Résumé

Melq'ilwiye : Union — carrefour entre identité, culture et santé des jeunes Autochtones vivant en milieu urbain

Natalie Clark, Patrick Walton, Julie Drolet, Tara Tribute, Georgia Jules, Talicia Main, Mike Arnouse

L'objectif de ce projet exploratoire de recherche participative en milieu communautaire était double : déterminer comment les jeunes Autochtones vivant en ville établissent leurs besoins en santé à partir d'un modèle de la santé et du bien-être qui est de nature culturelle, et créer de nouvelles connaissances de même qu'une capacité de recherche par et avec les jeunes Autochtones et les fournisseurs de soins de santé autochtones en milieu urbain. Les expériences visées par le projet ont été examinées au moyen d'un cadre méthodologique mixte reposant sur la participation à des cercles de la parole et la réalisation d'un sondage. L'étude issue de ce projet contribue au développement de la recherche anticoloniale dans la mesure où elle résiste aux explications en termes de maladie/malaise mises de l'avant par les paradigmes de recherche néocoloniaux. L'un des principaux axes de la recherche était l'élaboration de stratégies permettant de tenir compte des *aspirations* des jeunes Autochtones vivant en milieu urbain, afin ainsi de construire les assises grâce auxquelles ces jeunes pourront alimenter, soutenir et concrétiser leur potentiel en matière de santé et de bien-être. La contribution de la présente étude consiste donc à proposer une nouvelle façon de concevoir la santé des jeunes Autochtones vivant en milieu urbain, conception s'appuyant sur un cadre axé sur la culture, culturellement approprié et apte à reconnaître à la fois le lien profond qui rattache les jeunes Autochtones en milieu urbain à leurs terres, leurs langues et leurs traditions ancestrales et la nature des espaces entre lesquels ils évoluent.

Mots clés : santé des jeunes Autochtones, culture, cercles de la parole, recherche anticoloniale, traditions ancestrales

Melq'ilwiye: Coming Together — Intersections of Identity, Culture, and Health for Urban Aboriginal Youth

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The goal of this exploratory community-based participatory action research project was twofold: to determine how urban Aboriginal youth identify their health needs within a culturally centred model of health and wellness, and to create new knowledge and research capacity by and with urban Aboriginal youth and urban Aboriginal health-care providers. A mixed-method approach was employed to examine these experiences using talking circles and a survey. The study contributes to anticolonial research in that it resists narratives of dis(ease) put forth through neocolonial research paradigms. A key focus was the development of strategies that address the *aspirations* of urban Aboriginal youth, laying foundations upon which their potential in health and wellness can be nurtured, supported, and realized. The study contributes to a new narrative of the health of urban Aboriginal youth within a culturally centred and culturally safe framework that acknowledges their strong connection to their Indigenous lands, languages, and traditions while also recognizing the spaces between which they move.

Keywords: Aboriginal health, collaborative research methods, culture, gender, health promotion, youth health

Introduction

Our work together began with a story told by a Secwepemc Elder who assisted and guided our participatory action research project as a gate-keeper. *Melq'ilwiye* is a Secwepemc word that means "coming together." The research took place in the interior region of British Columbia through a community-university partnership between the Interior Indian Friendship Society and Thompson Rivers University, both of which are located on the traditional territories of the Secwepemc peoples in the city of Kamloops. The Interior Indian Friendship Society is part of a network of 119 Friendship Centres in Canada and is a member of the National Association of Friendship Centres (NAFC, n.d.). Friendship Centres are the primary providers of culturally enhanced programs and services to urban Aboriginal people. For over half a century they have been facilitating the transition of Aboriginal people from rural, remote,

and reserve life to an urban environment (NAFC, n.d.). For many Aboriginal people they are the first point of contact for referral to culturally and socio-economically based programs and services. The urban Aboriginal population is the fastest-growing segment of the Canadian Aboriginal population (54% in 2006) (NAFC, n.d.), yet in Kamloops there remains a temporal component to one's location and identification as "urban Aboriginal," varying according to the person's life history and story. Elders, Aboriginal youth, and community contributed to all phases of the research. Our research team comprised Elders, Indigenous youths, community partners, Indigenous faculty, and allies for this particular project.

