

Digital Storytelling as an Indigenous Women's Health Advocacy Tool: Empowering Indigenous  
Women to Frame Their Health Stories

Shelley Wiart

## **Preface**

This research paper is original, unpublished, independent work by the author, Shelley Wiart. The research outlined in this paper is covered by Ethics File number 23355, issued by the Athabasca University Research Ethics Board (AUREB) for the project “Digital Storytelling as an Indigenous Women’s Health Advocacy Tool: Empowering Indigenous Women to Frame Their Health Stories” on March 26, 2019. This research also received a Northwest Territories Scientific Research License number 16553, issued by the Aurora Research Institute on May 29, 2019.

## **Positioning**

Before I begin sharing my findings about Indigenous women’s digital health stories and how this decolonized research contributes to reconciliation in health care, I first need to position myself in this pursuit. As an Indigenous researcher, my positioning honours the “Indigenous ideological understanding of the world predicated on relationality and agency” (Martin, 2017). I accept the responsibility to respectfully locate myself within this research process and in relation to the communities and women that I worked with co-creating digital stories. I am Métis and a board member of the North Slave Métis Alliance, Yellowknife, Northwest Territories (NT). I have long-term community relationships and ties to both Treaty Six (Lloydminster, on the border of Alberta and Saskatchewan) and Treaty Eight (Yellowknife, Northwest Territories) through my health promotions program, Women Warriors and as a member of the North Slave Métis Alliance.

## Table of Contents

1. Background.....	4
1.1. Lloydminster and Onion Lake Cree Nation, Alberta/Saskatchewan Demographics....	5
1.2. Yellowknife, Northwest Territories Demographic.....	6
2. The Methodology of Indigenous Digital Storytelling .....	7
2.1. Insights on the Methodology of Indigenous Digital Storytelling in Health Research.....	10
3. Indigenous Models of Determinants of Health – Proximal, Intermediate & Distal.....	16
3.1. The Legacy of Residential School & Indigenous Women’s Health.....	17
3.2. Traditional Knowledge & Healing Practices.....	25
4. Knowledge Translation Events.....	28
5. Results & Conclusion.....	29
References.....	42
Appendices	
A. Fragmented by Maxine Transcript .....	47
B. Broken Trust by Beatrice Transcript.....	50
C. Secrets Revealed by Sheryl Transcript.....	52
D. Living Our History by Dorothy Transcript .....	54
E. Tuq&urasiit by Tanya Transcript .....	56
F. The Methodology of Digital Storytelling in Health Research by Shelley Transcript..	58
G. Stanton Territorial Hospital Health Care Provider Evaluation.....	63
H. General Internal Medicine Retreat Questionnaire.....	64

## 1. Background

Indigenous women's health stories are complex due to their intersecting identities of race and gender, their experiences of colonialism, and social determinants of health. All of these factors can make it challenging for them to access culturally appropriate healthcare.

Historically, through colonial policies like the Indian Act and the imposition of patriarchy on matriarchal societies, Indigenous women have been and continue to be marginalized by mainstream society (Dodgson & Struthers, 2005). A consequence of this marginalization is health disparities between Indigenous and non-Indigenous women. Indigenous women experience the highest rates of chronic illnesses such as diabetes and heart disease, and have lower life expectancy, elevated morbidity rates, and elevated suicide rates in comparison to non-Aboriginal women (Bourassa, et al. 2004). Indigenous women past the age of 55 are more likely to report fair or poor health compared to non-Indigenous women in the same age group (Bourassa, et al. 2004). Furthermore, social determinants of health for Indigenous peoples reflect major disparities in relation to non-Indigenous Canadians including “higher levels of substandard and crowded housing conditions, poverty, and unemployment, together with lower levels of education and access to quality health-care services” (Greenwood, et al., 2018).

