



January 2015

Participatory Action Research with a Group of Urban First Nations Grandmothers: Decreasing Inequities through Health Promotion

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Recommended Citation

Ginn, C. S., Kulig, J. C. (2015). Participatory Action Research with a Group of Urban First Nations Grandmothers: Decreasing Inequities through Health Promotion. *The International Indigenous Policy Journal*, 6(1) . Retrieved from: <https://ir.lib.uwo.ca/iipj/vol6/iss1/4>

DOI: 10.18584/iipj.2015.6.1.4

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Abstract

Inequities experienced by Aboriginal people in Canada due to residual effects of colonization and assimilation are evident; research is needed focusing on positive strategies for health and healing in urban settings. Participatory action research (PAR) is identified as an appropriate method of research for engaging collaboratively with Aboriginal people. This study involved seven First Nations grandmothers in a small urban community in Alberta, Canada. The grandmothers linked personal health with family and community health, and practiced health promotion through maintaining cycles of support between themselves, their families, and communities. These grandmothers recognized their invaluable roles as leaders in health promotion in families and communities. The collective knowledge of Aboriginal grandmothers has potential to affect health inequities on a broader scale.

Keywords

Canada, Aboriginal health, health promotion, Indigenous population, inequities, participatory research, social determinants of health, urban

Acknowledgments

This research was funded by the Canadian Institutes of Health Research Frederick Banting and Charles Best Canada Graduate Scholarships- Master's Award (CGM-89148). We would like to acknowledge the grandmothers without whom this study would not have occurred.

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Participatory Action Research with a Group of Urban First Nations Grandmothers: Decreasing Inequities through Health Promotion

This article will briefly review the effects of colonization and assimilation on Aboriginal people in Canada, identifying them as a vulnerable yet resilient population. Participatory action research (PAR) will be outlined as a fitting method to engage in research because of its emphasis on participants as co-researchers. Study design, data collection, and analysis with a group of seven First Nations grandmothers in a small urban community in Alberta will be described. Findings of the study will be discussed in relation to roles of grandmothers in health promotion, the social determinants of health for Aboriginal people, and the ultimate potential for contribution to health policy.

Much has been written with regard to existing inequities for the 1.4 million Aboriginal people in Canada, 70% of whom live off-reserve (National Association of Friendship Centres, 2013; Statistics Canada, 2013). Aboriginal people have been described as strong and resilient with a holistic world view that has potential to contribute to the overall health and well-being of all Canadians (Kirmayer, Simpson, & Cargo, 2003; National Collaborating Centre for Aboriginal Health, 2013); however, they have also been identified as the “most distressed group in Canadian society” (Knopf, 2008, p. 5). Residential schools¹ have detrimentally affected individual as well as collective health for Aboriginal people (Mikkonen & Raphael, 2010; National Collaborating Centre for Aboriginal Health, 2013; Waldram, Herring, & Young, 2006). The residential school era was compounded by the “Sixties Scoop,” wherein disproportionate numbers of Aboriginal children were adopted by non-Aboriginal families or entered foster care. This wave of assimilation has been linked to intergenerational disparities and inequities in individual and collective health (Royal Commission on Aboriginal Peoples, 1996; Waldram et al., 2006). Inequities in health resulting from the trauma of assimilation are systemic and ongoing. Four percent of Aboriginal children in Canada are foster children as compared to 0.3 % of non-Aboriginal children, and Aboriginal children aged 14 and under currently make up 48.1% of children in foster care (Statistics Canada, 2013). Although the Government of Canada has issued an apology for the immeasurable damage incurred through efforts to separate and assimilate children into the “dominant culture” (Government of Canada, 2008), colonizing attitudes continue to pervade the collective consciousness of Canadians.