The goal of this community-based exploratory study was twofold: to determine how urban Aboriginal youth in Kamloops identify their health needs within a culturally centred model of health and wellness, and to create new knowledge and research capacity by and with urban Aboriginal youth and urban Aboriginal health-care providers. A key focus was the development of strategies for addressing the *aspirations* of urban Aboriginal youth, laying the foundations upon which their health and wellness potential can be nurtured, supported, and realized. The project was aimed at addressing the need, identified by the NAFC, for more effective ways to promote health among urban Aboriginal youth. It was also aimed at addressing the recommendation of the Senate Standing Committee on Aboriginal Peoples (2003) with respect to promoting "urban First Nations health research initiatives that could provide valuable information on the needs, experiences and priorities of First Nations youth living in urban centers under a First Nations controlled design" (p. 3).

Context

Recent research offers a range of ways to view Aboriginal health, from studies that locate health narrowly such as the absence of disease (Devries, Free, Morison, & Saewyc, 2009; Kaufman et al., 2007; Perry & Hoffman, 2010); to more complex and holistic analyses of health, including social determinants (Mehrabadi et al., 2008); to collective health concepts that are Indigenous-centred; to health-system analyses (Anderson, Smylie, Anderson, Sinclair, & Crengle, 2006; Burack, Blidner, Flores, & Fitch, 2007; Ungar, 2008).

Institutional and systemic racism in Canada negatively impact health, with studies demonstrating the need for increased research in this area due to health determinants, the physiological health impact of racism, and inadequate access to or isolation from health care (Andersen et al., 2006; Ungar, 2008; Veenstra, 2009; Wexler, 2006). Poverty, racism, violence, and

assimilation pressures all contribute to the increased vulnerability of urban Aboriginal children and youth, as do the history of colonization and the subsequent colonialism that persists to this day (Justice Institute of British Columbia, 2002, 2006).[1]

Many studies have identified disproportionately severe health challenges for Aboriginal youth, such as higher rates of sexual and physical abuse; suicide as the leading cause of death, especially for Aboriginal males; higher rates of violence against Aboriginal compared to non–Aboriginal females; racism; and increased tobacco and marijuana use (BC Children's Commission, 1999; McCreary Centre Society, 2000; Saewye et al., 2008; Tonkin, Murphy, Lee, Saewye, & McCreary Centre Society, 2005). However, much of the research does not place the issues within colonization and ongoing colonialism, nor within a strengths-based and culturally centred understanding of youth health.

The literature that does exist in this area indicates that healthiness among Indigenous youth is promoted by aspects of cultural continuity such as cultural identity and pride, awareness of colonization and its influence on the present, ability to speak one's Indigenous language, and the sharing of a collective identity (Anderson et al., 2006; Chandler & Lalonde, 1998; Croll, Neumark-Sztainer, Story, & Ireland, 2002; Jacono & Jacono, 2008; Kaufman et al., 2007; Mehrabadi et al., 2008; Ungar, 2008; Wexler, 2006). Research linking positive health outcomes, including decreased suicide, for Aboriginal youth living in reserve communities where there are strong cultural components has been established (see Chandler & Lalonde 1998). However, the link between cultural continuity and urban Aboriginal health in smaller cities has not yet been examined. Indigenous youth are the fastest-growing youth population in Canada. In Kamloops more than half the Aboriginal population is under the age of 25 (compared to 30% of the non-Aboriginal population) (Statistics Canada, 2010), which points to the relevance of the present study.

The McCreary Centre Society's recent Adolescent Health Survey (Smith et al., 2009), a province-wide survey of over 29,000 high-school students, found that high levels of certain protective factors predicted less likelihood of engaging in risky behaviours. For example, youth who felt highly connected to their culture or ethnicity were less likely to engage in binge drinking, physical fighting, or weapon carrying. They were also less likely to report suicidal ideation and less likely to rate their health as poor, compared to those who scored low on cultural connectedness.

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[1] For a discussion of colonization, or the "invasion and eventual domination of North America by European Americans," and the subsequent, ongoing colonialism experienced by Indigenous communities, see Alfred (2009).

Cultural strength, identity, and pride, in particular, have been found to be protective of health among rural youth (Clark & Hunt, 2011; Smith, Leadbeater, & Clark, 2010). This type of health promotion includes developing a politicized identity, developing resistance, engaging in social action against discrimination, and building knowledge about the impact of colonization (Chandler & Lalonde, 1998; Croll et al., 2002; Ungar, 2008).