In order to close the gaps in health outcomes between Indigenous and non-Indigenous communities in Canada, it is critical that Indigenous people's voices are central to the process of reconciliation in healthcare<sup>1</sup>. Reconciliation in healthcare aims to close the gaps in health outcomes that exist between Indigenous and non-Indigenous communities, and support Indigenous peoples as they heal from colonization, the legacy of residential school, and the

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<sup>1</sup> Reconciliation in health is recognized in two documents that serve as a framework for reconciliation across Canada and internationally: The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) Article 24, and The Truth and Reconciliation Commission of Canada's Calls to Action (2015) #18-24.

ongoing systemic racism embedded in our institutions. Indigenous women's knowledge is integral to sustaining traditional knowledge systems, and healing practices, and decolonizing knowledge production (Kermoal & Altamirano-Jimenez, 2016).

### **1.1 Lloydminster Demographics**

The City of Lloydminster consists of approximately 20,000 residents with less than 10% identifying as First Nations, Métis, and Inuit descent (Statistics Canada, Lloydminster, 2016). Lloydminster is located on the border of Alberta and Saskatchewan – Canada's only border city - with the hospital located on the Saskatchewan side and the responsibility of the Saskatchewan Health Authority ([www.saskhealthauthority.ca](http://www.saskhealthauthority.ca)). The dual healthcare system being provided by Alberta Health Services and the Saskatchewan Health Authority complicates the delivery and access to healthcare services. I could not find any Lloydminster area reports or initiatives online regarding cultural safety or reconciliation in healthcare on behalf of Saskatchewan Health Authority.

Onion Lake Cree Nation, consisting of approximately 6,400 Plains Cree members with 4,000 living on reserve, is located approximately fifty kilometers north of the City of Lloydminster. It was the site of two residential schools, St. Barnabas Indian Residential School (1892-1943) and St. Anthony's Indian residential school (1894-1974). It currently has its own healthcare services including a full staff of health care professionals such as medical doctors, nurse practitioners, a diabetes educator, a certified dietician, laboratory technicians, pharmacists and a full range of services delivered at the Onion Lake Health Centre that includes medical, dental, and pharmacy. The costs associated with Treaty health care are the responsibility of the Government of Canada, under the control of First Nations and Inuit Health Benefits, therefore, the Onion Lake Cree Nation health system is separate from the Saskatchewan Health Authority.

## 1.2 Yellowknife Demographics

Indigenous peoples make up 50% of the population of the Northwest Territories (GNWT, 2018). The City of Yellowknife consists of approximately 20,000 residents with over 20% of the population identifying as First Nations, Métis or Inuit descent (Statistics Canada, Yellowknife, 2016). They experience a higher burden of some chronic illnesses and a wider gap in health disparities in comparison to other residents (GNWT, 2018). Health care providers often fail to create an environment of cultural safety, defined as an outcome where Indigenous peoples feel respected and safe from racism and discrimination when they interact with the health care system (GNWT, 2018). Moreover, health care providers may not understand the holistic health needs necessary to support Indigenous peoples, and the systemic racism within the health-care system continues to contribute to health inequity and reinforces disparities (GNWT, 2018).

In Western culture, good health is understood as the absence of illness with action only taken when illness is present, whereas Indigenous peoples' believe that poor health is a result of "disconnections, imbalances and disharmony" with healing defined as "something that is practiced daily throughout our lives" with the aim of "developing centeredness" (Hart, 2000, p.95). In order for health care providers to have respectful relationships with Indigenous peoples, they must honour the diversity between each cultural group and have an appreciation of the depth of First Nations, Metis, and Inuit concepts of "good health."

In this paper I examine how the use of Indigenous digital storytelling (DST) within the framework of Indigenous research methodology, allows Indigenous women to share their health stories in a safe and respectful context. This decolonizing methodology allows for self-representation that challenges stereotypes and allows Indigenous communities to prioritize their

own social and community needs and protect their identities and cultural values in the process (Iseke & Moore, 2011). Furthermore, it is essential to the decolonization process that “Indigenous people speak with our own voices about our histories, culture, and experiences as we continue to resist the onslaught of colonial structures, policies and practices” (Regan, 2010). The digital stories that I discuss below allow for participant and viewer reflection on Indigenous women’s health, advance the understanding of holistic health, and promote Indigenous women’s views on reconciliation in healthcare.