Colonization and its effects persist throughout Canadian society. Negative societal views have the potential to affect the well-being of Aboriginal people through discriminatory behaviours and attitudes. Aboriginal people in Canada perceive negative stereotyping by other Canadians in areas such as addiction, laziness, lack of intelligence, and poverty (The Environics Institute, 2012). The collectivist worldview of Aboriginal people does not fit the dominant capitalist culture in Canada and many misunderstandings have occurred due to this disconnect. Aboriginal communities were profoundly

¹Residential schools—with goals of assimilation and acculturation—were a government–church (Anglican, Catholic, Methodist, and Presbyterian) partnership that opened boarding schools across Canada. The removal of Aboriginal children from their homes and replacing traditional language and beliefs with European language and beliefs was an attempt at “civilizing” and “re-socializing.” Conversely, the results were horrendous, resulting in neglect, mistreatment, and abuse of thousands of children, reaching to future generations through forced removal of traditional values and bonds of parental love. The last residential schools closed in the 1970s in the United States and in 1996 in Canada.

changed during colonization through treaties, land claims, and the enactment of a complex web of documents such as the Indian Act² and Bill C-31.³ In terms of health legislation, the White Paper Policy⁴ was withdrawn following protest from Aboriginal groups, while the Indian Health Policy⁵ revised the approach to Aboriginal health and slowly Aboriginal people progressed toward greater involvement in their own health. Recommendations for increasing health equity were co-created at a forum held by Commissioner Roy Romanow in co-operation with the National Aboriginal Health Organization (NAHO). Aboriginal Health Partnerships were proposed as strategies for health promotion. These partnerships were to be community-centred (rather than government-centred), holistic, rooted in cultural traditions and values, and encompass community, regional, or urban partnerships (Romanow, 2002). These partnerships have yet to be fully implemented in Canada.

While remaining cognizant of the ensuing negative effects of colonization, looking forward and strategizing for progress is essential. The Urban First Nations Health Research Discussion Paper (2009) recommended attention to strategies and processes for healing and health in urban settings (Browne, McDonald, & Elliott, 2009). Much of health literature is focused on deficits such as marginalization and loss, and an emphasis on positive health promotion strategies in urban centres is necessary: “Studies are needed that explore the processes that support health and healing—that is, the strategies used by people to stay healthy, mobilize social support, and develop a sense of community in urban settings” (Browne et al., 2009, p. 37).

The Government of Alberta (2010) identified Aboriginal people as part of a vulnerable population requiring collaborative research to generate solutions for reducing disparities in their health. Reducing inequities in accessing the determinants of health for vulnerable populations in Alberta “is thought to have the potential to yield health benefits similar in magnitude to those that would accrue from reductions in lifestyle risk factors for the major chronic diseases” (Government of Alberta, 2010, p. 25). Research with Aboriginal people in Canada must attain a balance between identifying existing inequities and hidden strengths within the Aboriginal population. The aims of this study were two-fold: first, to engage with a group of First Nations grandmothers in collaborative research; second, to gain understanding about health and ways of promoting it in their families and communities.

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

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

⁴ The White Paper Policy was created in 1969 and proposed to transfer health care from federal to provincial governments, phasing out the Indian Act, reserves, and separate services for Indians.

⁵ The Indian Health Policy was first introduced in 1974, followed by another in 1979, which recognized the need for improvement of health through the participation of Indian people.

Methods

Participatory Action Research (PAR)