Many studies point to the need for specific health promotion strategies for youth that centre Indigenous culture and wisdom. They also indicate a need for culturally specific health strategies, such having Elders teach youth, involving family members, focusing on interdependence, and using culturally based Indigenous community research to develop health intervention and prevention strategies and culturally safe health services (Anderson et al., 2006; Chansonneuve, 2006; Clark & Hunt, 2011; Majumdar, Chambers, & Roberts, 2004; Steenbeek, 2004; Tuefel-Shone, Siyuja, Watahomigie, & Irwin, 2006).

Furthermore, the NAFC has identified the need for more effective ways to promote health among urban Aboriginal youth, while the Senate Standing Committee on Aboriginal Peoples (2003) has recommended promoting "urban First Nations health research initiatives that could provide valuable information on the needs, experiences and priorities of First Nations youth living in urban centers under a First Nations controlled design" (p. 3). One of the two youth peer researchers for the present project described it thus:

> *Being an urban Aboriginal youth, I could relate to how they would feel and how we could engage other urban Aboriginal youth. I thought it was a great idea to have youth representatives on the team. It was easier for us to explain the questions to the youth. It was easier for us to engage the other youth. I have sat on many youth councils related to health. I always wanted to be a youth advocate and put a youth view and ideas onto projects like this.*

The other youth peer researcher also described her experience:

> *Very educational! Being a part of the project helped me to grow many strengths through interviewing others, putting myself out there in the community, and learning to work and be accountable. It also helped with my self-confidence and it was really interesting to learn about different aspects of various youth. It also expanded my view on how we can help others through research and focus group conversations. Presenting the findings in Toronto at the conference made me feel proud and helped me to know that I am valued and that I can make a difference for my Aboriginal people.*

The study contributes to anticolonial research in that it resists the narratives of dis(ease) put forth through neocolonial research paradigms and instead considers past and current forms of colonization. "The rusty cage may be broken," writes Taiaiake Alfred (1999), "but a new chain has been strung around the indigenous neck" (p. xiii). Anticolonial scholarship can theorize about not only past forces of colonialism but current ones as well. Examples of neocolonialism can be found in the research and discourse about Indigenous youth that construct narratives of (dis)ease, are not based in the strengths and resistance of Indigenous cultures and peoples, and do not recognize the diversity of Indigenous youth. Many Indigenous scholars acknowledge that we need a theory for the multiplicity of Indigeneity that has emerged from colonization — Métis, full-blood, half-blood, community member (Ermine, Sinclair, & Jeffery, 2004; Grande, 2004, 2008; Simpson, 2003). Intersectionality is a concept and framework that developed out of the lives and resistance of African-American feminist activists (Combahee River Collective, 1977). The term was coined by the critical race scholar Kimberley Crenshaw (1989) to describe the oppression structurally produced and simultaneously experienced and resisted individually and collectively through and across diverse social categories of identity. To Indigenous peoples, however, intersectionality is not a new concept. Prior to colonization, many Indigenous communities had strong matrilineal traditions, multiple categories of gender, and holistic understandings of and approaches to health (Yee, 2009). There is increasing recognition that the concept of intersectionality "complements growing discussions about the complexity and multiplicities involved in being indigenous, in the category of indigeneity, and in indigenous people's health and well-being" (de Leeuw & Greenwood, 2011, p. 54). An intersectional lens facilitates recognition of the diversity of Indigenous youth and examination of the issues that impact youth, including dichotomous notions of urban/rural and male/female. Studies with Indigenous and "urban" youth frequently leave gender and other intersecting factors unexamined.

There has been an increased focus on Indigenous youth in large cities (MacKay 2005). However, there have been few studies that adopt an intersectional framework and acknowledge and incorporate multiple intersecting factors that address space, place, or location in a small city as impacting health, and fewer still that take a community-based participatory action approach (de Finney, 2010; Downe, 2006). In the report *Growing Up in BC,* the Representative for Children and Youth, British Columbia (2010), recognizes that children and youth in the interior and northern regions of the province face significant health disadvantages. According to the report, the adoption of "a lens that recognizes that multiple forms of discrimination occur simultaneously would identify and

shed light on differences in health outcomes, pathways, and access to services related to the intersecting factors that have long-term health consequences for individuals and populations" (p. 25).

