way” for example, the researcher does not take time to develop trusting relationships with participants, especially elders and instead poses questions, then the teachers (elders) will either respond indirectly without full
answer or not at all (Archibald 2008). Researchers need to be respectful and get to know the elders/teachers by learning to listen and hear their stories and to learn more about the cultural context for stories before engaging in the challenge of making meaning and gaining understanding from the elders’ talks and actions. Archibald (2008) asserts that respect must be an integral part of the relationship between the elder and the researcher (learner) – respect for each other as human beings, respect for the power of cultural knowledge, and cultural protocols that show one’s honour for the authority and expertise of the elder/teacher. Furthermore, the principle of respect includes trust and being culturally worthy. Archibald (2008) mentions that being culturally worthy means being ready intellectually, emotionally, physically and spiritually to fully absorb cultural knowledge.

**PRINCIPLE TWO: RESPONSIBILITY THROUGH PARTICIPATION**

As a responsible Kwakwaka’wakw health researcher, I ensure that my interview process results in participant empowerment by building on their strengths and knowledge. The participants’ research (data) contributions are analyzed in a wholistic way (physical, emotional, mental and spiritual) and that also includes responsibility to self, family, and community, as well as relationships to all living things in the world. It is through this type of relationality and responsibility that I established the research ethics and protocols to carry out the research at Kla-how-eya by receiving permission from its administration and participating in a staff discussion circle to introduce the research and to ask for their involvement in the study as a way to begin relationship-building with the staff. This last point about relationship-building as a signal of respect is reinforced by L. Smith (1999) who writes, “Indigenous people have philosophies which connect humans to the environment and to each other and which generate principles for living a life which is sustainable, respectful and possible (p. 105). As a child, I was taught to respect and to demonstrate responsibility not only to the animals but also the earth upon which the animals walked. There are many teachings about our interconnectedness and relationships to all animate and inanimate things that are found on this earth.

Archibald (2008) reasserts that one of many responsibilities of a researcher is to follow cultural protocol based on cultural responsibility and reciprocity. She uses the example of Verna J. Kirkness, of the Cree Nation of Manitoba, a well-known educator, who compiled
and edited the life story of Dr. Simon Baker, Khot-La-Cha of the Squamish Nation. Kirkness honours Khot-La-Cha’s wishes to write his life story in his own words. My understanding of this request is that when we are representing a person in our writing, especially a life story, it first needs to reflect the voice of the storytellers. Secondly, the story should be written in a way that moves readers, listeners, especially teachers and academics so that it remains in their mind, heart, body and spirit. Kirkness as learner and researcher carries out her role in both respectful and responsible ways. I will speak to Khot-La-Cha’s motive for publishing his life story in the next section under Principle Three, Reciprocity.

**PRINCIPLE THREE: RECIPROCAL RESEARCH RELATIONSHIPS**

Indigenous storywork speaks to reciprocity in terms of researcher and research participant, in particular, how they both need to understand their roles of being a listener, storyteller and also following cultural protocol in relation to stories. Khot-La-Cha and other Indigenous storytellers have teachings embedded within their stories. His motive for telling and publishing his life story is to share cultural teachings that were taught to him so that his grandchildren and school students at all levels would know his history and that of Aboriginal people in Canada. My research is focused more on the area of health and, despite the cultural diversity between myself and the research participants, I believe that we are learning and educating one another, sharing our gift of knowledge, experiencing a back and forth feeling for the power of the stories. I discuss the experience of reciprocity in the interview method section.

Reciprocity in my research will be further demonstrated when I share the final thesis with Aboriginal community members and the urban Aboriginal agency involved in the research, as a form of knowledge transfer. I will also share my research results with Aboriginal agencies that provide health services to urban Aboriginal people, the Ministry of Health, Fraser Health Authority and other Health Authorities. I hope that my findings will help improve health policy and programs for urban Aboriginal people.
PRINCIPLE FOUR: REVERENCE FOR STORIES AND SPIRITUALITY

Establishing meaningful relationships with elders and hearing their stories and those of other storytellers develops appreciation and reverence for the stories. It is this type of reverence for elders or respected storytellers and Indigenous knowledge that creates an opportunity to activate a story’s life force (Archibald 2008). During my research, I understood more fully that developing a feeling of reverence toward the elder participants and Indigenous knowledge helps me learn more from all the participants’ stories. I believe that my grandparents’ teachings and ways of helping me learn important values and beliefs instilled a sense of reverence in me about stories and culture. These teachings and this understanding of reverence forms the basis of my personal research ethics. I also appreciate the way that Kla-how-eya Aboriginal Cultural Society allows families that have lost a loved one, have the funeral service and cultural ceremony at their facility, which demonstrates reverence for families and ceremony.

PRINCIPLE FIVE: HOLISM USED IN STORYTELLING

Archibald (2008) suggests that stories have a holistic\(^{39}\) nature, which includes spiritual, emotional, physical, and intellectual dimensions. Sometimes a story listener (or researcher) will relate to aspects of a story through one dimension such as the emotions, sometimes two or more dimensions will connect the listener to the story. This holistic principle is similar to that of the Indigenous Medicine Wheel, with the four dimensions as noted above. Archibald adds that the relationships among oneself, one’s family, one’s community, and one’s Indigenous nation or larger society are part of this holistic principle.

In talking about the reverent and holistic power of stories, Robert Matthew, of the Secwepemc Nation, says, “The storyteller gives some ‘cues’ about elements of life, connection to land and community, to the story listener” (cited in Archibald, 2008, p.139). Another time Matthew told Archibald, that he thought the Rabbit, in a story that he told her, is symbolically like an Indian doctor who uses culture to heal, to make people healthy in a holistic way – spiritually, emotionally, physically, and intellectually. I agree with Robert

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\(^{39}\) Archibald does not use the “w” for holistic in her 2008 publication; therefore, I use her spelling when discussing her use of holism.
Matthew’s thinking because as a nurse at St. George’s Hospital, Alert Bay, BC, I have witnessed elders who were hospitalized for hip fractures, but who went on day passes to potlatches. I have seen other elders who could barely move or stand up, participate in traditional potlatch dances, without their walkers or assistance from a family member. I believe that the elders receive healing through potlatch songs and stories, giving them the strength and spirit to be able to participate in traditional dancing, to have fun through singing and drumming, yet at the same time acknowledge reverence towards their ancestors who passed on cultural teachings.

The potlatch is a cultural gathering where knowledge, values, practices, and kinship are reinforced, lived, and passed on to the younger generations and those who are interested in learning more. The experience that I describe above was and continues to be holistic in nature. The stories also reflect this holistic nature. In my research, I examine the holistic nature of participants’ perspectives, experiences, and stories. I use the potlatch example above to exemplify how participants’ cultures and their stories could have holistic and healing possibilities.

**Principle Six: Interrelatedness**

Archibald (2008) suggests that stories’ holistic nature, which includes the spiritual, emotional, physical, and intellectual dimensions, may take on an interrelated dynamic when one dimension intersects with another, when the meaning-making process begins. Each dimension may not be equal in strength, depending on individual development and life experiences. Sometimes a story listener (or researcher) will relate to aspects of a story through dimensions such as the emotions; sometimes two or more dimensions will connect the listener to the story. The relationships amongst oneself, family, community wider world and the environment also influence holism. In chapter five, I use this concept of interrelatedness during the wholistic analysis process when I review the participants’ stories and perspectives.

**Principle Seven: Synergy in Storytelling**

Archibald (2008) writes that “it was the magic of the storytelling skill that allowed the thoughts and meanings to meet and create new patterns of understanding; personal and
 communal knowledge found a meeting place with orality” (p. 77). The power of Indigenous storywork to make story-meaning is enhanced by a synergistic action between the story, the context in which the story is used, the way the story is told, and how one listens to and works with the story. The action of synergy takes place when participants build upon each other’s ideas and stories. Each person tells her/his own story or tells about the meaning one takes from another’s story. The important point is that there is a linkage between each person’s talk that builds upon a topic, which becomes the focus for discussion, instead of each person trying to ‘out-story’ someone else.

I can best convey the principle of synergy in my research through how I adopt Archibald’s (2008) Indigenous storywork principles throughout the thesis. All of the seven principles are found in, and applied to my culture, although I am not Coast Salish (the main cultural area of Archibald’s research). It took time, but I eventually acquired an in-depth understanding of the Indigenous storywork principles and subsequently used these principles in my research. The actual use is part of the action of synergy.

**PRINCIPLE EIGHT: RELEVANCE, INDIGENOUS PERSPECTIVES AND EXPERIENCES**

To facilitate relevance to Aboriginal perspectives and experience, my methodology is rooted in Tlawitsis teachings and experiences, my own story (personal context), and storytelling from the perspectives of urban Aboriginal people. In the planning stages of my study I received indications of support from some leaders, board members and staff who had been associated with the Kla-how-eya for several years. I also received feedback from them about my study questions and methodology to ensure relevance of the study and to ensure that it met identified health needs of the First Nation and Métis people living within the inner cities of Vancouver, BC.

This study is guided by a Medicine Wheel approach, which is culturally relevant to many of the research participants in my study. I use the wholistic circle and place words or parts of stories in one of the four quadrants: physical, emotional, mental/intellectual and spiritual/cultural health realms in the analysis phase. I understand that one’s experience may

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40 The Medicine Wheel philosophy and its origin are often attributed to the Plains Indigenous cultures of North America (Bopp, Bopp, Brown, & Lane, 1984).
reflect more than one dimension and that an experience may not be easily reduced to one or more quadrants. However, this initial use of a wholistic frame helps me to understand the story inter-relationships, inter-connectedness and synergy amongst the quadrants of Hamumu’s wings, backbone or spine, eyes, antennas and, most importantly Hamumu’s environment.

This study is also culturally relevant to Métis people. Canada (2012) a Métis scholar notes that the Métis have their own storytelling protocols that are grounded in shared understandings of Métis principles: respect, self-determination, patience and responsibility. Canada adds that Métis storytelling was, and is important among Métis both for education and entertainment (p. 45). The Métis storytelling protocols are similar to the 4 R’s, as previously discussed, and other principles of holism, interrelatedness and synergy. Many Indigenous people follow similar teachings that are based on their lived philosophies of traditional living where respect and accountability are taught daily. I remember my grandmothers in the village when they visited frequently and shared meals together as families, they often told stories or recalled stories of long ago. Each storyteller always acknowledges who first told the story or where the story originated, which is an important ethical action.

**Ethical Approach to Indigenous Qualitative Research**

Archibald (2008) mentions how the elders with whom she worked during her research remind her of the great importance of ethics that need to be adhered to when doing research with storytellers, especially the elders who are the protectors of the stories. Elders such as Simon Baker, Vince Stogan, Ellen White, and the Stó:lō Elders recount how their ancestors demonstrated respect by acknowledging the original storytellers of the stories that they told. Archibald’s interviews with the elders are respectful, honest and genuine.

In my interactions with elder participants, I follow Archibald’s (2008) respectful ways of working with the elders, remembering that it is the elders’ knowledge and contributions that will eventually unfold through our research work together. As I went out to gather information for my research I continually reminded myself about whom I am ethically responsible to in terms of my multiple roles as a researcher involved in a study with the
University of British Columbia, Kla-how-eya, and Kekinow Native Housing participants, and as a former employee with Fraser Health. Furthermore, I am a First Nation who has resided most of my life within urban environments, I am a residential school survivor, and thriver, like most of Kla-how-eya’s clients that are mothers or grandmothers.

Amongst many Indigenous cultures, the traditional practice of asking permission to enter another’s traditional territory is a common ethical protocol that demonstrates respect for the people and their territories. I also followed this protocol in approaching the Aboriginal organization’s decision-makers and members that is the main site of my research.

PART TWO: RESEARCH METHODS

RESEARCH APPROVAL FROM THE SURREY ABORIGINAL CULTURAL SOCIETY, KLA-HOW-EYA

The setting for this study is Kla-how-eya previously named the Surrey Aboriginal Cultural Society located in Surrey, British Columbia (BC), Canada. Surrey is located within the Fraser Health region, in the lower mainland of BC. Surrey has the second largest Aboriginal population, next to Vancouver, BC. Kla-how-eya as the chosen research site represents a key environment in which cultural-based health and social services are provided; has a large volume of diverse Aboriginal people who access this centre for health and social services; is administered mostly by Aboriginal employees; and the services are provided mostly by Aboriginal health and social care providers. The clients that access this health resource centre are mainly Aboriginal people from across Canada. The research activities are carried out in several different health and social departments, for example, social programs, employment, education and recreation services for Aboriginal people of all ages.

I acquire approval to conduct my research at Kla-how-eya through their board of directors. I also gain approval from other organizations that are implicated in the study: (1) Kekinow Native Housing Society where many of the participants live; and (2) Fraser Heath Authority. I also receive approval from the UBC Research Ethics Office. Kekinow Native House Society assists with participant recruitment and allows interviews to be conducted there. Approval is also obtained from Fraser Heath Authority where I was a former employee from March 2005 – August 2008.
PARTICIPANT RECRUITMENT

The recruiting process begins when I arrive for a meeting with the Executive Director of Kla-how-eya. Firstly, I telephone the director then follow up with an email on the same day. We agree on an arrangement to attend their next Monday morning sharing circle meeting.

Coincidently, my research strategy includes the sharing circle as an Indigenous approach of bringing the participants together. I am aware that many of the employees are from eastern Canada; I know that employing circles is a sacred part of their culture as it is ours. The Coast Salish, on whose unceded territories I was employed at that time, also use the circle. Each participant in the sharing circle has the opportunity to speak while the others listen attentively. Talking circles are based around respect and non-judgement. Everyone looks so comfortable, expressing freely the topic at hand. I realize at that moment that gathering participants together is an important cultural protocol to use. I realize that using a sharing circle is helpful in creating a safe, comfortable environment where the urban Aboriginal participants can express their perspectives and experiences about accessing health services. The arrangement works out, as most employees are in attendance, and I am given adequate time to introduce myself as the researcher. A prayer starts the morning meeting, followed by introductions around the table. The introduction of everyone in the sharing circle helps me immensely as I learn what everyone’s role is, and what services and programs exist.

The director/founder of Kla-how-eya asks me to introduce myself to the sharing circle and to outline the purpose of the research study. I share my cultural identity, my traditional territory, and employment background. Then I share information about the study, the planned process of recruitment, the ultimate reason for this study, and its importance for the benefit of the recently relocated the urban Aboriginal people. One criterion for participant volunteers includes that they have either worked or received services from Kla-how-eya for at least five years to strengthen relevancy to the purposes of this study. The range of study participants that are sought include: (1) Aboriginal people who use Kla-how-eya’s health/cultural/social services; (2) those who did not, but who want to discuss their experiences of accessing health services in the urban area of Surrey; (3) and Kla-how-eya staff and Board members. I ask staff members who are interested to contact me either by
phone or email. Following the sharing circle meeting, two non-Aboriginal professionals who are very interested in being a participant of my research study approach me. A couple of lead employees approach me to suggest potential clients/participants. The participants are suggested as potential study participants because of their knowledge, expertise and engagement with the over 70 programs/services Kla-how-eya provides.