PAR encompasses a philosophical stance stemming from social constructionism and pragmatism, a theoretical framework interconnecting ways of knowing with ways of living, and a method linking research to social action. Social constructionism blends the material and symbolic, or common sense and philosophy (Burr, 2003; Edley, 2001). Pragmatism stems from social constructionism and is the “recognition of an inseparable connection between rational cognition and rational purpose” (Peirce, 1905, pp. 162-163)—in other words, thinking followed by doing. PAR links research with action, and is a theoretical framework as well as a method found throughout the work of noted scholars, such as Dewey (1859 - 1952), Collier (1884 - 1968), Lewin (1890 - 1940), Horton (1905 - 1990), Freire (1921 - 1997), and Borda (1925 - 2008), over the last century. Dewey built on pragmatism proposed by Peirce, moving from philosophizing to action in helping people solve their problems. Dewey wrote extensively about social environments and their effects on people’s lives as individuals and communities. When people with shared values struggle together for community survival, it demonstrates the positive side of human nature; on the other hand, those with a love of power tend to perpetuate oppression and removal of other’s freedoms (Dewey, 1989). Collier (1945), the Commissioner of Indian Affairs in the United States from 1933 to 1945, described research action as compelled by identified areas of need within society, and emphasized the responsibility of researcher and participant to work together, integrating knowledge that the “Indian” provided in order to make positive change. Collier (1945) described the damage done to First Nations people through processes of colonization as tantamount to the horrors of WWII expansionism and resultant devastation. He wrote about the loss of community and applying integrative action research as a way “to deepen our realization of the potentialities of the democratic way, as well as our realization of our own extreme, pathetic shortcomings” (Collier, 1945, p. 276). Lewin (1946) coined the term “action research,” and emphasized involvement of communities in facilitating change. Lewin stressed the need for a two-way democratic process to bring about social change rather than decisions being made by the most powerful on behalf of the less powerful. He categorized “minority problems” as also being “majority problems,” arguing that those in the majority should work to increase the self-esteem of individuals and groups of people who are in the minority, and decried the harmful historical effects of colonization through the imposition of colonial policies (Lewin, 1946). Horton founded the Highlander Folk School in 1932 to enrich the culture of Indigenous people living in the Appalachian Mountains in Tennessee. He began by working with people to strengthen unions and increase economic justice through education of the workers, which led to increased involvement in human and civil rights. Rosa Parks, who sparked the civil rights movement by refusing to give up her seat on a bus to a white man, was an alumna of the school; Martin Luther King, Jr. was a colleague and friend of Horton’s (Horton & Freire, 1990). Freire and Borda were the founders of PAR. Freire’s work in Brazil placed the illiterate and less powerful in the center of knowledge creation, engaging in research as social action to break the power of the oppressive and dominating political structures of society (Freire, 1993). Borda lived out processes of radical social transformation, assisting grassroots groups in Columbia with incorporation of local knowledge into power for change. Borda emphasized making a conscious effort to combine our life experiences with how we live in such a way that radical change is possible: “Therefore, we must know how to select that which is in harmony with our vision of social responsibility; and, at the same time, that which satisfies our life experience” (Borda, 1979, p. 33). He described the importance of exploring the oral traditions and stories of Columbian elders who possess wisdom and common sense

about their own histories, as differing from the written books by others about them: “Thus we recover the popular (unofficial) version of history and strengthen the culture and self-esteem of people at the grassroots” (Borda, 2013, p. 160). These early descriptions of action research emphasized the importance of engaging communities throughout the research process in order to bring about understanding and societal change.

A PAR study in three Indigenous communities in Ontario explored why externally imposed public health programs are often ineffective (Smylie, Kaplan-Myrth, & McShane, 2009). Community representatives and governing bodies identified community research team members who assisted with recruitment, data collection, analysis, synthesis, and approval of study results in collaboration with Aboriginal and non-Aboriginal researchers. The study findings suggested that without understanding of each local community knowledge translation activities would likely be ineffective. Some common themes were discovered and included the value of experiential knowledge, the influence of community, and the dissemination of information through family and community networks (Smylie et al., 2009). This model of community and family dissemination has not been fully realized by researchers and policy-makers. The centralized system of the First Nations and Inuit Health Branch of Health Canada has developed and transferred knowledge in a hierarchical manner not congruent with effective knowledge translation in Aboriginal communities (Smylie et al., 2009).

To achieve useful and meaningful policy development, local community expertise is a prerequisite. PAR is an effective method of research that engages communities in research and knowledge development. Due to its inherent principles of cultural sensitivity, inclusion, community decision-making, empowerment, respect, and emancipation, PAR is particularly fitting for research with Aboriginal people (Cochran et al., 2008; Maar et al., 2011; Purden, 2005).

Setting and Sample

A participatory design and community engagement is essential when engaging in research with First Nations people (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010). This article presents findings from a PAR study conducted during graduate studies of the first author under the supervision of the second author. The research occurred in collaboration with a group of urban First Nations grandmothers in a small city in Alberta, Canada. The study builds upon existing literature noting that First Nations grandmothers are known to pass on traditional knowledge and create support networks for their families and communities (Hungry Wolf, 1980; Meadows, Thurston, & Lagendyk, 2004; Royal Commission on Aboriginal Peoples, 1996; Tjepkema, 2002; Young, 2003). The study also adds to the body of literature noting that First Nations women in Canada do not routinely experience trust or respect during their encounters with health care professionals (Browne & Smye, 2001; Fiske & Browne, 2006). Experiences of lack of trust, stemming from colonization, have been identified in the connection between Indigenous peoples and research: Indigenous communities agreeing to participate in research “tend to be persuaded not by the technical design, however, but by the open and ‘good’ intentions of the researchers. They also expect and appreciate honesty” (Smith, 1999, p. 140).