The present study was conducted by an intersectional research team comprising a diverse group of Aboriginal youth and Elders, Indigenous community practitioners through the Interior Indian Friendship Society, Aboriginal health through Interior Health, and Indigenous and non-Indigenous university researchers. Intersectional research teams choose to create a research space that asks about everyone's agenda in doing the work and uses all of the different knowledges in the room (Aluli-Myer, 2008; Clark, Hunt, Good, & Jules, 2010). Through this process, (dis)ease-focused research questions are resisted in favour of culturally relevant and culturally appropriate questions.

Four research questions were developed by the research team as a group: (1) *Which cultural components are linked to the health needs of urban Aboriginal youth? (2) Will the identified Aboriginal cultural components differ by gender, ability to speak one's Aboriginal language, sexual orientation, and type of school attended (high school, alternative school, university)? (3) What are the cultural safety priorities identified by urban Aboriginal youth in meeting their health and wellness needs? (4) What supports do Aboriginal students and the Aboriginal community need to facilitate their health needs (mentors, Elders, access to Aboriginal faculty, learning resources, interventions)?*

Methods

This exploratory study was guided by an Indigenous research paradigm, which centralizes relationships and accountability to these relationships (Aluli-Myer, 2008; Kovach, 2009; Wilson, 2008). It was also guided by the concept of looking in one direction and having "a good heart" (Wilson, 2008, p. 60). Further, building on the knowledge and wisdom of the youth and Elders who were involved in the project and who shared the importance of us "all looking the same way," the study placed urban Aboriginal youth in a central role as peer researchers and collaborators.

This project observed culturally determined ethics and guiding principles (Alderman, Balla, Blackstock, & Khanna, 2006; Tuhiwai Smith, 2001) and used a checklist developed by the authors and a colleague that reflects a number of ethical guidelines, including human rights, the four R's (Kirkness & Barnhardt, 1991), OCAP principles (Schnarch, 2004), and ethics as determined by the Indigenous community (Justice Institute of British Columbia, 2002, 2006). According to Clark et al. (2010), "Researchers who are connected to the community are therefore accountable to the community for the ethics, practice and outcomes/action of the research. The findings are more than data, but are stories and

actions in relationship with people and Communities" (p. 250). Ethics approval was obtained from the community and the university and Tri-Council Research Ethics Guidelines were followed. Finally, consistent with Aboriginal knowledge translation (Estey, Smylie, & Macaulay, 2009), the findings were presented by the youth peer researchers at an Indigenous youth health conference organized in Kamloops by the research team and attended by more than 200 Indigenous youth from rural and urban communities. In addition, the findings were presented in 2011 by the youth researchers, together with members of the team, in Toronto at the first national conference on urban Indigenous health, Fostering Biimaadiziwin [Fostering the Good Life].

The theoretical and applied framework guiding this project built on the work of Irihapeti Ramsden, a Maori nurse, and the work of Dianne Wepa (2003, 2005), a Maori social worker, who, together with Maori national organizations, developed the concept of cultural safety. Cultural safety focuses on power relationships between the colonizer and the colonized and is linked to Aboriginal self-determination (Chansonneuve, 2006). The emphasis is on the experience of the service user or client in defining the experience as culturally safe, thus shifting power relationships. Additionally, the research team focused on culturally safe research within an intersectional research team and grounded in Indigenous methodology and Indigenous ethical protocols.

Ermine et al. (2004), in their review of research with Indigenous people, identify participatory action research as one of the best methods for addressing the complexity of the issues currently facing Indigenous communities: "The participatory action research approach to community issues is a culturally relevant and empowering method for Indigenous people in Canada and worldwide as it critiques the ongoing impact of colonization, neocolonialism and the forces of marginalization" (p. 9). This view is echoed by other Indigenous scholars, such as Eve Tuck (2007), who writes of the "radical possibilities of PAR spaces as spaces in which sovereignty can be recognized, practiced, theorized, and cultivated" (p. 163). Furthermore, community-based participatory action research invites youth to "critically investigate the social policies that construct and constrict their lives, interrogating policies that ravage their communities and threaten their imaginations" (Torre, Fine, Alexandra, & Genao, 2007, p. 238).