I make pamphlets that include an outline of the study, relevant information about the researcher, including contact information, and the extent of the commitment for the participant. I ask a couple of programs leads, if they are interested in being the main contacts for those interested in being participants. I emphasize that participants have a choice to withdraw from the study at any time, without any repercussions. Participants are recruited via advertising posters that are posted, with permission at Kla-how-eya Aboriginal Society and the main office of Kekinow Native Housing. Following the distribution of study posters, two weeks are given for potential participants to contact me. I receive a response to the advertising posters from 14 people wanting to participate in the study. Following telephone contact with the potential participant, an interview appointment date, time and place is set. As well, participants are notified that a study pamphlet is going to be made available through either the director or leads of programs. Right away, I feel the number of people interested justifies the purpose and need for his research. There is an equal mixture of staff and Kla-how-eya urban Aboriginal clients. Consent forms are subsequently given out to those interested in participating. As mentioned previously, the pamphlets outline the study and invite participation.

**Research Participants**

Data from 15–20 people—sometimes less—is sufficient to provide a comprehensive understanding of the phenomenon under study (Browne, 2003). I receive a response to the advertising posters and information pamphlets from a mixture of seven staff/board members and seven clients of Kla-how-eya. In my study, the sample of staff/board who are mainly Indigenous participants include those who are either working in one of the social or health departments, or a board member. To protect the anonymity of the staff participants in a small organizational setting, very little detail is provided about their particular work positions/roles in this thesis. The other seven participants are regular clients of Kla-how-eya
that include parents (single and married) with young children and elders. The ages of the participants range from their early 20s to late 70s. They are from various First Nations and Métis ancestries in Canada. There are a few participants who ask if they can remain anonymous, therefore, I decide to maintain anonymity for everyone and use pseudonyms.

**Interviews**

I conduct individual interviews for the first part of the data gathering process. The individual interview questions include both semi-structured and open-ended questions. The interviews take place from November 24, 2010 - February 10, 2011. Transcriptions are completed by October 13, 2011. Interviewees choose their preference mode (telephone or face-to-face), time and place for the interview. Individual interviews via telephone usually last one and one-half hours while participant face-to-face interviews last at least two hours. Participants speak mainly in narratives, using a storytelling-like form. Quite often the participant and I get into a conversation, although we manage to stay on topic by addressing the interview question.

In the interviews, I begin by introducing myself and telling them a little about my background as an Indigenous person, where I come from, my parents, where and how I grew up. I want to assure them that I am interested in what they have to say, by me doing less talking once they start telling their stories. I try to not be overpowering by showing them total respect and appreciation for their way of storytelling. I give participants time to think and speak. I encourage participants to take as much time as needed to tell their stories. In order to get the participants to talk about their lived experience through storytelling, I structure the interviews as close to an everyday informal conversation as I did when I worked as a community health nurse.

While I listen to their ‘voices’ attentively and with sincerest respect, I am mindful not to rush participants. Many Indigenous people require more time to respond, needing time to think before they speak. Like myself, I do not respond quickly without thinking over the question. I do not put any time limit on the interview sessions, but most of the interviews take on average, 1 hour 45 minutes. Each interviewee receives transcribed copies of their individual interview to ensure that what was transcribed reflects what they had meant to say,
plus being true to their own wording, most important of all participants are encouraged to make any changes they wish to make once reading over their transcribed copies for accuracy. I do not receive any notice from participants to make changes to their transcription.

**SHARING CIRCLE**

I use an Indigenous sharing (talking) circle as a second part of the data gathering method. I use some major themes from the initial analysis of the individual interviews as discussion topics for the sharing circle. The sharing/talking circle concept builds upon a common core principle of an Indigenous circle that represents wholeness, togetherness, community, and harmony. Marsden (2005) states that the purpose of a talking circle is to share perspectives and experiences and to decide on important issues, or issues that can’t be resolved individually. Graveline (2000) proposes that the *talking circle* as a method allows each voice to be acknowledged and heard in turn, and goes on to say that we each have our own voice with which to speak the truth and tell our own story (p. 364). The Indigenous talking circle is widely used for emotional healing purposes, but has more recently been adapted for research purposes (Archibald, 2008; Graveline, 2000; Marsden, 2005).

I am familiar with talking circles, and I am spiritually inclined to think that those who participate in this type of circle gain an appreciation for the concept of inter-relatedness, and that we are “all one,” especially when we join hands for prayerful words. For me, it is a very reverent process.

The Indigenous talking circle strikes me as most appropriate for facilitating group discussions because only one person speaks at a time; a person has the choice to speak or not; everyone’s stories and perspectives are respected; time is not limited; and there is opportunity for a multitude of ideas and issues to be voiced and heard. Often in a talking circle, participants are asked not to discuss what was said. Because this discussion is shared for research purposes with participants’ permission, I use the term, sharing circle, to reflect the research context in which this group discussion took place.

Out of the total number of 14 participants, 11 people participated in the sharing circle that includes seven clients and four employees. Of the seven clients, only two talk during the
sharing circle. The four staff members include two Aboriginal and two non-Aboriginal who work full time and have worked at Kla-how-eya for at least five years. They are very experienced working in the area of Aboriginal health. The participants’ ages range from 30 – 65 years. Their education levels range from high school, college and university education. I notice during the sharing circle that the participants who receive services from the staff of Kla-how-eya are less vocal than during our one-on-one interviews. One of the challenges I observe during our sharing circle is that participating clients’ comfort level is affected by the presence of staff. During our one-on-one interviews, the study participants are more audible, speak with confidence and open with their storytelling. I have the feeling that the participants who receive health and social services from the staff in attendance are hesitant to respond or make any comments due to fear of possible repercussions. The participants had previously been informed that they are under no obligation to participate, and their non-participation makes no difference to their care provider – client relationships.

**Interview and sharing circle analysis**

A content thematic analysis approach is used to interpret the meanings of the 14 individual interviews and facilitated sharing circle that includes 11 participants. I utilize a combination of a conventional and directed analysis approach. A conventional approach is used in terms of coding the words most commonly used, then they are put into categories that are about relationships with staff, identification of caring practices, working conditions, effective communication and working together in an appropriate physical environment. A directed approach uses a theory for guidance in determining initial codes. I use concepts such as accessibility, availability and acceptability for this directed approach. Chapters Five and Six elaborate on the analysis themes.

The following is a description of the stages of data analysis. I first have individual participant’s stories transcribed, followed by the transcription of the participants in the sharing circle. I literally identify and count descriptive words used by participants that express their feelings and perspectives on questions asked during interviews. I then group these common words under one of the three main research questions. I also color code and organize the common words into what started to appear as repetitive themes under each question. Upon reflecting on the questions and participants’ responses I then group the
identified common themes into the following headings: Accessibility, Availability and Acceptability. In the next analysis phase, I place the themes of what facilitates and hinders availability, accessibility and acceptability in an adapted wholistic Medicine Wheel Framework that includes the following health realms: physical (body,) emotional, (heart), mental (mind), and spiritual(cultural).

**CONCLUSION**

In this concluding section, I share some of the highlights of carrying out the methods for this study. I did not mention the role of food during the research process, so it is included here. Food is an important and successful aspect of our visits (interviews and sharing circle). A blessing occurs before the meals. We have breakfast before our first gathering. When I return to give a presentation of the preliminary findings, we are gifted with a beautiful luncheon created by the Kla-how-eya Culinary students. Culinary courses are available every three months as part of the students’ preparation to go further in their post-secondary education. Food is reverent as in our culture food sustains us, in return we show our respect and responsibility towards caring for our lands and oceans.

The interviews often become conversations between the research participant and me. I think the reason is that there are so many similarities between our respective stories that I easily identify with their experiences. I can ask for more information about some sensitive matters because I understand issues such as the impact of residential school. The participant may be more willing to discuss these difficulties because they are talking to someone who has lived it too. A greater depth of understanding awakens some dormant memories of my own Indigeneity and as a result, impacts my understanding of this sensitive research topic. This learning allows me to appreciate the possible connections, similarities and differences of research paradigms pertaining to different worldviews.

During the elders’ conversations, I experience their respectful, genuine, compassionate and honest connection with their heart, mind, body and spirit. I look at the heart as the emotional dimension, the body as the physical dimension and the mind as the mental and the spirit as the spiritual dimension. The stories that are told with these qualities make them seem real and stir up emotions inside me. These stories captivate my attention and resonate with my
upbringing and Indigenous ways of being, such as feeling ‘one with everything around me’ and feeling safe.

On the other hand, when I interview the younger generation who were born in and have lived their lives within the cities, emotions are stirred up in them such as sadness, especially participants who do not have family or community with whom to make that connection and interrelatedness. During the interviews a lot of emotions are expressed. When emotions arise, I sit in silence to show my respect for their feelings. I give them a few minutes until I can see that the participant is feeling better. I mention to them, after a couple of minutes, that whenever they are ready, we can continue, only if they wish, which they are always willing. When I reflect on both methods, each of them comes across as being therapeutic for the heart, mind and soul; it certainly gives me deeper understandings of what shapes their feelings.

The upsetting stories about non-Aboriginal health care providers’ responses to the participants stir up feelings for me, as I vividly remember how I was treated differently years ago when I had lost my ‘voice’. I feel deep empathy listening intently to each urban Indigenous participant’s story about their challenging experiences of attempting to get the health services they need. Each participant that is interviewed, shares their stories of racist, discriminatory, demeaning experiences of living away from their familiar, safe feeling and welcoming communities. Being an Indigenous person who has lived most of my life away from my family, culture and community, having relocated to cities and urban suburbs, I certainly relate to the participants’ perspectives and experiences.

Reflecting on my years spent at the residential school, I recall the sad feelings of being away from family, culture and community. I experienced the difficult physical, emotional, mental and spiritual effects that the urban Indigenous participants are experiencing. When I attended high school at Abbotsford and Chilliwack I experienced loneliness, isolation, racism, and despair, which continued in different urban sites during my nursing programs.

Being an Indigenous person, student and nurse, I recall the many institutional places where our culture, language and history are not acknowledged. In choosing my research topic about urban Indigenous people’s experience with health services, the driving thought in my
mind, heart and soul is about finding ways to improve the health and well-being of Indigenous people who re-locate to cities. Furthermore, this main thought becomes a shared vision and action towards improving access to mainstream health services. Hanson (2009) refers to this approach as, “co-keepers of a shared space in which people come together from differing cultural backgrounds and in which cultural competence can be experienced” (p. 246). The empathy towards urban Indigenous people in alien environments experiencing challenges motivates me to do research where the protocols, beliefs and values of Indigenous people are recognized and acknowledged. It is my hope that the results of urban Indigenous voices are heard and support a process of wholistic health planning for all Indigenous people. The acknowledgement and use of urban Aboriginal people’s beliefs and worldviews in an urban landscape, can also be looked upon as tools to help them overcome their fear of racism and discrimination. The next chapter focuses on the ‘voice’ and perspectives of the research participants for these purposes.
CHAPTER FIVE: BEGINNING HAMUMU’S TRANSITION

In the previous chapter I described the research design, methods, ethical considerations, and analysis process used in this study. In this chapter, I present the participants’ stories and perspectives to illustrate the analysis and findings from individual interviews and the sharing circle (focus group) session. The chapter begins with the establishment of Kla-howeya based on the memories of its co-founders. Then some of the urban Indigenous clients’ and elders’ stories about what facilitates accessibility, availability, and acceptability of health-related services at Kla-howeya are presented to show respect for and to privilege their voices and perspectives. I then present both clients’ and care providers’ perspectives about what hinders and facilitates the use of both mainstream health and social services and those of Kla-howeya using an Indigenous health wholistic analysis framework that includes physical, emotional, mental and spiritual realms. The chapter concludes with a discussion about the major themes from the interviews and sharing circle. Hamumu begins its transformation with the wholistic findings of what facilitates and hinders health-related services for urban Aboriginal people in this chapter.

ESTABLISHING KLA-HOW-EYA: CO-FOUNDERS’ PERSPECTIVES

In this section, the establishment of Kla-howeya is presented through the memories of its co-founders, Jane and Tim. Jane, one of the administrators and her husband moved to the BC Lower Mainland in 1979. Jane got so lonely being so far away from her homeland in eastern Canada that she looked in a phone book and saw a listing for the United Native Nations Society (UNNS). The UNNS was formerly known as the BC Association of Non-status Indians (BCANSI) that was established in 1969. The United Native Nations Society was formed in 1977, as a non-profit BC organization to address the political and socio-economic concerns of Aboriginal people living off-reserve. Jane spent a lot of time there. At that time, Surrey had the highest rate of Aboriginal people; however, except for a small Métis centre, no other social services existed for Aboriginal people in this city. Tim, the former president of this Métis centre felt that this centre was too small for their membership. Jane and Tim met together and they both agreed that they needed something bigger that was totally Aboriginal.
The first place established for Aboriginal people was in Jane’s garage, the second place was at a warehouse, then the third venue was at a common room at Kekinow Native Housing until an executive director was hired to manage and to acquire Kla-how-eya as it sits today on 108th Avenue and King George Highway in Surrey BC. The administration suggested to board members that Kla-how-eya become an Aboriginal Friendship Centre with the official name of the Surrey Aboriginal Cultural Society (SACS) in 1993 to expand their facilities.\(^{41}\)

When speaking of their own and their clients’ experiences, Jane and Tim emphasize the disconnection and separation from their communities, cultural activities and other Aboriginal people. Jane reinforces the importance and influence of learning one’s culture and identity and how this cultural knowledge influences urban Indigenous peoples’ self-esteem, confidence, strength and sense of belonging within society. Jane mentions how learning about and connecting with Indigenous identity helps the clients connect to their families, communities, culture and spirituality.

Jane shares that upon realizing the volume of Indigenous people that had located to the inner cities of the Vancouver region she also appreciates that just getting together as Indigenous people is important for many of the urban Indigenous people. Furthermore, she discovers that good quality services for the people is about being connected to each other in one way or another. Getting together with one another is mentioned repeatedly by each interviewed participant.

Another profound aspect mentioned by the co-founders is the theme of learning about one another and having a place to gather and tell their stories to one another about their aches and pains and their challenges. Having such a place enables them to support one another and gain strength as a collective to carry on in city life. The co-founders discuss the diverse range of elders, young mothers, fathers and other clients that use Kla-how-eya’s services. Despite their diversity, a common theme is – their love for one another, respect, affection, caring, sharing and learning. The next section reinforces the co-founder’s perspectives about

\(^{41}\) In 2011, Kla-how-eya or the Surrey Aboriginal Cultural Society changed its name to, the Fraser Region Aboriginal Friendship Centre Association (FRAFCA).
the value of Kla-how-eya where participants’ stories reflect commonalities in terms of shared values, beliefs and worldviews as urban Indigenous people.

**Participants’ Positive Stories—Successful Health Services**

In this section, seven participants’ stories of positive experiences and their perspectives are presented through their quotes and my paraphrasing of their main points. Their stories and perspectives include aspects of a wholistic approach that relate to one or more realms (physical, emotional, mental, and spiritual) and are inter-related in that the realms may influence one another.

Annie, an elder who previously worked at Kla-how-eya for six years with elders and children, shares the following about her positive experiences:

> They do have lot of people coming here. You get to know the people who work here, different people and you feel at home with them. You’re made to feel welcome. You know they all come together and feel good. You’re all on the same page …even though [many] might come from different areas. People feel free to come here, all ages, all the way up to their 80s, [children] less than 6 years old, family oriented with extended families. What they’re doing is good, I trust the care they’re going to give, [we are] treated respectfully. Care they give is Indigenous based or something, like values, supportive, they listen without judgement. (Interview, 2011)

Annie notices that there are many non-Aboriginal people who are delivering health and social services for urban Aboriginal people. Annie shares, “Here at Kla-how-eya they would know you, your history, it’s not like walking into a clinic where you don’t know anybody” (Interview, 2011). She mentions how apprehensive people feel when they do not know people.