Engaging in collaborative research should include the researcher and the community, should benefit the community, and produce valued outcomes relevant to the community. PAR involves knowledge users

assisting with development of the research questions as well as collecting and analyzing data with researchers learning to work collaboratively with the group being researched (Parry, Salsburg, & Macaulay, 2009). In PAR, the knowledge users include the community being researched as well as the researcher. The community representative for Aboriginal seniors confirmed the importance and appropriateness of a study of this nature, suggested the research questions, and assisted with development of the proposal. The research questions were as follows:

Research question 1: What does health mean to urban First Nations grandmothers?

Research question 2: How do they promote it in their families and communities?

The proposal was submitted for ethical approval to the University of Lethbridge, Human Subject Review Committee, and then presented to and approved by the First Nations Community Association (FNCA). A group of seven grandmothers between 48 and 80 years of age from Cree and Blackfoot tribes volunteered to participate in the study. This group of grandmothers requested to be described as First Nations.

Data Collection

The grandmothers received opportunities for group and/or individual interviews, resulting in four group interviews and one individual interview over a four-month period. A member of the FNCA chose to participate in the study, setting the time and place for the first interview. The grandmothers and the community representative determined subsequent times and locations for interviews. The process not only included interviews but also communal activities that were of significance to the group—cooking in particular. One of the grandmothers made bannock, some of the grandmothers wrote out their recipes, the first author brought ingredients and learned to make each grandmother’s version of traditional stew. While cooking, the grandmothers discussed content from the transcripts that they felt were meaningful and deserving of follow-up. Throughout the study, the first author was invited to participate with the grandmothers in a community garden project, cultural awareness days, and a health fair. Participating in these community events was enjoyable and educational, adding significantly to understanding of the grandmothers and their families; therefore contributing to increased richness of the data. The first author completed the transcribing and provided copies to the community representative one week following each interview for distribution to the grandmothers. Some of the grandmothers requested summaries of key points to avoid the lengthy reading; these were provided following subsequent interviews. Another grandmother asked for more questions before each interview; these were developed from additional topics she wished to explore and passed on to the community representative for distribution to the group.

The grandmothers’ contributions such as suggesting additional questions and topics from their transcripts for subsequent interviews aligned with principles of ownership, control, access, and possession (OCAP), which are essential in research with Aboriginal people. Ownership encompasses more than simply owning a copy of the transcripts or thesis; it means that the participant is regarded as a co-researcher and feels that his or her perspective and knowledge has been accurately represented in the findings (Schnarch, 2004). Due to the sensitive nature of what they revealed during their interviews, the grandmothers decided against owning copies of the tapes themselves, lest they “get into the wrong hands.” The grandmothers further requested not to be identified by numbers in the transcripts, as they

had been “given enough numbers by the government;” therefore, pseudonyms were developed by the first author with meanings resembling notable personality traits of the grandmothers. These names and meanings were discussed and heartily approved by the group, amidst much laughter.