The present community-based participatory action research study was carried out in Kamloops, British Columbia. It was conducted within an Indigenous research paradigm using mixed methods, including four talking circles with approximately 40 participants and 78 surveys completed by urban Aboriginal youth (60% female, 40% male) aged 12 to 25. The data were collected in 2008–09 and further analyzed in 2010. Three

educational sites were used: an alternative Aboriginal high-school program, a number of mainstream high schools, and a university campus.

All survey and talking circle questions were developed in consultation with the project's advisory board, including community partners, Elders, and Aboriginal youth. The original items for the survey and the talking circle were piloted, revised, and then reviewed again by the research team. The survey items were then divided into questions that could be answered on a Likert scale and items that required further explanation. Consistent with an Aboriginal worldview, survey and talking circle items included questions from the physical, cognitive, emotional, and spiritual domains. Four talking circles were conducted, two male and two female. Two Aboriginal youth researchers were trained to collect the data and were part of developing the survey. The talking circles were audiorecorded and the recordings were transcribed into MS Word. The transcripts were shared and read by the research team using a grounded research approach that facilitated the identification of key themes and issues. The findings were analyzed by and with community partners, Elders, and Aboriginal youth to ensure meaning and understanding. A training session on research methods was conducted with Aboriginal youth members of the research team and mentoring was ongoing. The survey was administered by urban Aboriginal youth members of the team at an alternative Aboriginal high-school program, a number of mainstream high schools, and a university campus. The survey results and the transcripts from the talking circles were examined together. The meaning of the quantitative results was better understood by considering the complementary nature of the two data sets.

Often, resource-allocation decisions are based on "hard facts" and the "bottom line," while much of the evidence surrounding the experiences of Aboriginal communities is qualitative in nature. As observed in a study commissioned by the Cariboo Tribal Council,

> personal experiences are not somehow more "truthful" when there are numbers attached to them, nor is research likely to uncover information that could not be obtained from comprehensive personal narratives. However, when research supplements such information sources, those experiences or narratives cannot be dismissed as "merely stories." (Chrisjohn & Young, 1994)

Findings

The Aboriginal youth reported connections across a wide range of factors related to their health needs, including identity, culture, knowledge about and resistance to colonialism, and recommendations for culturally safe health care. The findings are organized under four headings:

Indigenous Identity and Resistance, Cultural Connectedness, Colonialism and Structural Racism, and *Culturally Safe Health Care.* Our results are consistent with those of the limited research that has been conducted to date reporting that young speakers of Aboriginal languages cite culture-based spirituality and traditional Indigenous healing methods as important for their health (First Nations Centre, 2005; MacKay, 2005).

Indigenous Identity and Resistance

The overwhelming majority (96%) of Aboriginal youth reported that they were proud of their ancestry. Participants in the talking circles referred to their diversity as Indigenous youth, describing themselves as "short," "tough," "tall," "brown," "nice," "outgoing," "pretty," "non-judgemental," "random," "honest," "athletic," "not racist," "joyful," "happy," "not a Christian," "two-spirited," "Christian," "singer," "dancer," "fun," "pothead," "jud," "someone that drinks all the time," "stud magnet," "another Native," "another Chilcotin," "baller," "I introduce myself with my full name," "awesome," "wonderful," "courageous," "curious," "creative," and "mean." They also expressed strong resistance to the labelling of Indigenous youth:

> *Putting signs on an office saying Mental Health Counsellor . . . is not where we want to be seen going, because we don't want to be labelled, we do not want to go to certain labelled services [mental health]. But school counsellors' office, FNEW [First Nations Education Workers] office, hospital, clinic — they're not embarrassing offices to access, Friendship Centres.*

Another youth echoed this view, stating that we should "stop young people from going to counselling because it labels us."

In addition to challenging mainstream notions of Indigenous youth identity, participants challenged dichotomous notions of urban/rural in terms of Indigenous youth. A number of youth were currently urban but had moved on and off reserve throughout their lives. Both of the peer researchers identified as urban currently and helped the research team to understand the movement of many of the participants on and off reserve. Few participants identified as uniquely urban and many described living in multiple localities and moving back and forth to see family, access supports, or take part in ceremonies. For many participants, distance from Elders was an issue:

> *I only see my grandma . . . once a month, when she comes to town, but it's important for my health.*

> *I don't see my grandma much, but when I do it makes me happy.*

> *My grandma lives in [another city], so distance is an issue.*

Table 1   *Responses for Select Survey Items*

	Strongly Disagree %	Disagree %	Undecided %	Agree %	Strongly Agree %
I am proud of my Aboriginal ancestry	0	0	4	24	72
I can speak my Aboriginal language	19	30	19	27	5
Racism has negatively impacted my health	8	27	42	17	6
I would like my Aboriginal culture reflected in health services I use	17	44	14	19	6
I use the Internet to get information on my health	14	22	15	39	10

Comprehending and challenging dichotomous categories of who is urban result in a more nuanced understanding of the resources available and barriers to "urban" Aboriginal health.