There are healthy lunch programs for the pre-post natal programs, which are provided by Kla- how-eya’s culinary education program. The culinary program provides many nutritious well-balanced meals for Kla-how-eya’s health and social programs and services. Annie observes that
every day there are well attended programs and services, attended by different ages and gender for different programs. Most of our clients are under the age of 60, there are healthy living and life-skills programs and services for youth, young moms and families…. We have over 70 programs here at KAS.\textsuperscript{42} we desperately need more space for programs as well as a place where we could take children out for fresh air, Fridays are park days with bagged lunch. (Interview, 2011)

Caroline, a mother, talks about how in the past it was difficult to attend cultural events, she would just stay home, furthermore she said she just isn’t a person who searches for help. She once had a bad experience with a counselling place where a negative experience prevented her from seeking future counselling help. She goes on to say it is still hard and embarrassing for her to go out in public, although she admits that she needs to change her thoughts on getting help. Caroline shares how she feels about using services at Kla-how-eya:

I wish this was here years ago when I first moved away from home. I am making friendships. Everybody is laughing, talking and helping one another. You can get childcare, gift cards for groceries and transportation. Great support, a lot of information on raising children. I am communicating with mothers. Relationship building, all of us mothers built that relationship, and we’re still in contact today. Care here is without judgement. Workers are nice and friendly, you can go up to them and talk, [they are] down to earth people. I receive call-backs to see how we’re doing, especially if I haven’t attended a program for awhile, they do call-backs just to make sure we’re doing good. I tell [my] cousins about this place, I tell everyone I know. I even was going to enrol in Culinary school but didn’t have a scheduled babysitter. I probably would be just sitting at home and avoiding everything. It gets me out and puts a smile on my face every week. I’d like to go to family nights, but it’s getting there [is a problem]. (Interview, 2011)

Living within the inner city, Caroline feels not only strange but alienated from whom she is as an Indigenous person, always feeling embarrassed, lonely and different. In addition, she

\textsuperscript{42} Some participants referred to Kla-how-eya as KAS (Kla-how-eya Aboriginal Society).
experiences feelings of isolation, not knowing anyone or anywhere to go. Most of all, Caroline feels like there is no one trustworthy out there to sincerely meet her basic needs, nor specialist services. She decides that she would just stay home following a very negative experience, in fact, she feels that she can no longer leave her home. If her mother hadn’t suggested this good place to go (Kla-how-eya - KAS), her life would not have changed for the positive.

Caroline got up the courage to attend KAS, furthermore, she started to access and utilize its services. Caroline’s life changed with the provision of consistent cultural kind care and understanding staff who relate to the perspectives and experiences of urban Aboriginal clients’ lives. Positive changes started happening to her in a wholistic way, her physical, emotional, mental and spiritual needs are met through the development of relationships and trust from the healthcare providers. Furthermore, now Caroline feels safe, comfortable and so good about KAS services that she returns weekly.

Joey, a father, summarizes what he likes about the centre in the following way:

I like lots of things about Kla-how-eya. They help access housing, there is a printout of homes available. So unlike hospitals and elsewhere, we must line up for a long time with a whole bunch of people, since it is only Aboriginal, they help Aboriginals and makes things go quicker, and you do not have to go to many other places. You end up with more time, yeah, they don’t rush you. Referrals to Aboriginal Healing Place – pretty much circled around infants and pregnant women, it’s very family oriented. I prefer to go here because Aboriginals are all the same, pretty much like family. Early childhood education is all about family. Spend time with each other, the whole family participates. Workers ask about you, take time for you; calm and slow. Had some problems, they cared about me and the situation. The employment service is good, clipboards with jobs available, construction and transportation, [which] really helps a lot. It just feels so different here because you know everyone; [it is] family oriented. I like this place a lot but one thing it could be expanded and have all services here that Aboriginal people need in this area. (Interview, 2011)
Joey is young and far away from his homelands. His parents separated when he was very young. He really appreciates the friendly staff, environment and clients; they spend a lot of time together and the whole family participates. Joey’s perspectives about what makes urban Aboriginal participants prefer to attend programs and services provided by Kla-how-eya illustrate the different feelings people have when they attend responsive services provided by Aboriginal people for Aboriginal people. Services provided by people who are “like you” have that contextual understanding and know your needs because they may have shared the same experience, therefore they have “been there” and know what it is like to be unacknowledged, unrecognized, and treated disrespectfully. Joey recalls that his father was never around and how he was not able to parent him; he was basically abandoned and still today he experiences a lot of abandoned feelings. His mother did her best with what she knew about parenting. There are many who reside in the inner cities who have difficulty parenting. The theme of parenting difficulties is an effect of residential schools that causes pain and feelings of unworthiness (TRC, 2015). These effects cause a lot of inner turmoil and suffering for the young people who are not nurtured or cared for by parents who show love to their children. Often the parents did not receive loving care in residential schools which also impacts their care once they return to their home communities. These feelings of abandonment and feeling alone further contribute to their sense of disconnection from their families and culture resulting in their loss of identity and loss of traditional knowledge (TRC, 2015).

The theme of learning about and connecting with Indigenous identity seems to be recognized as an aspect of gaining confidence, self-esteem and resilience in taking steps to be more vocal with their health needs. The young participants further describe the meaning attached to these relationships with the healthcare providers, especially the Indigenous care providers and how significant they are in assisting clients to become empowered, and helping clients to develop into resilient Indigenous people within the urban environment. Shirley, a mother of six children including foster children, lives in Kekinow Native Housing. She speaks about the importance of this sense of understanding and awareness about how Aboriginal people have been affected:
To look deeper than what the paper says, to get a better understanding of why Aboriginal people are struggling. Here at Kla-how-eya they [the staff] take the time to do things that will make them understand the types of care a person needs. For example, the care providers do an intake that includes a client’s history, culture and their socio-economic status, ensuring to take care of their basic needs otherwise [the client’s] are in a struggle mode. (Interview, 2011)

Harold, an elder, who was formerly employed as a construction worker to build Kla-how-eya, describes how older people may not understand all the time, how they get confused, and that they really don’t understand what is going to happen to them. He shares the significance of attending the services provided at Kla-how-eya, “the relationships with people here is excellent, everyone works together, helping each other, cooperate with one another. People are smiling and enjoying life, especially kids being happy” (Interview, 2011). He appreciates how the staff help elders and emphasizes that the environment at Kla-how-eya is more welcome, open, and comfortable.

Harold, also talks about his accomplishments when he worked at Kla-how-eya. He speaks about how he feels helping others in need. He also briefly mentions being in a residential school for a few years and how this experience had made a difference in his life. He chose to leave the bad experiences behind and chose to have a more positive outlook on life, therefore his stories reflect resilience rather than deficits. He now shares his positive stories with the younger generation to encourage them to move forward and gain a greater understanding of what their parents may have experienced in residential schools. He believes that his positive stories contribute to the young people letting go of their negative feelings and experiences.

Trisha is both a staff member and utilizes Kla-how-eya’s health services. Trisha performs many different roles including administration, children’s programs, and client referrals. She shares some of her successful experiences as a client and ways that Kla-how-eya makes a difference in delivering services to urban Aboriginal people, saying

when I compare Kla-how-eya to the other services, we’re like family, we interact with one another that shows our values, people are kind. [We have a] sense of
family, everyone is great and so easy to get along with, makes it enjoyable to come here. I feel so comfortable with the Nurse Practitioner, she is warm hearted, kind, not hurried, talks to you like a person, not a client, takes time to get to know clients, committed and caring. (Interview, 2010)

Trisha (Interview, 2010) describes her days at work as, “it’s great to be here and people that come here say the same thing, how great it is here.” She emphasizes how the environment is appreciated because of the services they offer and that it’s free, which is so important for people on limited income. They don’t have to face so many people they do not know, which reduces their discomfort. Trisha says, “I love my job helping and watching children grow from toddler to little people, that I just love so much.” She mentions how the environment gives them a sense of family and makes them feel like they belong: “everyone is just great and so easy to get along with…makes it so enjoyable to come here, and most of all we leave here feeling good and looked after.”

Lily is an Indigenous elder, who has worked at Kla-how-eya for five years. Lily received her Dogwood certificate at the age of 50. She enjoys working with young people including very young children. As well she supervises the children whenever the parent/s are attending programs. Lily speaks with pride when telling her story about being recognized and that children are happy to have her around daily, therefore she feels this is her most important role: being an adopted grandma. She states most children come from separated families who have no grandparents in the city.

Getting to know the children and families is critical before they begin to trust Kla-how-eya’s care providers, including the Indigenous workers. The clients are not judged, they are made to feel comfortable and special in their own way. Most staff mention that the clients probably would not go to regular places, meaning mainstream services. If they went to these services, they would not share what is wrong with them in terms of their health problems especially social health problems because they fear being judged negatively. At Kla-how-eya, the clients feel more comfortable, recognized, and acknowledged. They are not “judged or put down.” The staff often wonder what would happen if Kla-how-eya closed, where would the urban Indigenous people go for help? The staff know each client as individuals
and they state that it takes almost a year for them to gain the clients’ trust. The staff have
gained enough knowledge through clients’ stories to know that the clients would not access
mainstream services because of their fears of past social suffering, and experiences of
racism and discrimination.

As stated earlier in this chapter, I present participants’ perspectives in their own words with
additional text that paraphrases their experiences in a story format to honour their expertise
of their personal knowledge. I now show what I have learned from the participants
(wholistic analysis) in Figure 12 that shows the positive common themes that emerge from
participants’ perspectives about Kla-how-eya’s health services. These themes are placed in
the Hamumu wholistic health image: Physical reflects the welcoming environment,
collaboration amongst people involved with Kla-how-eya and its resources; Emotional
reflects caring ways, understanding, and kinship; Mental reflects different (relevant) care,
good fit and empowered approaches; Spiritual reflects Indigenous knowledge, ceremonial
events and cultural ways. These positive themes are elaborated upon in the next section.

Figure 12. Availability, accessibility, and acceptability of health services at Kla-how-eya.
PARTICIPANTS’ CHALLENGING STORIES OF HEALTH SERVICES

When the participants discuss their positive experiences at Kla-how-eya, they usually compare their stories to their negative experiences of trying to access provincial health services. This section uses the wholistic analysis framework (physical, emotional, mental, and spiritual realms) to present participants’ perspectives regarding attempted access to provincial health services.

While this section emphasizes the difficulties with attempting access to the provincial health care system, these challenges are contrasted with positive experiences participants had at Kla-how-eya or what they hope for in the future. The following four themes emerge: (1) Physical Realm: Cold environment, Racist attitude, Lack of resources, and Lack of collaboration and communication; (2) Emotional Realm: Colonial injustices, Alienation, Relationships and trust, and Assumptions; (3) Mental Realm: Lack of understanding, Health and literacy, Different care, and Disempowerment; and (4) Spiritual Realm: Lack of Indigenous knowledge, The need for a wholistic approach, and Disregard of culture.

NARRATIVE THEMES

1. Physical Realm

Cold environment

One of the participants’ biggest challenges is accessing health services. At a basic level, the physical structure of medical buildings creates barriers to health services. The structure of buildings, their location, the inside environment and staff behaviour negatively impacts the participants when they attempt to access non-Indigenous health services.

One participant, Annie, who was formerly employed by Kla-how-eya and who is now retired, contrasts the cold unwelcoming feeling imparted by mainstream facilities that are usually located within large concrete buildings with the warm welcoming feelings, friendly voices and smiles imparted by Kla-how-eya’s indoor environment. Annie mentions the significance that the Aboriginal workers and mentors have on the Aboriginal clients’ lives. She also describes how this positive influence greatly contributes to clients’ decisions to continue using services at Kla-how-eya. The positive relationships that clients have with the
Kla-how-eya staff, who are mainly Aboriginal, contribute significantly to clients’ continued usage of these services. Annie put it this way:

Have you ever noticed non-Aboriginal health and social services? I think it is quite impersonal because the building is too big, and they deal with so many people, I wonder how they can keep track of everybody? Big fancy building in Surrey, X-Ray, Lab versus Surrey Aboriginal Cultural Society, looks like a smokehouse, big house, feels like home, we all know each other, we need to go somewhere where they know us, and care for us, respect us. (Elder Interview, 2011)

_Racist attitude_

Several participants are concerned that health care providers have racist attitudes or as gently described by participants, they lack respect for Indigenous perspectives and ways of knowing. Regardless of how this negative treatment is characterized, its actions (which portray a physical movement) have a detrimental impact. Many of the participants emphasize the importance of showing respect in their relationships to move to a positive direction. They also believe that respect is one of the most important actions lacking in mainstream care providers’ practice. In addition, participants add, how this lack of respect sometimes leads to challenging encounters in developing good relationships between client and nurse/care provider.

Other women have delivered their babies at Surrey Memorial Hospital (SMH) and have had excellent experience, no issues or concerns but Aboriginal people…have had a totally opposite experience. There’s just a whole variety of things that give them the lack of wanting to go to the doctor, clinic or hospital, all of this just doesn’t take place unless the Ministry of Child and Family mandates that they have to go and do this check up now. (Family support worker, Interview, 2011)

One elder highlights the difficulties urban Indigenous people experience when attempting to develop relationships with provincial health care workers and how this affects their decision not to go to those health care services again.
Sometimes when we go to different places and they know you’re Aboriginal, they put you to the last before they do anything. I’ve seen that a lot of times. Even these days, oh yeah, I’ve seen it a lot. You wait in line, like being put last. I know an elderly woman who had a stroke and was taken to SMH, never got the care, this happened twice and she never was told that she had a stroke. The third time, she went to Royal Columbia hospital where they informed her of the stroke. The elder had to return to SMH to get exercise and speech therapy which she never did receive. She kept waiting and waiting, kept asking and asking, months went by, she had two more smaller strokes and she passed away. (Elder Interview, 2011)

It is apparent from the responses that some families are reluctant to access mainstream health and social supports due to lack of trust, fear of racism and discrimination. Most participants have a tie to the history of residential schools either through grandparents or other relatives, therefore, past fears of institutions still exist especially for health and dental clinics, emergencies and hospitals operated by non-Indigenous people. Most participants prefer to attend an Aboriginal one-stop-shop place where services are provided and there is no need to travel to many places and endure other barriers such as lack of money and extra costs to bring children.

**Lack of resources**

As mentioned in Chapter Two there are numerous documents with recommendations and directives referring to the provision of equal and equitable health services for all British Columbians. Health documents and reports are from various levels of governments: World Health Organization (WHO), Canada Health Act, Federal - Health Canada (HC), Provincial - Ministry of Health (MOH), and Provincial Regional Health Authorities. Participants unanimously agree that one of the federal and provincial governments’ responsibilities is to improve access to health facilities and agencies. Evident in respondents’ stories is the dire need to improve lines of communication amongst governments, provincial health authorities and the Aboriginal peoples who have located to the inner cities of Canada, in this case within the inner cities of metro Vancouver region.
Kla-how-eya is a non-profit organization that is required to reapply for funding annually. Its main funding is from the BC Ministry of Children and Family Development (MCFD). The Surrey Aboriginal population is growing at a rate of 7.9% per year while Vancouver’s Aboriginal growth rate is at 1.3% per year. Despite the fast growth of the self-identified Aboriginal population in Surrey, Kla-how-eya receives very little funding to meet the wholistic health needs of Surrey’s urban Aboriginal population (Telephone conversation, current director, October 2016). Many participants recommend that a full time Nurse Practitioner (NP) is needed. They use the “moccasin telegraph” to tell others about the good service that the NP provides, which has led to a dramatic increase in clients wanting to see the NP. To supplement its limited funding, Kla-how-eya has multiple partners and each relationship is linked to a specific program or initiative.