Data Analysis

Data analysis involved coding and theme development with the grandmothers, using a method documented by Bartlett, Iwasaki, Gottlieb, Hall, and Mannell (2007). The first author printed 556 paraphrases of key statements from the transcripts on index cards with corresponding statements, page, and interview numbers cross-referenced on the back. These cards were laid out on tables with the grandmothers walking around the room, picking up the cards most meaningful to them. Cards containing statements about residential schools were placed in a separate pile as the grandmothers decided the statements on these 106 cards should be woven throughout the data rather than having a separate theme because they described residential schools as affecting every part of their lives. During two consecutive meetings, the grandmothers chose cards most meaningful to them, 129 in total. Those who were unable to see or understand the cards due to vision difficulties or language barriers were assisted by other grandmothers who read the cards out loud, at times in their first language. As the grandmothers held their cards, they spoke out ideas for themes regarding health, which the first author wrote on sticky notes and placed on walls around the room. The grandmothers then placed the cards they had chosen under themes they determined fit their statements. While choosing cards and placing them under themes, their consensus regarding the words they had chosen helped to establish rigor, ensuring credibility of the findings. Many of the cards they chose were statements made by one of their friends rather than their own, and they marvelled at their combined knowledge. When reviewing transcripts and organizing the findings, the grandmother who had spoken the least throughout the interviews said, “I know a lot.” This recognition of contribution is essential in maintaining credibility, as is engagement and interaction with the participants (Ryan-Nicholls & Will, 2009). Consistency was maintained through member checking occurring with the second author and the community representative throughout the research process, ensuring transferability, dependability, and confirmability of the study results (Lincoln & Guba, 1985).

Findings

The grandmothers co-created 12 themes under an overarching theme of “staying healthy,” which they defined as a balance of physical, emotional, mental, and spiritual health. One of the grandmothers brought up the concept of a medicine wheel to describe this balance, but the group determined not to use it because they did not all feel comfortable with it as a model. Therefore, they continued with naming and positioning three themes into each of the four quadrants of health. They described their physical health including role-modeling, educating, and living off-reserve; mental health including knowledge of who to trust and distrust, problem-solving, and enjoying life; emotional health including resiliency and surviving, staying positive, and constructively addressing racism; and spiritual health including spirituality and culture. At the second data analysis meeting, one of the grandmothers identified a missing theme: They discussed a major part of living healthfully as listening to their intuition and following dreams. Initially, the group was reluctant to include it in case certain audiences might consider it too mystical, but through their thoughtful discussion they concluded dreams and intuition fit as the final theme under spirituality.

Physical health encompassed role-modeling, described by the grandmothers as “changing myself first;” educating or “increasing understanding;” and reserves, resulting in “splitting us up.” Strong relationships with grandchildren were seen as catalysts for change. When role-modeling interactions with her physician, Joan said:

I wouldn't let myself be intimidated, I would ask the questions that needed to be asked because I always thought, “my kids will have to learn from me how to do this.”

Formal and informal education was viewed as a way to bridge gaps between cultures. Similar to residential schools, reserves assimilated the grandmothers into physical spaces that were not traditional lands and not home. The grandmothers asserted that choosing to live off-reserve resulted in decreased material resources but increased health and opportunities to be physically present and available for their grandchildren.

Mental health encompassed learning whom to trust and distrust, clarifying that “trust is difficult;” problem-solving or “planning how to stay healthy;” and enjoying life through “using humour.” Letting go of negative influences and developing positive relationships helped move them away from difficulties with trusting those in authority following residential school. The grandmothers encouraged each other to try new things, develop self-confidence, let go of anger, and replace it with gratefulness. Brigid described humour as:

One of the blessings, cause even if we had a really bad day in class, we'd all be in the rec room and there'd be nothing but laughter.

Prioritizing mental health allowed the grandmothers to build on strengths from past experiences, helped them cope with present daily events, and provided opportunities for sharing these strategies with grandchildren.

Emotional health involved resiliency, which the grandmothers termed “we're still here;” keeping a positive outlook through deciding to “turn things from negative to positive;” and encountering racism or “being treated differently,” learning from it, and educating others about cultural differences. Brigid described it in this way:

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

Realization of personal value and resiliency helped to build strong relationships with grandchildren, as did focusing on “changing things from dark to light.” Alice related:

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

The grandmothers observed that health care providers lacked understanding and listening skills and that they, generally, were not culturally sensitive or aware. Ida explained:

They talk so much you can't get in edge-wise so you just give up; you leave without telling the main thing that's bothering you . . . You just can't be healthy, no matter what you do. Through the doctors you try to be healthy, but you bump up against the wall with these doctors.

Positive encounters involved those who took time to listen, took action on what they heard, and took time to follow up. The grandmothers persevered in their determination to "turn it around" as they described their methods of changing things for the better for their communities, families, and themselves. Joan described the grandmothers feeling unsure and afraid at times following the experiences of residential schools:

Sometimes they don't find that worth in themselves because of residential school, they've been so beaten down and they need to have somebody build them back up . . . when their kids are being raised in that kind of attitude where their caregiver feels like they're nothing, how can their kid feel like anything?