Cultural Connectedness

In a separate question, 42% of participants indicated that their culture-based spirituality was the foremost influence in their health and how they lived their lives. In our search for links between health and Aboriginal culture, we asked participants if they could speak their Aboriginal language. Although we did not assess language competency, 32% reported that they could speak their Aboriginal language. Further analysis found that youth who could speak their language participated more in traditional Aboriginal ceremonies. Most of the Aboriginal-language speakers (16/25, or 64%) reported significantly more participation in Aboriginal ceremonies for health, compared to non-speakers (17/53; 32%): $F(1,76) = 5.16$, $p = .026$.

Participants were also asked if they had used traditional Aboriginal healing approaches. Surprisingly, 48% indicated that they had done so and 52% reported that Aboriginal ceremonies were important for their health. This raises questions about what healing approaches they were accessing, and where, and whether these should be made more widely available to youth. One participant contrasted Western medicine with Indigenous healing approaches:

> *I want to learn how to make Indian medicine, because one time I was heating up and I felt like I was cold to being really hot. I had to go to the hospital for a day, but I felt better after taking the Indian medicine.*

Another spoke of the importance of sweats:

> *I wish more sweats were accessible. I haven't been in one since I was little, but I found it helpful. I felt better physically, emotionally, mentally, and spiritually.*

To the participants, access to and connection to Elders was important for their health. In the talking circles Elders were described as "comforting":

> *They are just like parents, but they are your grandparents . . . sometimes I can connect better with them because they're not as strict as my parents.*

> *I have a great relationship with my grandparents. I see them . . . every weekend. Meals together are important. They are hilarious.*

Relationships with Elders were central to the health of the youth. Participants identified a range of things they would want to learn from an Elder:

> *I would want to know how to get an Indian name, how culture started, tradition, history, to speak my traditional language, and cooking.*

Colonialism and Structural Racism

Participants indicated that they understood the impact of colonization and ongoing colonialism. Although 82% indicated *(agree or strongly agree)* that they understood how residential schools affect Aboriginal people, this included significantly more females (45/47; 91%) than males (21/31; 68%): $F(1,76) = 6.98, p = .010$.

We were interested in whether the youth experienced instances of racism and if this affected their health. Of the participants, 23% reported that racism had negatively impacted their health. The talking circles provided rich examples of racism, and the impact was multi-generational:

> *I was at [a restaurant] with some friends and an Elder and we were so angry because they put us in a corner. The server was ignoring us because we were Native, and when I finally asked him if we were going to get some service, he directed a female server to serve us but he was serving other white people. Later, during our meal, there was a hockey team being really loud and they asked our table to be quiet but they didn't say anything to the hockey team. The Elder that was with us got so mad too and she cried.*

> *We were in [a supermarket] gas bar and the guy said, "You should get those Native people to do the rain dance," and it was totally sunny out.*

Youth also identified the impact of the intersection of race with gender and gender identity: "People won't hire because of race and sexual orientation." Gender differences were noted with respect to speaking up about racism, with 68% of males indicating that they spoke up, compared to 36% of females: $F(1,76) = 6.10$, $p = .010$. One male participant said,

> *I get discriminated [against] all the time, but I just speak up and say, "Is it because I'm brown that you're staring at me?"*

Culturally Safe Health Care

One quarter of participants stated that they encountered difficulty accessing health care. Health-care centres such as the Interior Indian Friendship Society health centre were identified in the focus groups as important. Furthermore, youth did not believe that having an Aboriginal health-care provider was important. They believed that all health-care providers should have the skills needed to work with Aboriginal youth:

> *Non-Aboriginal health-care providers should be skilled to work with Aboriginal youth. All health providers should be skilled to work with FN youth. [I should not be] pawned off to an Aboriginal worker because white people don't know how to deal with me.*

> *I go to anyone that will acknowledge my culture, grandparents, Elders.*

Further analysis found that having Aboriginal health-care providers was more important to females than to males: ($F(1,75) = 6.54$, $p = .013$).