In British Columbia, whenever there is an anticipated funding source available, communities including those located off-reserve go into a competitive, proposal driven process to access the already limited fiscal resources. There are rules and regulations that are based on national regulations even for small organizations either on-reserve or off-reserve. Sometimes despite the needs assessment carried out by Kla-how-eya’s programs and services, the Ministries of Health and Social Development disregard the data given knowing that the Aboriginal population continues to grow at a rapid rate compared to Vancouver, which receives a lot more funding than the city of Surrey. In other words, from the onset there exists at Kla-how-eya an adherence to the rules, standards and regulations of forces outside their control. The current executive director (in 2016) mentions that they no longer have a Nurse Practitioner, yet the previous director couldn’t praise the Nurse Practitioner enough for her success in gaining so many clients in a very short time and that she was the most seen practitioner on site. Staff members believe that when there is an identifiable need for programs and services, and they have proven success, their funding is cut off. There are less services now than before!

Nevertheless, the need for funding, resources and space are greatly needed. Indeed, as one Indigenous employee, who works with children at Kla-how-eya observes, “Minor core funding will never meet the needs of urban Aboriginal [people]. When you look at funding [what] they give to mainstream programs compared to what they give to our programs, it
just doesn’t match up, even mileage and wages are not on par” (Interview, 2011). During the sharing circle an Indigenous staff member voices frustration about inequitable funding and the additional health-related services that are needed:

People don’t have that understanding that we have the bare minimum funding to meet a need (gap) that is greater than you will understand! Is there anything available for our families to deal with the PTS (post-traumatic symptoms) and multigenerational trauma of residential schools, no! Has there ever been, no! (Sharing Circle, 2011)

Another Indigenous staff member who provides services to the families goes on to share, “Health services are high in demand, it’s almost surprising and amazing to see how needed this clinic is, and how much it is utilized, and to think what these families were doing before?” (Interview, 2011). A Kla-how-eya staff member observes that clients do comment that the mainstream programs are great, they have wonderful buildings, equipment and facilities but that feeling of belonging or acceptance doesn’t come into play. They have great centres but it’s just different here at Kla-how-eya Aboriginal Society (KAS). Its location is key, close to transit, one block from sky-train. A lot of times it is too hard for families to go to Dr’s appointment because they don’t have the money or don’t have the bus fare to other transit to make connections. (Interview, 2011)

*Lack of collaboration and communication*

Aboriginal people often have a contradictory relationship with the various levels of Canadian government. Whether in individual interviews or in the sharing circle (focus group), the participants voice deep grievances as represented by the following common comments: “the education system has failed us; the justice system is biased against Aboriginal people, the prison system has failed us; and the health care system has failed us” (Sharing Circle, 2011). The federal and provincial government programs and policies are often not in touch with the reality of the third world conditions Indigenous people live in across Canada. Silver (2008) concurs, noting that
government programs and policies repeatedly betray a lack of understanding of Aboriginal issues; that government has created an ‘Indian Industry’; that there are too many reports, too many programs, too many ineffective and costly big projects, as opposed to grassroots projects; that policies are short-sighted and do not have a long-term vision; and that government has created a culture of dependency among many Aboriginal people. (p. 165)

Indigenous conditions create jobs and the ‘Indian Industry’ jobs are usually filled by non-Indigenous people. The way the urban Indigenous people are treated when they first access mainstream health services impacts greatly their decision not to return to use these health services. The participants’ stories of difficult experiences with insensitive non-Indigenous health care providers aligns with Silver’s perspectives noted above. Furthermore, the urban Indigenous people who are treated negatively by mainstream health services prefer to be accompanied by Kla-how-eya care workers when attending appointments that involve mainstream health and social services.

2. Emotional Realm

Colonial injustices

The impact of historical colonial injustices still exists today. Urban Indigenous people continue to be confronted with rude, insensitive stereotypical remarks and stares as well as other negative body language or are simply ignored. Elder participants are kind in their perspectives about the source of these forms of racism by saying that people are ignorant and have not taken the time to learn about Indigenous cultures and peoples.

Indigenous people also may not feel safe asking for help at a mainstream health service because they are afraid of having their children apprehended. One Kla-how-eya employee participant elaborates, saying

based on what I hear from our clients daily is, they just feel more welcome. They feel safe and they have this feeling that if they do come to see NP about something they are not going to be condemned or judged for it. Cause a lot of times again, these parents just put their things on the back burner cause they’re afraid to disclose anything because it might affect their chances of having their
child apprehended or it might affect the fact that they have their child in their care as it is. A lot of times they just will not go to mainstream because of those issues. They do eventually, if we’re here, again a lot of us can support and actually go physically with our clients to appointments like BC Children’s, Sunny Hill, physiotherapy or occupational therapy. (Interview, 2010)

Reflecting on the services and type of care provided at Kla-how-eya, one caregiver believes that the guidelines of the Ministry of Children and Families Development program results in high rates of apprehension of Indigenous children:

The saddest thing about their policies for apprehension is that when it comes to our young moms who are having babies especially in these regions, Surrey Memorial Hospital (SMH) has the highest apprehension rates of Aboriginal children. On the average three – five children weekly. Can’t we reach them before apprehension? Could we not work together to do something before that? (Interview, 2009)

At the same time, this caregiver notes the opposite treatment of non-Aboriginal parents and their children, which points to possibilities of systemic racism: “Non-Aboriginal young moms and women do drugs and never lose their kids, furthermore if out in mainstream” (Interview, 2009).

Caroline, a young single mother describes how she tried accessing mental health services in Langley to overcome her inability to talk and to deal with severe anxiety whenever she leaves her home, which is rare. Caroline describes how painful this process is for her and how she wants badly to overcome her anxieties. She shares her first experience learning about residential schools. Caroline had heard and seen a bit about the topic, but her mother hadn’t told Caroline any stories about her experiences at a residential school. When Caroline learned more, she was overwhelmed because she just didn’t know this happened to “our own people.” She describes how she learned about boarding homes and foster homes as she experienced looking after 14 siblings. Caroline is the eldest of a mother who abandoned her at a young age which is when she decided to move to Vancouver. Caroline also learned that her grandmother had attended a residential school. The young woman describes how she
Caroline longs to make connections with family, to find out where they were, and to learn about her Indigenous community and culture. Caroline visited a counsellor to start learning about her identity, so she could move forward in life with improved self-esteem and confidence.

**Alienation**

Urban Indigenous populations continue to struggle with social marginalization by mainstream health care providers, and alienation from society. For those who have not experienced colonial cultural suppression, it is difficult to understand the level of mistrust held by Indigenous people toward any large, impersonal institution providing social or health services. There have always been promises made and broken by the federal and provincial governments regarding their responsibilities towards Indigenous people with respect to their social, economic and political policies and practices that deprive Aboriginal people of their wellness opportunities (Royal Commission on Aboriginal Peoples, 1996). Broken promises and irrelevant policies and practices have left a legacy where Indigenous people often mistrust mainstream society and its governments.

Mainstream health care providers who do not take the time to understand the history about Indigenous people may feel that the meaning of ‘mistrust’ applies to them personally rather than understanding this term from a social-cultural historical perspective. Mistrust from Indigenous perspectives has more to do with how they have been mistreated under colonial oppressive and dominant attitudes. For example, colonial laws and institutions like the residential school system and the prison systems have all scarred Indigenous peoples physically, mentally, emotionally, and socially. An example of urban Indigenous people being affected by the isolation and alienation that occurs within inner cities is articulated by a Kla-how-era staff member in the following way:

The 60s scoop of Indigenous children impacted a lot of families to lose their trust in non-Native care providers. Health care providers need to learn and develop an understanding and awareness’ about how Aboriginal people have been affected. Outside care providers need to look deeper than just what the paper says, to get a better understanding of why Aboriginal people are struggling in everyway. A lot of people don’t feel they can reach out to get support, so they just stay to
themselves for fear of the underlying reasons outside care providers may want to see them. Especially the young mothers are required by social workers to have urine screen for drug testing for child protection stuff. Another young mom had to get hair test done by a social worker, no regard for cultural protocol about our hair. How heartless, took no time to take young mother’s history as a child … the pure ignorance of people not understanding. (Interview, 2010)

Furthermore, participants often mention how they prefer to just stay at home unless there is something they can attend at Kla-how-eya due to the racist and discriminatory attitudes of mainstream society. A Kla-how-eya staff member who had worked for mainstream health services echoed her clients’ fears, saying that

the young girls are not accepted out there [in mainstream services]. I believe them when they say they are treated differently. Young girls are afraid at hospitals, especially if they put Aboriginal on the form, social worker shows up, and ready to apprehend children. Young moms will not attend prenatal classes or even see a doctor for months if she’s pregnant for fear of being targeted by social workers. (Interview, 2010).

**Relationship building and trust**

When asked about their thoughts on how the mainstream health services might incorporate Indigenous cultural components to health and social service delivery, most respondents emphasize that trust building, and respect are important considerations for this process. Culturally speaking it may be hard for somebody outside Indigenous cultures to grasp Indigenous peoples’ concepts of lack of trust and lack of respect, especially when there have been minimal changes in health policies and practices towards Indigenous people. Many times, the question is posed: Why trust? On the other hand, there are more non-Aboriginal health care providers who are trying to learn about Indigenous historical colonial devastating atrocities.

There are mainstream health care providers who are truly trying to help, but it usually takes at least a year to gain the trust of First Nations and Métis clients. Most of the participants often mention the following thought during the individual interviews and sharing circle, “if
your heart is in the right place that’s all that matters” (Individual Interviews and Sharing Circle, 2010, 2011). As we can see from the participants’ responses, their view of the time it takes to build trusting relationships is intertwined with the concept of respect. It takes time to build trust, and respect for Indigenous people and Indigenous culture needs to be embedded in the trust-building process.

Relationship building and trusting the mainstream health care workers are huge challenges to many urban Indigenous people. Compassion plays a critical role in alleviating these challenges. Hanson (2009), states, “The experience of human compassion is founded on human beings coming together in a relational space that provides for respect and dignity. Compassion combined with understanding ensures a willingness to connect and respond to the dynamics of a relationship. Even with profound differences in culture, compassionate understanding provides the connection to make relationships work.” (p. 244). Hanson’s point about compassion makes me wonder if non-Indigenous people only understood our history and the impacts of colonial policies on our people, would this knowledge make a difference to how they care for our people? Knowing about Indigenous history and culture, is important, but the participants’ quotes above about having “heart” reinforces Hanson’s point. Hanson also states, “it is behaviour and compassion on the part of the provider that contribute to the possibility of successful engagement with a person or group from a different culture. The recipient of care [client/patient] also has to take a step into the relationship to be able to see cultural competence at play” (p. 245). I also think that this relational space can be where cultural information can be shared or strengthened. More importantly, this common bond of humanity is consistently demonstrated through the actions of the client/care-provider relationships at Kla-how-eya. A family worker says that they have to feel welcome and comfortable; they’ve taught me to learn patience; once they trust, they’re for life. We have to see them right away, otherwise they won’t come back, may end up on the street or need housing. There’s no difference, treat everyone equally; no racism within our own. We’re one culture but different traditions – respectful, reverence of one culture. If they don’t like something, then that’s their choice, they don’t have to. (Interview, 2011)
One of the urban Indigenous single parents expresses her appreciation for the support she receives from Kla-how-eya compared to mainstream services, saying that the services are non-judgemental, understanding, much easier to get services as I was impacted by mom being in residential school, and my dad in custody a lot. Everyone educates themselves on different cultures, they’re open to learning. A lot of supports available. Timelines are available, perfect time for people to access. (Interview, 2010)

Relationship building is one of the key themes that emerges in the study. The urban Indigenous clients and care providers of Kla-how-eya believe that the personal support clients receive, and the support given by care providers makes the clients feel respected, like family; they are comfortable and well-treated. Timely provision of health and social services of all types is appreciated.

I draw upon Archibald’s (2008) notions of respect. She states that during her interviews with elders, she came to realize that respect must be an integral part of the relationship between an elder and the researcher – “respect for each other as human beings, respect for the power of cultural knowledge, and respect for cultural protocols that show one’s honour for the authority and expertise of the elder teacher” (p. 41). Just as the elder participants in Archibald’s study emphasize the culturally specific ways of expressing respect, in addition, the participants in my study believe that the Ministry of Health and their sub-organizations should acknowledge the importance of incorporating cultural knowledge into programs and services to facilitate feelings of comfort and relevance.

Assumptions

Furthermore, Indigenous people continue to experience racism, and discrimination and are treated differently when attempting to get help in an urban clinic, store, hospital and emergency. Participants’ narratives speak of negative experiences and perspectives when attempting to access different types of services including doctors’ offices, hospital emergencies, laboratories and X-Ray services, bus services and stores. The following statement by an elder describes disrespectful treatment this way:
I do not know why our people are treated disrespectfully, we are good people and they try very hard to walk a good road, they regularly attend programs here so that they can survive the outside world, and to learn how to get around in this huge system. (Interview, 2010)

The way that Indigenous people are treated in the public such as in retail stores leaves them with negative feelings that stay with them as they enter health sites. A young mother recalls her experience of being treated differently, saying

we are looked at and treated differently when we walk into a store, any place, sometimes I think that they all have that belief that we all steal, and we’re followed around a store, and even in a restaurant, as if we are different, I know we are different, but we are looked at differently in a negative way. Almost always we just leave because it is too uncomfortable and embarrassing to be watched all the time. Why do we have to be treated differently? (Interview, 2010)

An Aboriginal worker discusses the complexity of cultural difference that is connected to one’s educational level in the following way:

Cultural difference is what keeps our people back a lot from going and getting services that they need, and keeping their children up to date, and it is the same with the dental system. There’s a whole whack of upkeep that they’re not going to do because you try something once and it doesn’t work, they tend to not go back. I think that’s the biggest thing I notice is just that cultural difference and that barrier that is always there. You’re not perceived in a certain view or a certain eye to them, I say that because I go to a doctor for prenatal care, she knows my background, my education, all my experiences, she treats me differently. It’s like, oh well you already know all this, you have no problem...I kind of think in the back of my head. I know certain clients that do not get treated that way because they also look at, well you’re educated and you’re this, so you can take care of yourself ... whereas some of them can’t. (Interview, 2011)
There are too many colonial assumptions made by mainstream health and social care services that I have witnessed as a registered nurse who has worked for the past 44 years in the various hospital settings and health field. Nurses covertly made negative comments about admissions or discharges of Indigenous clients. Discriminatory remarks were usually based on either their lack of understanding, colonial assumptions or racist views. The admission forms were mostly check marks, partly based on the client’s physicality and devoid of any in-depth questioning. For anyone to get to know a person they need to know their family and cultural background. The whole history about the clients was usually omitted, so how could a care provider provide complete care?

3. Mental Realm

Lack of understanding
Aboriginal people who know about their cultural ways, usually know that health is about balance and the interconnectedness of all living matter, but our philosophy of health and wellbeing has been shackled and reshaped by colonialism. The modern mainstream health care system dedicates too much time to a sickness model and very little to prevention and wellness (Adam, 2015, p. 167).