The grandmothers' choices to be emotionally healthy involved a transparency regarding the past, and a recognition of their worth in the present.

The grandmothers described spiritual health as a daily occurrence through "everyday experiences;" living within two cultures or "mine and the mainstream;" and in dreams and intuition or as they described "things we can't explain." Religion imposed by residential schools led to confusion regarding traditional beliefs and a loss of the ability to maintain healthy, loving relationships. Alice described it this way:

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

Daily living in a spiritual way involved being part of a bigger plan, having faith, employing prayer, and maintaining gratefulness. Practicing traditional knowledge and ceremonies increased abilities to maintain spiritual health while living in two cultures. Brigid explained:

I've lived away from the reserve for so long, that I've developed my way. It's based on knowledge from both cultures that I live within.

Utilizing knowledge gained from both cultures facilitated health promotion activities with their families while maintaining First Nation identities. The grandmothers did not expect their families to engage in healthy activities without role modeling, as described by Alice:

Fixing myself first, because being in this area [i.e., the control imposed by residential school] for so long I have to fix myself before I can walk my talk.

Clara described her strategy for staying healthy and positive:

For me its faith, and being able to have, to hang on to someone, a higher power, knowing that I'm not walking alone with this problem that I have.

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

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

Living daily in a spiritual way strengthened the grandmothers by assuring them of their ability to carry on no matter what they had previously endured and no matter what was to come.

Discussion

PAR was a complementary method of research for the grandmothers, providing opportunity to demonstrate respect for their capabilities and knowledge, and a means to engage effectively with them. The First Nations grandmothers participating in this study possessed profound understandings of themselves, their families, and their communities. They clearly were experts in health promotion and ways of decreasing inequities within their own social context. Their holistic views of health as being a balance of physical, emotional, mental, and spiritual health were in stark contrast to the “health” enforced at residential schools through regulations, work, cleanliness, and avoidance of cultural practices. The grandmothers chose ways of improving their own health through maintaining mobility and strength, managing chronic health conditions through exercising and eating well, maintaining healthy body image, and choosing to live off-reserve. Living off-reserve has been outlined in other studies as a healthy strategy for improving well-being because of increased access to housing and clean water, closer proximity to children and grandchildren, increased educational opportunities, and avoidance of individuals on-reserve who have hurt them in some way (Balfour, 2008; Bharadwaj et al., 2006; Browne, Smye, & Varcoe, 2005).

The grandmothers described numerous challenges in encounters with health care providers but utilized them to role-model effective communication techniques. They did not develop a formal strategy for educating health care providers, but encouraged each other to “use your voice” when encountering challenges within the health care system. This collective knowledge-sharing has been identified as facilitating understanding between Aboriginal women and health care providers (Wild et al., 2013). The grandmothers' availability to their families and communities counted as a rich resource, which they practiced innovative means of health promotion. They resolved to speak up and out, taking a stand

against injustices while changing things for the better to turn it around for their families and communities.

This group of urban First Nations grandmothers has experienced many inequities throughout their lifetimes. Their collective knowledge and resiliency has contributed to the well-being of their families and communities, with potential to contribute to the overall well-being of Canadians. Many of the social determinants of health are inherently linked to this study and include Aboriginal status, early life, education, income and income distribution, social exclusion, and the social safety net. The International Symposium on the Social Determinants of Indigenous Health (2007) identified colonization as a fundamental underlying health determinant for Indigenous people. Recommendations included restoring control over their lives through self-determination and involvement in policy development and provision of health services (International Symposium on the Social Determinants of Indigenous Health, 2007). The grandmothers in this study were unaware of the social determinants of health in a formal manner but vocalized awareness of their importance throughout the interviews. The health inequities that these grandmothers, their families, and communities have experienced are directly related to colonization, and, in order for health reform to occur, family and community involvement is vital as well as respect for the knowledge that First Nations people bring to their own health management.