Approximately 49% of participants used the Internet to find health information. This raises the importance of making health information available online and presenting it in ways that are youth-friendly.

Discussion

Key findings of this study include the importance to youth of a strong Indigenous identity, cultural connectedness, and awareness of and resistance to colonization, colonialism, and structural racism. Consistent with the literature, the findings have implications for culturally centred and culturally safe health care that involves Elders, families, communities, and traditional healing methods (Anderson et al., 2006; Long et al., 2006; Majumdar et al., 2004; Skye, 2002; Steenbeek, 2004; Tuefel-Shone et al., 2006).

The findings support the call by Secwepemc Elders and recent work by Secwepemc scholars for a return to cultural teachings and language

(Billy, 2009; Manuel & Posluns, 1974). As described by the international Indigenous rights activist and Secwepemc chief George Manuel, co-author of the 1974 book *The Fourth World,* "residential schools were the laboratory and production line of the colonial system" (quoted in Billy, 2009, p. 63). Manuel's father, a traditional medicine man, came to believe that learning about the culture and speaking the language were a detri-ment to his son: "Things are going to be different from here on in. I don't think it is wise for me to teach you to go into the mountains. I think it will be a detriment rather than an asset for you" (p. 68). Manuel's father told him to be "white," but then later, on his deathbed, said, "My son, I made a mistake. You raise your children and your grand-children as Indians" (p. 68). In her doctoral dissertation, Janice Billy, a Secwepemc woman, interviews Secwepemc Elders, who not only lament the devastation of colonization but point to language and culture as the way forward; Irene Billy, an Elder, describes attending Kamloops residen-tial school for 9 years, from 8 to 17 years of age, and now, at age 82, "as grandmother and great grandmother I can pass on my language but not much of our culture. I am learning about our medicines and other things I didn't learn when I was young" (Billy, 2009, p. 90).

The participants in our study expressed pride in their Aboriginal identity, a keen interest in learning their traditions, and the importance of traditional medicines for their own health. One of the few Aboriginal youth health surveys conducted in Canada, designed specifically to examine health-information issues, reports that youth are interested in learning about and using traditional medicines (First Nations Centre, 2005). Furthermore, previous research with urban Aboriginal youth (Belanger, Barron, & McKay-Turnbull, 2003) found that cultural identity is formed through a wide circle of activities, including access to Elders, language, First Nations education, community health spaces such as Friendship Centres, and the Internet. Tradition is inclusive of modern technology. In our study, 49% of youth accessed the Internet for health information. The research team has since considered how the Internet might be used for health promotion purposes, such as reviewing existing Web sites, suggesting changes to these sites, and finding ways to integrate culture into technology. Further research on health promotion and inter-vention by and with urban Aboriginal youth is an area to be investigated.

Youth were also aware of the structural factors impacting their health, in particular colonization and ongoing racism. However, gender differ-ences were noted on this question, with females giving a higher rating to their knowledge of residential schools. In contrast, males were more likely to speak up when encountering racism. Furthermore, speakers of an Aboriginal language rated their health higher than those who did not

speak an Aboriginal language and also indicated that their culture-based spirituality was the most important factor in how they lived their lives.

This research is a first step in identifying what Alfred (1999) describes as a need for "self-conscious traditionalism" — not a return to the past but concern about survival in the future (p. 166). The study not only sheds light on the experiences of urban Aboriginal youth who long to sustain and build on their tribal roots, but also theorizes about mixed, urban, status, and non-status (Alfred, 1999, p. 173). As Bonita Lawrence (2003) reminds us, "for Native people, individual identity is always being negotiated in *relation to* collective identity, and *in the face of* an external, colonizing society" (p. 4). The present study begins to tell the story of Aboriginal youth health within an intersectional and culturally centred and culturally safe framework. This framework consists of strong connections to one's Indigenous lands, languages, and traditions while also recognizing the spaces one moves between and around in navigating the process of growing up. MacKay (2005), in a study with urban Indigenous youth in Saskatoon, draws on the work of Norris and Jantzen (2003), who report that urban-rural mobility "is motivated by people moving to maintain family and cultural relationships" (p. 111). MacKay notes that ideas of identity and belonging are not contained within the boundaries of cities or reserves. One of the youth researchers in the present study described her own experience:

> *What health means to me is being physically and mentally healthy, to have balance in your life by staying in touch with your culture and family. When I moved from a . . . town to a city, I found it hard to find health services. I do still go back to my small town to get my health needs met, because that is all I know. So I do find it hard to find some services. I have moved out of my home for a few years now and I do feel a loss of home and family. I would have to make time to see them.*

While clearly appreciating the advantages of her new urban environment, this youth describes the challenges of leaving her reserve and her need to stay connected to family and culture. Furthermore, in our team's analysis of the data, she helped make meaning of the movement of the participants in the study. For the youth researcher and her friends, a move back to the reserve often coincided with a need to seek extra support or with a life transition.

These findings contribute to an anticolonial scholarship that resists narratives of disease. They provide new, more nuanced and complex stories about urban Aboriginal youth. Future research could examine the complexity of how racism impacts the health of urban Aboriginal youth and how the gender differences, gender-identity, and sexuality noted in the present study also impact health. For example, male participants were

found to be more likely to speak up about racism. The impact of speaking up for males and of silence for females requires further exploration. The trauma literature offers some analysis in this regard; for example, males are more likely to externalize and females to internalize trauma symptoms. Does speaking up lead to further criminalization for male Aborginal youth? Does silence on issues of racism contribute to higher rates of mental health difficulties for Aboriginal females? The Indigenous researcher Jo-Anne Fiske (1996) reminds us that in research we need to present multiple realities, in contrast to the construction of "narratives of oppression" that prevent contrary and contradictory stories from being heard (p. 665). By creating innocent victims, we "inscribe them in terms not of their own choosing" (p. 666). Fiske argues that the narratives previously constructed by the colonizer must be "subverted, their subject reclaimed" (p. 666).

However, there are ways in which this research also extends colonial narratives. Of the participants in our study, seven self-identified as two-spirit, one as gay, and one as bisexual. Similar to the challenges of determining who is "urban" Aboriginal, binary analyses of gender preclude an understanding of the spiritual role encompassed within a two-spirit identity. Intersectionality scholarship calls on us to move beyond the binary constructs of gender found in the categories of male and female. Qwo-Li Driskell (2011), a Cherokee two-spirit academic, reminds us that gender itself is a colonial construct. Driskell points out that prior to colonization some communities had up to 12 genders and that colonization has altered our memory of gender. Colonialism and patriarchy need a gender binary system, as colonial domination is impossible without binary constructs. Driskell notes that, while re-learning Cherokee, s/he has been reminded that Indigenous languages were always multifaceted and multidimensional, as suggested in references to two-spirit people as having "a different heart" or having "two hearts." According to Driskell, "unless two spirit people are listened to we won't achieve" decolonization. We need research that listens to the unique experiences of two-spirit Indigenous youth and Elders, given the key role accorded to Elders by the Indigenous youth in our study with respect to their health.

Conclusions

Urban Aboriginal youth are living histories born of "a context of concrete social, political, and historical struggles and success" (Downe, 2006, p. 14). Although their identities and health needs are framed within ongoing experiences of colonization, residential schooling, and removal by child-welfare authorities, they are inheritors of rich narratives and histories of resistance and strength. Health programming based on Western

value systems only serves to further colonize the bodies and identities of Aboriginal youth. The health of urban Aboriginal youth must be addressed in models that are based on Indigenous traditions and belief systems and local knowledge and that corporate spiritual, emotional, mental, and physical health. Let us not promote any one model with a fixed concept of Indigineity, gender role, sexuality, or other aspects of identity. Programs that can respond to the unique needs and experiences of urban Aboriginal youth will be able to more meaningfully foster resilience and community connectedness. According to the Indigenous youth activist Jessica Yee (2009), resistance lies in finding "practical ways to translate all of this into modern terms for our young people to use so they can recover what past generations may have lost, and re-assert themselves as the resilient, fierce, and knowledgeable young people who were once upon a time, the most sacred in many of our cultures" (pp. 3–4).

Our exploratory study raises important considerations for health design and delivery. Both participants and peer researchers recommended special training for all those working with First Nations youth, including the design of health centres and the creation of a Web site providing Aboriginal youth with information on traditional medicines and healing approaches.

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Acknowledgements

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