Many participants agree that due to the continuous existence of erroneous assumptions about First Nations and Métis people within the mainstream society, there is a need to educate mainstream society and the health care system about Indigenous historical and cultural knowledge. The participants feel strongly that the Ministry of Health and Health Authorities should support the development of an educational approach that would raise awareness and understanding of Indigenous people. In addition, the participants agree that an understanding that all Indigenous Nations are distinct in terms of their culture, values and traditions is helpful in terms of individual and community health plans. More importantly, the education required is the need for mainstream care providers to know their own history. The idea of knowing your own history is to understand that there is a cultural component such as philosophy, beliefs and values to all cultures. In addition to knowing or familiarizing themselves with their culture, people may realize that there are differences as well as similarities within each culture.
To overcome these societal barriers, mandatory education on true Canadian/Indigenous historical facts also needs to take place in hopes of changing stereotypical attitudes of those who work in the health-care system and is part of the process of knowing one’s history if they have grown up or live in Canada. Not understanding or not wanting to learn about the impact of colonization is not acceptable. Culturally competent education should be made compulsory for all those who provide health care to Indigenous people. This recommendation, included in the TRC calls to action (2015) will be discussed later. A Nurse Practitioner emphasizes the need for professional education to address stereotypical notions, saying

I think the different levels of government have to listen to people at this level with focus groups and get some feedback directly. If more people had a chance to take those kinds of courses I think it would help their understanding of Aboriginal people when they come across them. It would break down some of the assumptions. (Interview, 2011)

A couple of Aboriginal staff members in the sharing circle reinforce the need for Aboriginal studies/education to be offered to medical and nursing schools and health programs for all care providers within the mainstream health system because they themselves had negative experiences in the past. They said too many Aboriginal people are moving to the inner cities and they (staff participants) did not want the urban Aboriginal population to have the same negative health experiences as they had. Health care providers who learn about the impact of colonization and the issues that urban Aboriginal people face may then treat Aboriginal people with respect, which may encourage Aboriginal people to continue using health services.

Another elder expresses the need to have more Aboriginal people working as health care providers, saying “we just need more Aboriginal people in health. When clients see an Aboriginal person it’s easier for them to say things. I just think we need more of our own people out there” (Sharing Circle, 2011). One parent mentions the importance of having an Aboriginal health care worker, especially for those moving from a rural area into the city:
There are Aboriginal people coming into an urban setting, you all of a sudden don’t have services rural communities have, [an Aboriginal] support person to go in and help you. We need [an Aboriginal] health liaison to provide services. Would make a big difference to how the families and clients follow through with their needs. (Sharing Circle, 2011)

Implied in both statements above and what others said about Aboriginal health care providers is that they also need to know and understand aspects of Indigenous culture/knowledge and the impact of colonization.

The current director reinforces the above needs and benefits for developing trusting relationships, noting that “building trustworthy relationships is paramount, particularly so they can fill that gap of misunderstanding, misinterpretation, discriminatory attitudes, inaccurate beliefs and assumptions about our urban Aboriginal people” (Interview, 2016).

Participants throughout this study echo this thought: sincere attempts to understand and respect who we are as Indigenous people can and will positively improve available, accessible, and acceptable health care for Indigenous people.

Health and literacy

The low rate of high school graduation for Indigenous students is a real concern of many participants. One elder notes that “another thing is that Aboriginal people are ashamed to say that they do not know how to read, write and don’t understand but feel comfortable and safe without judgement when we’re all in the same boat, especially here at Kla-how-eya, we all know and help each other.” (Interview, 2011). At the same time, the Kla-how-eya staff and clients understand the problems of low literacy and are comfortable in helping each other in this regard.

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43 The BC Ministry of Education report that in 2015/16 the graduation rate (six-year completion from high school) for Aboriginal students was 64% compared to non-Aboriginal students who had an 86% graduation rate. A further examination of Aboriginal students in grade 12 in 2015/16, shows that 49% of these students completed a Dogwood certificate, which qualifies them for post-secondary education (2015/16 How Are We Doing Report).
Basic literacy/reading is one dimension of health literacy. According to the World Health Organization (Kickbush, I., Peliken, J., Apfel, F., & Tsouros, A. 2013), “health literacy means more than being able to read pamphlets and make appointments. By improving people’s access to health information, and their capacity to use it effectively, health literacy is critical to empowerment” (p. 10). Smylie, Williams and Cooper (2006) provide a definition of critical health literacy that reinforces the WHO concept of empowerment: “the ability of a person and a community to address the systematic factors that affect health” (p. S22).

Adding another dimension to the concept of critical health literacy, such as Indigenous health literacy, reinforces the participants’ views that Indigenous culture and Indigenous people being together and helping one another are fundamental components of well-being and self-determined development. The quote about helping one another demonstrates the notion of Indigenous health literacy that is based on Indigenous values. Such an approach challenges the frameworks and culturally based assumptions upon which mainstream literacy and health policies are often based. Indigenous health literacy needs to be firmly rooted in Indigenous perspectives, understandings, cultures, and socio-cultural realities.

**Different care**

The participants adamantly stress the importance of including cultural teachings and cultural knowledge into the planning and provision of health services because they have often experienced adversarial treatment. They continually remark during interviews and the sharing circle (focus group) that a strong presence of culture needs to be seen and felt when they access and receive health services. One Spiritual Elder contrasts the approaches of “good medicine” with those that were not beneficial:

Giving the person time, that is ‘good medicine,’ talking to them and valuing them. When you’re sitting down with a person and giving good medicine, it is very powerful – non- hurried, non-judgemental, inner-city Natives experience a profound feeling of respect, logic, care and empathy…. if a person feels an adversarial staff person, they won’t go there! Having knowledge and
understanding of the general needs of urban Aboriginal people makes a huge difference. (Interview, 2011)

In addition to understanding health and wellness practices, many participants reinforce the need for the mainstream care provider to understand health and wellness from a wholistic perspective, what in nursing is deemed to be a biopsychosocial and spiritual perspective, going beyond the biomedical model to acknowledge the wholistic health realms that include the physical, mental, emotional, and spiritual aspects of the self as an integrated whole.

**Disempowerment**

Many residential school survivors experienced a loss of culture and disconnection from their families, communities and nations, which resulted in the destruction of identity among Indigenous people. Therefore, many children of survivors experienced intergenerational loss of their Nations’ traditions, ceremonies, values and beliefs. Locating to inner cities across Canada often left them without their Indigenous identity. Consequently, the survivors’ children may not have a meaningful connection to their culture and teachings, where this loss is perpetuated intergenerationally. The cumulative result over years are feelings of disempowerment, social exclusion and social suffering. The participants who are young single parents attribute their mothers’ choosing abusive partners and difficulty parenting to their low sense of self-worth, which was fostered in the residential school.

The denial of a traditional cultural identity amongst the colonized such as First Nations and Métis is a form of what Henderson (2000) refers to as “Eurocentrism.” In Canadian universities and colleges, academic curricula often support Eurocentric contexts. When most professors describe the “world,” they describe Eurocentric contexts and ignore Indigenous worldviews, knowledge, and identity. In contrast, Indigenous scholar, Cajete (2000) refers to the Navajo cultural metaphor, *pin peye obe*, which when translated, means “to look to the mountain,” and refers to striving to gain the highest perspective of a situation. As a residential school survivor, I think Cajete’s metaphor of looking to the mountain is fitting since the wider perspective allows us to take the wide and long view of broad social-cultural movements that sought to grind out the humanity of Indigenous peoples. Cajete (2000)
completes this thought about the healing nature of Indigenous knowledge and relationships with environment and communities.

As Indigenous people recovering from centuries of colonization, we need a perspective from a higher place to understand where we have come from, where we are, and where we wish to go. As you might imagine, climbing this metaphoric mountain within your heart and your soul to reflect on the place that you have come from, on the people who have taught you and shared with you their sense of place and their understanding of life can only lead to healing and reconciliation. As we climb to the mountain and reflect on our past, we begin to understand that life and education are journeys. Indeed, life and knowledge are both ways of knowing ourselves in the context of rich relationships that make up our communities, our environments, and our worlds. (p. 182)

Indigenous scholar, Absolon (2011) reinforces the importance of cultural histories for sustaining Indigenous nationhood: “As cultural histories speak about the cosmoslogy of the universe and our location in it each nation retained, recorded and recounted its own cultural histories. These histories were/are relevant and meaningful to the lives, culture and survival of each Indigenous nation” (p. 26). Absolon’s observation is well supported by the diverse Indigenous participants who reflect on important teachings, and traditional knowledge passed on from their own families, communities and Nations to help them deal with disempowerment and denial of cultural ways through systemic processes.

4. Spiritual Realm

Lack of Indigenous knowledge

One of the challenges of living within an urban city is how difficult it is for urban Indigenous populations within Canada to practice spirituality without their immediate community or lack of a natural environment. These issues of availability and accessibility of nature and spirituality are reinforced by the following elder’s perspective:

Traditional teachings improve people’s access to health services. Sacred beliefs from churches and the residential school system tried taking away from natural based Spirituality; this upset the balance of Nature [Natural laws]. Even if we’re from different cultures, we have common grounding in Indigenous ways. We
learned that way of being with the Native people. It was a good way because we lived with nature. (Interview, 2010)

An Indigenous staff member who works in the cultural programs also demonstrates her/his understanding of the intimate link between nature and spirituality in the following way:

Well, traditional teachings, cultural knowledge is very important: the values of Indigenous culture kind of thing you know. Extended family values, hospitality, sharing, and all those things when you raise children, all of those things are important. Our ancestors honoured nature, therefore balance. There was ‘great spirit’, so in my books that’s God. So whatever way people are coming to that great mystery, whatever road they’re taking to the ‘Centre of the Medicine Wheel,’ kind of thing. They’re all on that path you know, so I think there was religion in that respect that it was through spirit, you know. Nature is the great mystery which is common to all of us Indigenous people. (Interview, 2011)

Participants quite often say that spirituality is just as important as other parts of their being: physical, emotional and mental health. They indicate that when these health realms are balanced and in harmony, it indicates wellness, through connectedness to one’s higher powers, the Creator, ancestors, the land and each other. This perspective about spirituality is reinforced by Indigenous scholar, Wilson (2008) who asserts, “For many Indigenous people, having a healthy sense of spirituality is just as important as other aspects of mental, emotional and physical health” (p. 89).

The elder participants reinforce the importance of traditional knowledge and how Indigenous knowledge either shapes or should shape the roles of healers and health caretakers. The elders identify traditional values that ideally should inform the practice of the caregiver such as extended family values, hospitality, sharing, living by natural laws of life, nature-based spirituality, and treating others respectfully (as reiterated by a single mom, Interview, 2011).

Another elder who works as a cultural worker asserts that traditional teachings also involve sweat lodges, pipe ceremonies, performing ceremonies such as weddings and funerals. The
urban Indigenous participants appreciate that spirituality is part of the health care services at Kla-how-eya (Interview, 2011).

The need for a wholistic approach

North American Indigenous peoples have been using wholistic paradigms, principles and processes in their daily lives for thousands of years, and since contact with Western European civilizations, to interact with non-Indigenous newcomers. A key principle of Indigenous wholism is inherent in the theme of interconnectedness. This theme, which is evident in many Indigenous traditions, emphasizes aspects of being – physical, emotional, mental and spiritual are components of relationships between all things (Hampton, 1995; Kirkness & Barnhardt, 1991; Wilson, 2008). One of the most well known visual models for Indigenous wholism is the circle, labelled by many as the Medicine Wheel. For the participants, their perspectives, stories of experiences, preferences and expectations come full circle and a whole relational construct emerges. Taking this view, Kla-how-eya is described many times by participants as an environment [space] that fosters communication and relationship building. All the participants contribute important ideas to the collective story of creating an acceptable space for relating to each other. An elder shared her thoughts about “good quality services” that she believes people want to return to:

Getting together with one another, each one sharing how, what, how and where they grew up [stories]; this place is needed to share with one another, about their aches and pains, their headaches to support one another, to be able to be strong and carry on in life. (Interview, 2010)

Another elder shared about how proud she is of her role at Kla-how-eya:

Getting to know the parents and children, some children have been here since birth up to their 4th birthday. We get to know the families especially the children quite well. The children are happy to have me around, their adopted grandma. We go out of our way to make them feel as comfortable as possible without judgement. We make them feel special in their own way. (Interview, 2011)
Many of the participants share stories about how the people gather together at Kla-how-eya to create an acceptable space for one another, cultivate a state of wholistic being that is non-judgemental, co-operative, understanding, use good communication and connect with one another. The wholistic approach includes: physical, emotional, mental and spiritual realms.

There is little information about effective ways of reducing existing health disparities among our Indigenous people. The participants’ stories about their negative experiences and perspectives on accessing mainstream health services tells us that marginalization of their physical, emotional, mental and spiritual wellness has deprived their productive capacity, opportunities and independence. The deprivation has left many participants still traumatized and dependent on a health system that chooses not to listen to their stories of suffering living within alien, uncomfortable and lonely inner cities in the Vancouver region. When there is such imbalance in living their lives, the urban Indigenous clients are always looking in new directions seeking whatever it is that can become a good fit to restore their well-being wholistically.

**Disregard of culture**

The sum of malaise and ill health suffered by Canada’s (and the world’s) Indigenous peoples is best understood not as some simple aggregate of the personal woes of separately damaged individuals, but as a culmination of “cultural wound” inflicted upon whole communities and whole ways of life (Chandler & Dunlop, 2015). Residential schools which Dion-Stout (2015) names *Kiskinwahamatowikanmokwa* or teaching and learning structure, were unnatural, unhealthy environments that severely damaged our cultures, language, traditions, and heritage. The net effect of these historical patterns is mayi-maymacihowin – the bad, ugly, nasty, evil, wicked state of physical, emotional, mental and spiritual unwellness which causes much suffering for Indigenous peoples in many communities. (p. 147)

As mentioned by a couple of elders, many of the people living within urban centres identify strongly with their culture and want more opportunities to learn about their historical roots, and to experience and practice their ceremonies. One elder, when asked about traditional teachings, emphasizes the following important aspects:
Well, traditional teachings and cultural knowledge is very important, the values of Indigenous culture kind of thing you know, extended family values, hospitality, sharing, all of those things when we raise our children, all of those things are important. For example, the following teachings, the Natural laws of life, centre of medicine wheel, nature-based spirituality, culture depended on nature, mountains, oceans, rivers, etc. Nature is a common thing to all of us Aboriginal people. (Interview, 2011)

Another elder puts it this way:

You know Kla-how-eya was started so that Aboriginal people would be able to come here and learn who they are and be proud of who they are, because if you don’t now who you are, you’re not going to be successful. Cultural identity is a big part of health knowing who you are and where you came from. For example, I know of four-year-old pre-school children who are taught to know where they are from, and their cultural given names and who they are named after, regalia, all of this ground them and they are successful. (Interview, 2011)

Many of the participants express the importance of maintaining their cultures because it reminds them of where they once lived, and that culture helps them make sense of their lives and gives them a sense of who they are and that they belong somewhere. A couple of the elders believe that when people are forced to leave their communities, the outcomes are not usually good, people experience breakdown and despair, eventually experiencing a loss of their cultural identity. Furthermore, the elders stress the need to enhance Indigenous cultures within urban areas. Figure 13 illustrates an Indigenous wholistic health framework that depicts participants’ negative experiences attempting to access provincial health services.
Figure 13. Hindrances to the availability, accessibility and acceptability of health services in the provincial health system.

CONCLUSION
The results of this study indicate that the seven urban Aboriginal clients feel safe and comfortable with health-related service delivery (availability, accessibility, and acceptability) at Kla-how-eya, often speaking about their positive feelings during the individual interviews. As well, the seven Kla-how-eya service providers emphasize their positive feelings in carrying out their responsibilities to the clients. The participants value Kla-how-eya’s service delivery approach that supports the physical, emotional, mental and spiritual well-being of clients and care providers. They also emphasize the importance of relationship building with clients; effective communication; teamwork; culturally appropriate inclusive space, and most importantly, being treated with respect and without judgement. Many participants appreciate the benefits of the central location of Kla-how-eya, which is close and convenient to the sky-train stations, bus routes and shopping centres.