Inequities in access to the social determinants of health may decrease material resources, but, for this group of grandmothers, with decreased material resources has come increased value of individual, family, and community connections. Waldram et al. (2006) wrote about viewing Aboriginal people as “indigenous, colonized minorities in their homeland” (p. 295) who are active in “improving their lot” and reacting in response to oppression rather than as “passive victims.” Uptake of these positive perceptions in Canadian society would go far to reduce inequities. Recognition of the human rights of urban Aboriginal people and communities is essential in order for them to work together for change because disrespect negatively impacts health in material and psychological ways (Senese & Wilson, 2013).

The grandmothers demonstrated great resiliency by role-modeling strength while progressing in their own healing. Living daily in a spiritual way, they gratefully practiced traditional knowledge and prayer. Linking personal health with family and community health, they maintained positive cycles of support between themselves, their families, and communities as they educated and passed on knowledge. This interrelated and collective model of health is noted in the literature as one reason that mainstream approaches to prevention and treatment of health do not fully address the complexities of health for Aboriginal people (Loppie Reading & Wien, 2009).

Limitations

The study was completed in the English language while only one of the grandmothers spoke English as a first language, two spoke both Cree and English, and four spoke both Blackfoot and English. Completing the study in their original languages may have resulted in richer data. The first author wrote out key statements on cards rather than having the grandmothers write out key statements and may have overlooked some themes that the grandmothers would otherwise have chosen. Data analysis occurred over two meetings, with one grandmother unable to be at either meeting due to illness. The community representative was a liaison during this process, keeping the grandmother who was ill informed and

adding her ideas as applicable. The success of the research was linked to the involvement of the community health representative but this involvement may have inadvertently impacted the overall research process. The grandmothers did not want to review the 106 key statements regarding residential schools; they kept them in a separate pile and requested that the first author weave them throughout the final manuscript. The first author may have placed them under different themes than the grandmothers would have. This study involved a small group of urban First Nations grandmothers and further research regarding on-reserve grandmothers would provide meaningful context. The grandmothers suggested more research regarding the place of men, both young and old, in their families and communities, as traditional roles were missing and along with those often a sense of purpose.

Conclusion

Engaging in PAR has the potential to contribute significantly to inequity-related research. According to Cochran et al. (2008), “the way researchers acquire knowledge in indigenous communities may be as critical for eliminating health disparities as the actual knowledge that is gained about a particular health problem” (p. 22). This concept was expanded by Bastien (2004), who described reciprocal relationships as one way in which researchers gain knowledge and in which Blackfoot people come to know. The importance of relationships can be traced back to First Nations “ways of knowing,” which existed long before Western philosophies, theories, and methods. The grandmothers in this study vocalized and confirmed with each other their innovative ways of maintaining and promoting health. Their insistence on “turning things around” for themselves, their families, and their communities provides promise for decreasing inequities in overall health for First Nations people in Canada. Brigid wisely stated:

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

Canada’s income inequality and poverty rate is among the highest of wealthy countries and community engagement through social movements is a useful method for pressuring policymakers and governments to support health (Mikkonen & Raphael, 2010). To improve well-being for Aboriginal people, effects of colonization on the social determinants of health must be addressed. Aboriginal seniors are among Canada’s most vulnerable citizens—living with poor physical and mental health due to the trauma of residential schools, low incomes, multiple chronic diseases, in isolated areas (usually on-reserve) and with poor housing (Health Council of Canada, 2013). Inequities in health for Aboriginal people are extensive and on the surface may appear beyond reparation. Colonization has occurred over hundreds of years and health reform for Aboriginal people will be a gradual process. In engaging Aboriginal communities, families, and individuals to work together to decrease inequities, Aboriginal grandmothers are a clear starting point.

Aboriginal grandmothers are leaders in their communities, having emerged through unimaginable circumstances with strength, resiliency, and wisdom. They possess traditional knowledge, know their communities and families, and are well positioned to work collaboratively to negotiate change. Aboriginal grandmothers are untapped resources in their communities and families who ardently engage in health promotion. They build and strengthen communities, provide links with cultural traditions, and are invaluable in promoting health and well-being. Collaboration with Aboriginal grandmothers in developing innovative strategies for health reform and policy development is a fitting start in reducing inequities in health for Aboriginal communities.

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