Participants also describe their satisfaction about being able to access children and families’ health and social programs ‘under one roof,’ especially for families with limited income.
The provision of Kla-how-eya’s one-stop-shop approach to health service delivery addresses the socio-economic needs of urban Indigenous people. The term, ‘one-stop shop’ refers to multidisciplinary health services located under one roof. These types of services include primary care services and other social-cultural support. Primary care is the medical care received from a community-based doctor or walk-in clinic.

The stories shared by the sharing circle participants reinforce the same positive messages about the good care at Kla-how-eya noted above. Similarly, the sharing circle participants share the same concerns about mainstream health services such as the lack of the following: collaboration, effective communication, understanding, wholistic approach, regard for culture, and Indigenous knowledge. In addition, sharing circle participants reiterate issues about disempowerment, and being treated negatively. The sharing circle provides further opportunity to explore and reinforce the common themes that emerge from the clients and staff/care providers’ interviews.

The sharing circle also affirms that given the appropriate space, supports and resources the following suggestions would come to fruition: resources, good environment, cultural approach, the right people to work with them, improved collaboration and effective communication with mainstream health services would enhance available, accessible and acceptable health service delivery to urban Indigenous people. However, a key challenge present throughout the discussion about mainstream health services is related to health workers.

**CHALLENGES: AVAILABLE, ACCESSIBLE, AND ACCEPTABLE HEALTH WORKERS**

The participants in the individual interviews and the sharing circle emphasize their lack of input in their own health care and specifically about how their health services are provided at mainstream health services, especially from non-Aboriginal care providers. It is this latter point, that I will discuss next. The Global Health Workforce Network (GHWN, 2016) operates within the World Health Organization (WHO) defines availability, accessibility and acceptability in relation to health workers as:

*Availability:* The sufficient supply and appropriate stock of health workers, with the competencies and skill-mix to match the health needs of the population;
Accessibility: The equitable distribution of these health workers taking into account the demographic composition, rural-urban mix and underserved areas or populations;

Acceptability: The health workforce characteristics and ability (e.g. sex, language, culture, age, etc.) to treat all patients with dignity, create trust and promote demand for services. (p. 1)

From the participants’ perspectives and from my personal experience, the Vancouver/Surrey urban mainstream health system does not have available, accessible, or acceptable health workers as defined by the GHWN above. In contrast Kla-how-eya, has both Aboriginal and non-Aboriginal health workers who meet the available, accessible, and acceptable criteria, although this organization needs more such health workers.

The point about participants believing that they do not have any input to their health service needs and delivery in the mainstream system is reinforced in another city and a recommendation is made about the role of Aboriginal organizations in providing health services. Silver et al. (2008) address this challenge as “There are, in Winnipeg’s inner city, deeply held grievances about non-Aboriginal people delivering [health-related] services to and for Aboriginal people … must be replaced by Aboriginal organizations run by and for Aboriginal people in a fashion consistent with Aboriginal values” (p. 156). Although it would be very difficult to offer specialized medical services, Aboriginal organizations could offer culturally responsive health-related services.

Kla-how-eya, an Aboriginal controlled organization provides wholistic health related services to urban Aboriginal people living in its catchment area and beyond. The participants in this study, value and benefit from Kla-how-eya’s culturally responsive and respectful services and approaches. At the same time, Kla-how-eya is not able to provide all the medical/health services that urban Aboriginal people need. If the professional and other staff of mainstream health services are able to be welcoming, non-judgemental, caring, and compassionate, then urban Aboriginal people might access these available services. If the professional and other staff also have knowledge and awareness about Aboriginal history and culture, then urban Aboriginal people might feel that mainstream health services are acceptable.
In the Hamumu story (Chapter One), the Hamumu (butterfly) created my Indigenous community of Kalugwis through her transformational powers and through her gifts of Indigenous strength, resilience, and resistance. This chapter titled, *Beginning Hamumu’s Transformation*, sets the context (or a new place) for the development or transformation of urban Aboriginal health services, which many participants call “good medicine.” The study participants’ cultural strength, resilience from colonization, and resistance to marginalization and racism are like Hamumu’s gifts that have transformational powers. The concept of good medicine is discussed in the next and final thesis chapter.
CHAPTER SIX: HAMUMU RETURNS WITH STRENGTH AND DETERMINATION

Nothing comes into being except through struggle; struggle is involved in the development of all things; and it is through struggle that things are negated and pass away. Conflict and contradiction are inevitable …. Struggle, and the negativity involved in it, are not merely destructive, but also productive. Struggle is a good thing, not a bad thing.

—Sean Sayers, *Forces of Production*, 1980

Sayers’ quote is a reminder of the urban Indigenous people’s struggles with accessing and using provincial health services, which were presented in Chapter Five. Despite their struggles, the participants had very positive health related experiences at Kla-how-eya. The urban Indigenous people, like Hamumu, require strength, resilience and appropriate conditions and environment to ensure positive health changes. These changes are brought about by a certain balance amongst the availability, accessibility and acceptability of responsive health service delivery. A balance is also needed amongst the health dimensions of emotional, mental, spiritual and physical as illustrated in Chapters Four and Five.

Recognizing and acknowledging that urban Indigenous people’s historical-socio-political contexts have contributed and continue to negatively impact their poor physical, emotional, mental and spiritual health is even more important today. The large children and youth segment of the Aboriginal population, especially in urban areas is an important driver for change.

Providing health and social services to distinct populations of First Nations, Métis, and Inuit has many hurdles including cultural barriers to accessing primary health services especially for those living in urban centres. Aboriginal people living in urban centres often face overwhelming social and health problems that are rooted in cultural dislocation and powerlessness, discrimination and economic hardship leading to emotional vulnerability, isolation, and alienation living in a hostile environment. Notwithstanding the many healthy urban Aboriginal peoples living in urban areas the inner core of Canadian cities contains a component of marginalized Aboriginal people who are disconnected from their traditional families, communities, cultures and nations.
Chapter Five shows that Urban Indigenous people’s stories and perspectives have the potential to contribute to the improvement of their health services within inner cities. This concluding chapter summarizes the key findings for the study’s three major research questions, presents continuing health challenges, introduces an Indigenous Good Medicine Theory, discusses policy implications of the findings, and concludes with sections about contributions and limitations of the research and my final reflections.

**BARRIERS TO PROVINCIAL HEALTH SERVICES FOR URBAN INDIGENOUS PEOPLE**

This section discusses the findings for the following research question: What hinders urban Aboriginal people’s use of provincial health services? Chapter Five, Figure 13, shows the results of the wholistic analysis about participants’ negative experiences with provincial health services that ultimately hinders access and use of these services. The physical realm includes an unwelcoming environment, racist attitudes, lack of resources, and lack of collaboration and communication between urban Aboriginal people and health care providers. In the emotional realm issues such as colonial injustice, lack of relationship building and trust, feelings of alienation, and negative assumptions about urban Aboriginal people dominate. The mental realm focuses on a lack of understanding, issues with literacy and communication, and disempowerment. The spiritual realm emphasizes lack of Indigenous knowledge, the lack of a wholistic approach, and disregard of Indigenous culture. An outcome of these negative experiences is a lack of trust, and intergenerational trauma and impact.

One of the most common responses to the question about what creates barriers to using services within the mainstream health care system is the lack of trust between Indigenous people and mainly non-Indigenous health professionals. Hanson (2009) makes this observation about the connection between communication and trust: “A health care provider is unable to respond to needs and preferences that are not communicated and communication is compromised by a lack of trust, which may be a common legacy of colonization” (p. 250). Indigenous scholars explore the relationship between communication and trust by describing the devastating effects of colonial Indigenous education, health, and
social policies on Indigenous people (Airhihenbuwa, 1995; Brown, 2005; Dion-Stout, 2015; Hanson, 2009; Smith, 1999).

Social disadvantages in Canadian Aboriginal communities, including urban Aboriginal communities have long been documented as having happened within a group of colonial socio-economic, cultural-historical and political factors. While there are non-Aboriginal people who genuinely are interested and want to help Aboriginal people, there exists continuous feelings of mistrust. In response to these colonizing factors mistrust becomes a huge barrier to many urban Aboriginal people from accessing mainstream health services because they don’t feel safe from stereotyping and racism. The non-Aboriginal health care system comes across to urban Aboriginal people as alienating and threatening, which makes them feel frightened.

These devastating effects have also led to silencing many urban Aboriginal people’s voices. Many of the urban Indigenous clients have encountered negative circumstances throughout their lives connected to the residential school experiences of their parents or grandparents, relocation, and poverty. The participants link the intergenerational effects of the residential school system to the disconnection from their family, community and cultural identity. Because of intergenerational trauma, young parents express parenting difficulties, fear of going out into society, therefore living in isolation and often in silence, enduring experiences of racism and discrimination, and experiencing lack of self-esteem and confidence. I found more commonalities than differences in the participants’ stories about how they are impacted by having a parent or grandparent that attended residential school.

The disempowering and coloniser policies led to paternalistic practices that left many Aboriginal people dependent on authoritative Western models of education, health and social service delivery. Urban Aboriginal participants mention that this forced dependency is worsened by racism and jurisdictional disputes, with the latter resulting in confusion created by different interpretations of ‘who’ is to provide ‘what’ by providers regarding different departments within provincial governments, which only heighten barriers to accessing urban mainstream health services. Given the current context of the existing characteristics of mainstream health services and the urban Aboriginal people’s description
of negative experiences encountered when accessing mainstream health services, it is apparent that what matters most to the urban Aboriginal clients is that the non-Indigenous care providers become educated about these issues, which may begin the reconciliation process to establish trust between clients and health care providers.

The participants emphasize the need for a safe place within the inner cities to be able to gather collectively. A place where they can speak freely and openly with their “own kind of people.” Furthermore, participants want to develop good relationships with care providers involved in their health care, care providers that listen without judgement, demonstrate respect and dignity, and show a genuine interest in hearing and acting upon urban Aboriginal people’s voiced health needs. I know from past work experience in health field that these characteristics that comprise quality care, decrease the influence of learned helplessness, increase autonomy and enhance health care outcomes. It is through the development of such client/care provider relationships that reciprocity may occur to create improved understanding of one another.

Responsibility speaks to both parties taking active responsibility in creating a good understanding and relationship that allows for an exchange of knowledge and contributes to empowerment on both sides, not just the health care provider, as it has often been. Aboriginal people have for too long been disempowered by health care professionals who think their ways and knowledge are superior to Aboriginal ways and being.

**Urban Aboriginal People’s Health Experiences at an Urban Aboriginal Agency**

This section addresses the following research question: What are the experiences of urban Aboriginal people in using health services at an urban Aboriginal cultural agency and elsewhere? Chapter Five, Figure 12, outlines the wholistic analysis of the positive experiences of urban Aboriginal people who use the health services at Kla-how-eya, an urban Aboriginal cultural agency located in Surrey, British Columbia. In the physical realm, a welcoming environment, collaboration among clients and health care providers, and culturally responsive resources and services are identified. The emotional realm emphasizes caring ways, acceptance/understanding, and feelings of family/kinship. In the mental realm, characterizations of a different (sensitive) care, good (cultural) fit, and empowerment are
important. For the spiritual realm, Indigenous knowledge, cultural events, and cultural ways are valued. An overall finding from the wholistic analysis is the importance of Kla-how-eya’s culturally responsive approach to its health services for urban Aboriginal people. Family, community, culture, relationship building, and communication are important components of this culturally responsive approach.

Kla-how-eya’s culturally responsive approach to its health-related services contribute to its well used facility. Family-like relationships, a sense of caring community, and cultural appreciation are core parts of this cultural responsiveness, which constitute participants’ characterization of Kla-how-eya’s “good fit” or that “it’s just different.” Relationships at Kla-how-eya are often described as ‘one big family’ that care for one another because they share similar past experiences. This emphasis on the family and community is a common attribute of Aboriginal people, generally, which contributes to health and wellness is reflected in this quote below.

First Nations people believe that wholeness includes the health and wellness of our body, mind, heart and spirit; families share and care for each other with respect and see each member as important; our communities are healthy and empowering and that each person has a place. Our families, communities and culture teach us how to live in balance, to care for others and ourselves and to restore balance when its lost. (Mussell & Martin, 2006, p. 3)

Relationship building between staff and clients is critical for increased usage of health services at Kla-how-eya. Staff took time to develop rapport and trust, which results in shorter subsequent visits. Workers develop good relationships with families to the point that some families utilized health and social services for at least 4 – 5 years. It is through the continued development of relationships that the urban Aboriginal people feel comfortable in accessing and using services at Kla-how-eya.

The provision of health and social services at Kla-how-eya are provided mostly by Aboriginal personnel who understand urban Aboriginal people’s perspectives, their background and history. This understanding results from spending a long time with the clients, getting to know them, and eventually gaining their trust. Most care providers at Kla-
how-eya said that the trust building took at least a year of being in a relationship with the clients before they start opening up and sharing their stories that are fraught with difficulties. Participants value the various positive ways that Kla-how-eya approaches, communicates and takes care of their clients, furthermore, clients and care providers refer to this kind of approach as, a different type of care than that received in mainstream health services.

Recognition of cultural ways is another theme identified numerous times, which describes the type and approach to care that the participants want and need. Common across the interviews and sharing circle are the distinct participant circumstances and practices that need to be understood to provide the most effective, safe care possible. Respecting differences implies valuing, acknowledging, and working with differing health needs and various Indigenous cultures and contexts. Recognizing and respecting cultural ways is similar to the concept of culturally safe practices (Smye, 2006, p. 9).

However, the former concept is necessary before Aboriginal people feel culturally safe. Reciprocity as defined by Kirkness and Barnhardt (1991) will occur when urban Aboriginal people trust and work with health professionals to understand Aboriginal beliefs and practices appropriate to their health and wellness and then combine these with what the health professionals may have to offer. Understanding cultural ways and implementing culturally safe health practices constitutes health professionals’ cultural competency.

The Health Council of Canada (2012) states, “Health care providers who are culturally competent take a holistic approach to care and consider how the circumstances of patient’s lives may be affecting their health” (p. 11). As one example, urban Aboriginal participants are not always able to make it to their appointments because they may have 3 – 4 children at home; food on table is more important than an appointment, or they may be caring for another person. A health professional who is not culturally competent may describe the client as non-compliant, whereas a culturally competent care provider asks, “I wonder what is going on in this person’s life that is making it difficult for them to make their appointment.”
availability, accessibility, and acceptability of health services for urban aboriginal people

This section discusses the following research question: How can an urban Aboriginal cultural agency facilitate availability, accessibility, and acceptability of health services for Aboriginal people living in the Lower Mainland of British Columbia? This section also highlights aspects of the Hamumu Theoretical Framework principles (Chapter Three, Figure 11): respect, responsibility, reciprocity, reverence, relevance, synergy, wholism, and inter-relatedness. The concept of availability discussed in Chapter Five focuses on having a sufficient amount of health care workers with the appropriate skill sets for the health needs of the population being serviced (Global Health Workforce Network, 2016). Kla-how-eya’s Aboriginal and non-Aboriginal health care providers certainly demonstrate culturally responsive health care knowledge and approaches in their relationships and treatment of urban Aboriginal clients, despite the limited number of available health care providers.

Respect, responsibility and reciprocity are very much shared at Kla-how-eya at various levels and in different ways. First of all, the care providers are responsible and respectful in treating everyone with good care (dignity, kindness, patience, appropriate health service) like the good care they would want for their own family members, including the treatment they would like for themselves. Another important aspect of being responsible towards urban Indigenous clients is that the care providers value proper work ethics towards the people they are serving or teaching. The clients (learners) appreciate the welcoming, warm, and receptive social and health environments that foster reciprocal respect between the clients and the care providers, which enhance learning about one another.

The urban Indigenous clients feel that the care providers are genuine in their respectful and responsible ways of caring for them. The relationships between the clients and care providers are built over time through both informal and formal experiences with each other. This form of relationship building establishes a collaborative connectedness where the client is open to being mentored and taught by the care provider. The clients’ apprehensiveness about health issues is lessened through their interactions with Kla-how-eya’s health providers. The participants describe the caregivers’ role as one of leadership, which includes
delivering care that makes a difference, someone who takes the time to get to know the clients, their history and their cultural ways.

Both the clients and the care providers praise the provision or availability of services at Kla-how-eya. Availability of services, according to the participants’ perspectives include culturally relevant services such as elders, cultural events, opportunities for ceremony, and wholistic services that address the physical, emotional, mental, and spiritual realms.

If the Global Health Workforce Network’s (2016) definition of accessibility in relation to health care workers is used for Kla-how-eya, it would almost meet the criterion of accessibly in that an equitable number of health workers with an appropriate skill set exist for the under-serviced population of urban Aboriginal people. However, the issue of not having a sufficient number of health care providers to service the volume of urban Aboriginal clients remains.

Although an increase in health care providers and health services is important, of equal importance is an emphasis on cultural sensitivity among the existing health care providers. The strong connection between safe cultural practices, health promotion and prevention at Kla-how-eya is evident in the learning that takes place between clients and care providers. The clients are first provided with a safe, comfortable environment to receive not only the care they need, but as well, support in fostering health and cultural learning. The urban Indigenous clients are expected to respect themselves as well as others. They are reminded that there is the expectation in the mainstream health services to assume responsibility for themselves and their actions, as well as demonstrate this responsibility for their well-being. Fostering a good safe place to learn is important for empowering the urban Indigenous clients to become confident with improved self-esteem. Instilling confidence and improved self-esteem is important and necessary for the clients to gain the ability to speak up and ask for what they need and want. Furthermore, this learning provides the clients with the knowledge and skills to look for the services they need within the inner cities.

Another important aspect of accessibility, is how an organization facilitates access of its services by being approachable and readily available. Despite Kla-how-eya’s limited funding provided by the federal and provincial governments, it still provides and makes
accessible relevant cultural services and support to children and families in need. Because many of Kla-how-eya’s clients live on limited incomes, the provision of bus tickets to assist in transportation, Kla-how-eya’s location close to a SkyTrain as well as services contained under one roof to meet children and family needs facilitate easier access and affordability of services. Kla-how-eya’s open door policy contributes significantly to people’s comfort level.

\textit{Acceptability} defined by the Global Health Workforce Network (2016) in relation to health care workers emphasizes their “ability to treat all patients with dignity, create trust and promote demand for services” (p. 1). Certainly, Kla-how-eya’s health care providers’ respectful, responsible, and reciprocal relationships with and treatment of urban Aboriginal people contribute significantly to the clients’ satisfaction of this organization’s health related services. The care provided is also commonly referred to as ‘like family’ allowing for non-judgemental, comfortable and relevant practices. The familiar environment, extra time, and effective listening on the part of the health care providers facilitate client space and conditions conducive to their individual development. Furthermore, these environmental conditions provide opportunities for the person being helped to be among care providers who respect and believe in him/her as a person with the ability and potential for wholistic development. As mentioned previously, a couple of elders describe ‘good medicine’ as caring words and the positive approach to clients.

Acceptability is further exemplified by young parents in how they are more comfortable talking about their health problems to the care providers who speak to the parents as if they are friends who have known each other for a long time. Furthermore, the young parents reinforce the feeling of trust that is developed over time due to the positive treatment and understanding they receive from the care providers.

In addition, the clients vividly remember walking into the Kla-how-eya building for the first time, the welcoming figure at the door, a totem pole with its arms outstretched welcoming each client as they enter, the open-door policy building, which makes them feel safe and accepted. They are accepted without any denial to the services. Each client has the opportunity to be seen by a worker upon entering the building. If a certain service isn’t
available, they are directed to another relevant, appropriate organization to service their needs. The notion of acceptability discussed here focuses on the person/client feelings of being accepted, which is important if he/she is to access and use health services.

Good quality services that participants emphasize and which they would return to include: getting together with one another; a safe gathering place to share aches and pains; and opportunities to support one another to become strong and to carry on. Elders emphasize common reverent teachings about love for one another, honesty, respect, caring and learning. Reverence for these teachings is reinforced by many of the participants, which constitute an important dimension of the meaning of acceptability.

**CONTINUING ISSUES WITHIN THE URBAN LANDSCAPE**

In terms of non-Aboriginal peoples’ provision of health care services to urban Indigenous peoples, the lengthy history of unresponsive provision of health and social services to Indigenous peoples’ in Canada has long been known and documented (RCAP 1996). Chapters One and Two, provide an in-depth presentation of colonial policies and legislation that have had adverse effects on Aboriginal people’s health and well-being, especially those who relocate to urban areas. This skepticism about the health system continues. More recently, Reading, Greenwood, Steinhauer & Dion-Stout (2015) state, “Currently, the forces of colonization are barely recognized in our health system. Although health disparities are very well documented, we have a hard time believing that our health system is set up to be equitable” (p.146). Browne, (2007) provide further comment about hearing too often of the explicit racism that Indigenous peoples face in schools, and health care settings, such as emergency departments at hospitals. Furthermore, Makokis & Steinhauer (2012) state, “there are too many instances where we hear Aboriginal peoples say that they feel it is ‘unsafe to go’ to the hospital or a clinic, or that they will only go there to die” (p.246).

For non-Aboriginal care providers who are employed within the provincial health care landscape to recognize and understand the differences between themselves and urban Aboriginal people, it is necessary for the health care providers to recognize and understand the sources of and to hopefully change any embedded negative stereotypical attitudes about Aboriginal people that they may hold. While some health services may be delivered with
positive intentions, service delivery and health education and training, have for the most part, ignored Indigenous people’s world view and have not accepted forms of health-based Indigenous knowledge (Adelson, 2006; Reading, 2006, & Waldram et al., 2006). As far back as I can remember being told, as Indigenous peoples we had our own medicines and medical systems. Walker & Behn-Smith (2014) concur and also reinforce the difficulties attributed to Western science and medicine: “The systems of care, medicines and ceremonies are specific to our families and communities and are deeply contextual and relational. Evidence-based medicine and the reliance on Western science as truth have made it difficult to have a balanced conversation about barriers to Indigenous health” (p. 244).

I believe that an Indigenous Good Medicine approach could contribute to bringing together Indigenous and Western medicine so that something good results from the struggles that both urban Indigenous people and mainstream health care providers experience. Hamumu transforms once more to create an Indigenous Good Medicine Theory that focuses on the 4 C’s of Culture, Comfort, Communication and Collaboration (see Figure 14).

These 4C’s are not new concepts, but together with Hamumu, they become a new form of health-related knowledge or policy direction that can be thought of as medicine to help urban Indigenous people become healthy. Hamumu symbolizes an Indigenous framework with its own values and principles that work along with the 4C’s, which is a new way of showing the guiding nature of Indigenous knowledge for health purposes.
INDIGENOUS GOOD MEDICINE THEORY

The 4 C’s of Culture, Comfort, Communication and Collaboration as indicated in Figure 14 above is a useful theoretical tool to construct and guide the transformation of the provincial health system such as services, health care providers, health education, policy development, health practices and pedagogical approaches to improve health outcomes for urban Aboriginal people. Indigenous scholar, Greenwood (2009) says that theories anchored in Indigenous ways of knowing and being serve as sites of colonial resistance and, most importantly, they can help us describe things in the world, explain the actions we take, and make predictions about the world. Another Indigenous health scholar, Gone (2009) emphasizes the need for culturally appropriate theories, and especially those that include some of the 4Cs such as culture, communication and collaboration.
Psychologists and other mental health workers need to collaborate more closely with the communities we serve to conceptualize culturally appropriate theories of the person and to employ these in designing alternative programs and services that are directly tailored to the experiences of Native people. Proper attention to these tribal ethnopsychologies will guarantee that services ‘fit’ the prevailing cultural norms, including those that govern communication and interpersonal interaction. (Gone, 2009, p. 427)

My understanding of the meaning and intended actions of these words, ‘Good Medicine’ has evolved from a three-strand approach that includes my examination of the literature; reflection of my personal experiences; and interviews and sharing circle with the urban Aboriginal clients, administrators and elders of Kla-how-eya. The notion of theory that I have used is founded on urban Indigenous peoples’ ways of knowing and being (Greenwood, 2009) so that the theoretical ideas of culture, comfort, communication, and collaboration may improve Indigenous peoples’ health services (Gone, 2009).

**CULTURE AS MEDICINE**

Today, the term, Indigenous knowledge, is commonly used in academe, often replacing the term, culture. The urban Aboriginal participants use the term, culture, not Indigenous knowledge. In respect to them, I use the term, culture, although I also believe that the meaning of Indigenous knowledge as articulated by Indigenous scholars, captures the same meaning of culture as used by the urban Aboriginal participants. Indigenous knowledge is personal, experiential, holistic, oral and often but not exclusively conveyed through narrative or metaphorical language (Brant Castellano, 2000). Battiste (2005) agrees and extends the definition of Indigenous knowledge:

> Perhaps the closest one can get to describing unity in Indigenous knowledge is that knowledge is the expression of the vibrant relationships between the people, their ecosystems, and the other living beings and spirits that share their lands. These multi-layered relationships are the basis for maintaining social, economic, and diplomatic relationships—through sharing—with other peoples. All aspects of this knowledge are interrelated. In addition, many definitions of knowledge stress it is the principle of totality or holism. (p. 42)
To show the lived experience of the IK definition, I share this memory. As Indigenous children, I recall that we were always taught to be aware of what is around us and to be aware of what the world around us brings for our survival. Furthermore, right from the beginning as young children and growing up, Indigenous children were taught to be respectful to other people and living things and to pay attention to our behaviour towards other people, especially elders. We were taught to share, care and be cooperative when anything needed to be done for others and in our communities. This memory confirms the importance of the family and community.

Aboriginal people believe that all life is interconnected, and a central cultural value is the family or group (community) (RCAP, 1996). Baskin (2006) reinforces another link between holism and the family and the negative outcomes that may result when either is disrupted:

A holistic approach aims to avoid isolating family members and the problems related to family violence. For example, mainstream service providers who work with abused women have been criticized for such isolation because they are seen as having a polarized understanding of violence against women rather than more holistic solutions which take many variables into consideration.

(p. 216)

Problems also arise when well-meaning health care providers try to implement some form of cultural recognition when they don’t understand the deeper meanings of these cultural ways.

In the past 45 years of my nursing experiences I have seen symbolic gestures of respect for Indigenous people’s cultures in various forms through speech, signage, documents, and artwork of carvings and framed prints, but, as Hobenshield states (2016), “… these demonstrations do not necessarily acknowledge a particular worldview and unique Indigenous knowledge systems. Without indication of a commitment to a deeper level of exploration and understanding of another way of existence and knowing, a culture of prescribed colonial policies is perpetuated” (p. 201).
Voices from the Indigenous community at large call for review and revisions of Indigenous health care and health education based on Indigenous knowledge or culture (Adelson, 2000; Cunningham, Reading & Eades, 2003; Kirmayer, Brass, & Tate, 2000; National Aboriginal Health Organization (NAHO), 2003; Wilson, 2002; Young, 2003). In their framework for guiding Indigenous health research NAHO (2003) expresses a timely urgency for the application of Indigenous knowledge for improving Indigenous people’s health and wellness.

Kla-how-eya uses Indigenous knowledge/culture to provide appropriate, relevant, effective care. Despite the diversity of Indigenous cultures represented by the numerous clients who use Kla-how-eya, the respect and openness that the staff demonstrate towards various forms of IK and the flexibility of approaches such as talking circles, social gatherings, and family/community-oriented events accommodate cultural differences. Urban Aboriginal people who do not know much about their culture, are given opportunities to learn more about their and others’ cultures through these culturally responsive approaches.

**COMFORT AS MEDICINE**

Chapter Five provides an overview of the range of negative feelings that the urban Aboriginal clients have regarding their experiences in accessing and using mainstream health services. Foremost is mistrust toward mainstream health care providers based on fear of having their children apprehended or fear of stereotypical or racist attitudes that health care providers may demonstrate. Participants also describe their experiences of feeling unsafe or at risk as another common consequence of residential school. In contrast, the health care providers and administrators at Kla-how-eya create a safe and comfortable environment, physically (Indigenous art and structure); emotionally (elders, empathy, support); mentally (health education, wholistic services); and spiritually (cultural events and ceremonies).

Staff at Kla-how-eya have meaningful understandings of the Aboriginal clients to whom they provide care. The care providers relate to the Aboriginal people because they have knowledge of Aboriginal clients’ connections to ceremonial practices, beliefs, values and the impact of colonial history. There is an obvious recognition and awareness that strong
and healthy relationships are one of the best forms of medicine at Kla-how-eya. Creating a comfortable environment where clients feel safe and a sense of comfort is a key principle or goal of good medicine because without it, good medicine may not occur.

**COMMUNICATION AS MEDICINE**

Some of the urban Aboriginal clients identify difficulty in communicating orally and with print literacy. Young mothers identify silence as being a significant pattern within their families. This type of silence is a response to fear and mistrust. Survivors of the residential school were not taught effective communication skills, and were punished when they did try to talk, especially in their language (TRC, 2015). Therefore, as they grew up outside the residential school life many survivors were unable to communicate in a healthy way or even express their feelings. This of course was passed on intergenerationally to many children of survivors who moved into the inner cities of Canada. Elders spoke about this silence, mentioning how quiet and shy First Nations people are as perceived by health care providers and how they are fearful to ask questions.

Sometimes the participants are not able to express their concerns. They believe that the mainstream care providers miss the real reasons that contribute to their quietness and perceived shyness. In contrast, most participants stress the importance of communicating in a respectful way between themselves and non-Indigenous care providers. Furthermore, participants share stories of a health care provider who demonstrates an outstanding ability of making her clients feel like they know her as a family member and that she treats them without judgement.

Trust is created when the participants feel that the care providers genuinely show care for them and their families. Participants comment on how care providers make them feel when they are given good medicine such as being treated with respect, when they take their time to explain procedures, call and check on them at home, and how they act in a natural manner towards them. Respect, responsibility, and reciprocity are embedded within the oral communication between Kla-how-eya’s care providers and clients. The area that still needs to be addressed relates to written communication, noted in Chapter Five. Those working in the educational and health systems could work collaboratively to ensure that written or
textual communication about health matters are presented in ways that urban Aboriginal people who do not have high school literacy can understand.

**COLLABORATION AS MEDICINE**

Riecken, Tanaka & Scott, (2006) whose health and educational research focuses on Aboriginal youth advocate for collaboration across disciplines and services: “Cost-effective, context-relevant, prevention and health care services for [Aboriginal] families demand interdisciplinary knowledge and collaborative strategies that reach across professional allegiances, health care organizations, and social agencies” (p. 31). The Calls to Action, 18-24, of the Truth and Reconciliation Commission of Canada reinforce the need for interdisciplinary, inter-agency, and inter-governmental collaboration to improve the health outcomes of Aboriginal people (2015, pp. 322–323). An example of collaboration is mentioned by participants regarding the Surrey Outpatient Clinic (SOC) located a few blocks from Kla-how-eya, which is being used as a training center for medical students. The young Aboriginal participants recount their experiences of having attended inner city hospital emergencies. Later, they would be referred to this new clinic without their consent. The clinic would call Kla-how-eya for the client’s records without the client’s awareness or permission.

The care providers thought that SOC could have found ways to collaborate with Kla-how-eya, for the benefit of the client, the mainstream care provider, and medical students. Some participants suggest that Kla-how-eya via its staff could provide teaching outreach to SOC staff by inviting them to attend the cultural workshops to increase their knowledge of Indigenous culture. Furthermore, it is suggested that SOC staff and the medical students provide inter-disciplinary support to Kla-how-eya. One worker says,

I’d like to see a nutritionist, mental health worker, a doctor filter through here time to time. I would like to see Kla-how-eya as a teaching outreach for students because I think that’s how a person in training for whatever practice, if they’re learning right at the groundwork like here at Kla-how-eya, how to do it differently, [care for clients] they’re going to likely do it differently. (Interview, November 2011)
Expanding collaboration between urban Aboriginal health/social service agencies such as Kla-how-eya, health care providers, and university health students in learning about Indigenous culture is viewed by most participants as supporting community-relationship-building and contributing to good medicine.

The 4Cs of an Indigenous Good Medicine Theory, culture, comfort, communication and collaboration emerge from the findings for the three major research questions that are discussed in this chapter. The participants’ perspectives and stories, my personal experience, and health related literature guide the development of these four principles. The eight theoretical and methodological principles of respect, responsibility, reciprocity, reverence, relationships, wholism, inter-relatedness, and synergy (Archibald, 2008, Kirkness & Barnhardt, 1991) are embedded in this chapter’s discussion about the findings. These eight principles also shape the development of the 4Cs. There are some policy implications that also emerge from the findings that warrant discussion, such as the educational preparation and professional development of health care professionals.

**Policy Implications and Updates**

Most participants recognize that non-Aboriginal care providers and health leads throughout the provincial health care system will always be a part of the care provided to them. Until there are more urban located and operated Aboriginal health and social centers and Aboriginal health professionals to service Aboriginal people within the inner cities, it is critical for non-Aboriginal people who are involved in the provision of health care to urban Aboriginal people to be educated about Indigenous principles such as relevance, respect, reciprocity, responsibility, and reverence to ensure safe care to the urban Aboriginal client. The 4Cs of an Indigenous Good Medicine Theory can be added to this set of principles. With these principles in mind, the non-Aboriginal care provider involved in the care of an Aboriginal client also needs to understand the negative experiences of urban Aboriginal clients accessing health and social services within the mainstream health care system.

Professional health education such as Nursing and Medicine, as well as related professional programs such as Social Work need to offer courses that will prepare future health professionals to understand Indigenous culture/health principles and the impact of
colonization on all people, not just Indigenous people. Non-Indigenous health professionals need to question and understand the sources of their beliefs about Indigenous people and their cultures. I believe this type of professional health education can play a huge part in the development of an appreciation and understanding of cultural difference and the need for tailored care, keeping in mind the social, political, economic and cultural context of each urban Aboriginal client.

Smith (1999), and more recently Dion-Stout (2015), PHSA (2016), and Fraser Health (2016) reinforce the need for the practice of cultural safety to be extended to respecting cultural differences of clients by health professional colleagues. To have this concept of difference included in the education of health care providers facilitates a general acceptance that cultural safety is primarily about difference, respect for difference, and lessening power relationships between people. A similar point is made by Smye (2013) who focuses on the concept of culturally competent care as, “The ability to provide care with a client-centered orientation, recognizing the significant impact of cultural values and beliefs as well as power and hierarchy often inherent in clinical interactions, particularly between clients from marginalized groups and health care organizations” (p. 9). More recently, the BC health system has worked on some policy directions that are included in the Transformative Change Accord: First Nations Health Plan (2005) and is discussed in Chapter Two. Most notable is the professional knowledge of health practitioners.

An on-line San’yas Indigenous Cultural Safety Training (ICS) program, a first of its kind in Canada, was developed by the Provincial Health Services Authority (PHSA) Indigenous Health Program. The PHSA mandated that all its employees complete the ICS education program, which is eight hours in total. This program was created, vetted, and piloted by a variety of PHSA agencies and Aboriginal partner agencies such as the Ministry of Health, Health Canada, First Nations Health Council, Métis Nation of BC, Regional Health Authorities, and other hospitals. The ICS program is intended for those involved in the provision of health and social services to Aboriginal people. The purpose of the online education program is to develop an improved understanding of the impact of colonial history on Aboriginal people and the importance of knowing about cultural differences.
In addition to the ICS program, the PHSA has developed an Aboriginal Recruitment Strategy with hiring targets to increase the number of Aboriginal professional and skilled people in health professions. To assist with retention, the PHSA’s recruitment services developed an online social networking site specifically for Aboriginal health nurses and Aboriginal Patient Liaisons to connect, mentor, and support their health career choices. The PHSA’s human resources department also supports the cultural competency online learning hubs.

PHSA’s Indigenous Health program, formerly known as Aboriginal Health Programs aims to improve Indigenous people’s health and well-being, and to close the health gap between BC Indigenous and non-Indigenous people. PHSA has a subcommittee with members representing PHSA agencies and partners that set Indigenous health goals, collaborate and exchange best practice knowledge in this area.

PHSA’s Indigenous Health Program has established an agency-wide feedback system that includes processes for verbal/oral feedback to improve Indigenous cultural safety and to improve access to health services. The value of PHSA’s Indigenous Health Program is demonstrated by PHSA’s other agencies and departments now seeking the assistance of the Indigenous Health Program when providing Indigenous health services. The Indigenous Health Programs support some BC community-based services, sponsor on-going training and conferences and support Qwal Lelulm, an Aboriginal nurse networking and resource site for Aboriginal nurses, patient navigators and doulas.44

The health service policy and programmatic advancements by the Indigenous Health Program of the Provincial Health Services Authority are significant. What is not evident is how urban Aboriginal people benefit from these or how urban Aboriginal health needs are addressed. Certainly, the online professional development course is important; however, it is only eight hours and as such provides an introduction to many important topics and issues. The professional education of post-secondary health students still needs much attention.

44 See http://www.phsa.ca/our-services/programs-services/indigenous-health
CONTRIBUTIONS AND SIGNIFICANCE OF THE RESEARCH

This thesis makes a contribution to the research literature by providing some insight to the complexities of availability, accessibility and acceptability (3As) of health and social services for urban Aboriginal people. My study examines these 3As for both provincial health services and those provided by an urban Aboriginal agency, Kla-how-eya, located at Surrey, British Columbia. The study participants include both clients and professional staff (health care providers, management, and board members) who had used or worked at Kla-how-eya for at least five years. Their perspectives, experiences, and stories are invaluable for the research outcomes. The study also adds to the body of sparse Indigenous health literature that focuses on urban Indigenous people’s knowledge.

As a Tlawitsis, Kwakiutl woman, an Indigenous researcher and health educator, I developed a new Indigenous Good Medicine Theory of culture, comfort, communication, and collaboration (4Cs), which is another outcome and research contribution to the health field for urban Aboriginal people. The 4Cs could be used for the provincial health and social services and in Aboriginal health/social service agencies.

Even though the major source of inspiration and knowledge for the Indigenous Good Medicine Theory are urban Aboriginal people, my personal and professional experiences, and Indigenous scholarship, I think that this theory is applicable to Aboriginal rural and other urban sites. The Hamumu story of transformation and the image of the butterfly shows how local Indigenous knowledge can be used for this transformational process to another context.

These research outcomes of the Indigenous Good Medicine Theory and use of the Indigenous methodology (8Rs) could be used for the development of regional or province-wide plans for responsive provincial health services for urban Aboriginal people. In addition, this study contributes towards wholistic health care and demonstrates a wholistic methodological analysis. The adaptation of the Medicine Wheel teachings, and the eight embedded Indigenous principles of respect, responsibility, reciprocity, reverence, relevance, wholism, interrelatedness and synergy, can be useful tools for examining, changing and transforming provincial health services and the education of health care providers.
Another strength of this study is the potential applicability of its findings to other Indigenous health promotion programs at Indigenous health centres, Aboriginal Friendship centres and non-Aboriginal clinics, hospitals, emergencies and diagnostic centres, especially non-Aboriginal facilities that provide services to urban Aboriginal people.

**Limitations of the Research**

This thesis is limited in terms of the scope of the study; 14 participants are but a tiny component of the 1500 plus that use Kla-how-eya monthly. To address this limitation, the participants are those who either use or have worked at Kla-how-eya for at least five years, to develop a longer-term perspective and picture. This criterion of length of time may have disqualified many people. Chapter Two highlights some urban Aboriginal issues, such as high unemployment, lower income, lower levels of education which contribute to transiency.

Another area that could be perceived as a limitation is the time lapse between the interviews and sharing circle, conducted between 2009-2011 and the final writing of this thesis in 2018. Changes have occurred at Kla-how-eya and in the provincial health system since the data was acquired seven years ago. To provide a current context, I updated various health data and pertinent policy information and included some updates about Kla-how-eya through recent discussions with its executive director. This study is not meant to be an evaluation of Kla-how-eya, so implications for it are not emphasized in this thesis. The participant data is still very relevant and applicable for the overall purpose of this thesis, which is to examine urban Aboriginal people’s experiences and perspectives about health care services that they receive in the mainstream health care system and at an urban Aboriginal agency. Their lived experience stories have many valuable lessons and understandings that are not limited to a timeframe.

**Future Research Implications**

Transformative action requires that Indigenous people become empowered to take responsibility for our wholistic health and well-being. However, the empowerment process also requires both the non-Indigenous care provider and Indigenous client to exchange their knowledges about their backgrounds and learn to understand one another. Further research
could be conducted about this reciprocal relationship process to understand how this mutual sharing could be done and what benefits such a relationship would have to improved health. Willie Ermine (2007) describes the space between Indigenous and Western spheres of culture and knowledge as an ethical space. In Ermine’s ethical space, the notions of equity and respect for different ways of knowing are critical. Perhaps this notion of ethical space could be used for future research about relationship building between health care providers and urban Aboriginal people.

Certainly, more research could be undertaken about other Aboriginal Friendship Centres and urban Aboriginal organizations that provide health services in other Canadian cities. Much more could be learned about the challenges and successes of their culturally responsive approaches, policies, programs, partnerships, and leadership/staffing.

**ONGOING REFLECTIONS**

One point that I believe in more strongly after conducting this research is that a relational approach recognizes that people’s health and illness are shaped by their social, economic, cultural, family, historical contexts as well as by their biology, gender, age, ability, etc. Relational practice focuses on how personal, interpersonal, and contextual elements shape peoples’ experiences and life situations. (Wilson, 2008). Included in this relational approach is an examination of how capacities and socio-environmental situations influence peoples’ management of health and illness experiences and their decision-making abilities. For example, risk behaviour in a mother like myself, is not interpreted as a problem or poor parenting or located solely in the individual circumstance of that individual.

Rather, a relational view is taken to consider how, for example, intergenerational experiences and traumas (such as the residential school), and structural constraints might be experienced within a person/family. The relational approach fosters comprehensive clinical decision making, ensures that people/families are treated with respect and dignity, and enables health care providers’ actions to be more effective and responsive in addressing risk. All of these aspects are central to contextualizing the complexities of urban Aboriginal families who are seeking to access provincial health and social services.
I believe that the following changes are required so that the mainstream health services, health care providers and system can effectively provide culturally safe health and social health services to urban Aboriginal people: (1) Transformative change to the provincial health care system to ensure Indigenous peoples are respected; (2) The need for recognition by the provincial health care system of the importance of Indigenous peoples’ values, knowledge/culture and worldview; (3) The need for culturally specific education to inform provincial health care policies and practices to meaningfully involve urban Aboriginal people’s voices, while ensuring equitable access to health services; (4) Strong relationships between the provincial and federal governments and Indigenous communities; and (5) Incorporate an Indigenous Good Medicine approach to policy and practices so that health service outcomes address the concerns and issues identified by urban Indigenous people.

In this chapter, Hamumu returning refers to either an individual Aboriginal person or a collective such as urban Aboriginal people who are either working together or in partnerships reclaiming an urban landscape as their own space. Urban Aboriginal people have passed through various stages in their lives enduring several changes and struggles since the first contact with Europeans, however, this was a forced change. However, as time heals our wounds, our cultural knowledge, beliefs, values and worldviews begin to emerge once again, like Hamumu. Certain changes are needed to achieve balance and harmony. The previous paragraph states the changes required for urban Aboriginal people to receive optimal, responsive, culturally appropriate health care services from mainstream healthcare workers, services and system. Hamumu is the same way, which if given appropriate, relevant and respectful conditions, it will organize itself at it’s highest level of metamorphosis. Urban Aboriginal people, if provided relevant changes can be empowered and reach their actualization of physical, emotional, mental and spiritual well-being, balance and harmony.

I return to the importance of healing from the land as part of wholistic well-being. In relation to urban Aboriginal people living in alien urban environments outside their tribal homelands, I offer additional perspectives and understanding through this research. I also return to Chief Leonard George’s (quoted in Neel, 1992, p. 53) reply to a question, “How can urban First Nations maintain their cultures which may have deep connections to the
land, in a city environment?” George claims that he used old philosophies as tools, calling it learning how to become a hunter in the city. So, for me using old philosophies is a relevant guide such as a hunter or berry picker in the forest, fisher on the ocean, or a clam-digger on the beach; the respect that we have for the sources (land, water, and air) of our food, we take only what we need, we bring the food back to community members and share with many people whose needs will be suited by the food.

In an urban environment, people and organizations can still practice old philosophies or use them as tools as they develop Indigenous-based, culturally relevant health services that sustain people in wholistic ways. Urban Indigenous organizations such as Aboriginal Friendship Centers provide cultural nights allowing different tribal affiliations to share their cultures on different nights in metro Vancouver. Kla-howey provides cultural land-based activities such as canoeing and hosts pow-wows as part of their cultural programs for Indigenous families.

The uses of three different sources of knowledge for this thesis create a wholistic overview of the availability, accessibility and acceptability of urban Indigenous peoples’ health services for their well-being: my personal experience story, participants’ experiential stories, and policy/research literature. Urban Indigenous peoples’ health-related stories have often not been given space and recognition. In this thesis, their stories and my story are told without fear of repercussion, discrimination and racism, with the goal of establishing learning relationships between urban Indigenous people and health care providers to ensure continuation of responsive culturally safe care. I acknowledge that my emphasis on informed and culturally responsive health care providers may seem to ignore the need to make policy and structural changes to a provincial health care system for urban Indigenous people. Even though I firmly believe that educating health care providers about Indigenous matters is a priority, I understand that this action is only one part of the on-going struggle to make institutional and structural change.

I recognize that current collaborative policy processes are being put into action through partnerships between the First Nations Health Authority, First Nations communities and the Provincial and Federal governments to improve the wellbeing of First Nation communities.
I believe that similar partnerships could be established for urban Indigenous people focussed on policy and programmatic considerations for culture, communication, collaboration and comfort that results in an Indigenous Good Medicine Theory.

I end this thesis with the thoughts of one of the elder participants who helped me think deeper and more broadly about the meaning of Good Medicine:

    Giving the person time, that is what we call Good Medicine,
    talking to them, valuing them and giving that person time, that is
    Good Medicine. (Interview, 2011)
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