## **2. The Methodology of Indigenous Digital Storytelling in Health Research**

Storytelling – a form of knowledge exchange – plays a vital role in Indigenous communities (Wilson, 2008; Smith, 1999; Kovach, 2009; Regan, 2010). Indigenous digital storytelling incorporates the cultural tradition of oral storytelling and is considered a way of “decolonizing research” (Smith, 2005) because it attempts to destabilize power dynamics and colonization by taking its cue from Indigenous scholars practicing methodologies such as “narrative research” (Hendry as cited in Cunsolo-Wilcox et. al, 2012, p. 129). Indigenous digital storytelling (DST) is respectful to culture and community because it is a “culturally appropriate way of representing the ‘diversities of truth’ within which the story teller rather than researcher retains control” (Bishop as cited in Smith, 2008, p. 146). It allows for communities to control their own narratives, and histories, and helps to build multigenerational relationships in Indigenous communities (Iseke & Moore, 2011, p. 34). One drawback of Indigenous DST is that it does not follow the traditional model of Indigenous storytelling, which is an interactive exchange between the listener and the teller. The digital stories are often a generic version of the story because it is not interactive, thereby losing some of its cultural significance built in by the Elders knowledge of the audience, their pauses for impact, and their inability to provide the

proper context for every story due to time constraints (Iseke & Moore, 2011, pp. 23-26). The advantage of Indigenous DST in research lies in its ability for storyteller and listener to open up, learn, and reflect (Cunsolo-Wilcox et. al, 2012). It is less about data collection and more about research as a “site of communion that occurs when sharing and bearing witness to stories (Hendry as cited in Cunsolo-Wilcox, 2012, p. 142).

Similar to my own research, *Digital Storytelling as an Indigenous Women’s Health Advocacy Tool: Empowering Indigenous Women to Frame Their Health Stories*, both Iseke & Moore (2011) and Wiebe (2019) state that community relationships are central to their research, more so than the development of the digital stories. I appreciate that having community relationships before starting the project established trust, which allowed the participants to be more comfortable sharing their personal health stories. Furthermore, mentorship and reciprocity were important features of my project, which included myself mentoring the participants to do media interviews, and being holistic in my approach of connecting land, language, culture, and community as factors that affect Indigenous women’s health. In addition, the act of making these stories may serve as a healing project for the participants and their community as stated by Kirmayer & Valaskakis: (2009) “...traditional healing is also healing through tradition. The recovery of tradition itself may be healing, both at individual and collective levels. Retrieving and transmuting the knowledge associated with healing practices reaffirms core cultural values and maintains the historical continuity of Aboriginal cultures” (p. 22).

An important lesson in Cunsolo-Wilcox et. al.’s (2012) research in the Inuit community of Rigolet was understanding that participants may expose their personal trauma to the facilitators and that the facilitators need to be trained to deal with heavy issues. This article, along with Hancox (2012) both stressed the importance of allowing participants to share their

trauma stories and “remembering” as a form of healing and therapy, which I believe my participants also experienced by sharing their stories with me and at the community event in Yellowknife, NT. Hancox (2012) shared the difficulty of conducting typical DST workshops with vulnerable populations, which reflected my experiences working with residential school survivors. My participants also did not have a lot of photos to work with, especially one participant who was placed in foster care from ages 4-19 years of age. An important skill for digital storytelling facilitators is learning how to edit a story with few personal photos, or being creative with sound and images so it can create materiality out of memories (Hancox, 2012, p. 69). As an Indigenous digital storytelling facilitator I attempted to use Juppi’s concept of “digital empowerment” with my participants by teaching them how to use the software, iMovie and getting them to record their narration on a professional audio microphone. It is my opinion that they also experienced “psychological empowerment” through deep self-reflection in our one-on-one digital storytelling workshop by sorting through old photographs and sharing childhood stories about intergenerational trauma and how colonization and residential school have continued to affect their holistic health.

Finally, I would state that my integrated knowledge translation plan – to share our stories with medical professionals – closely aligns with Wiebe’s (2019) focus on using mixed media to influence decision makers and social policy through “sensing policy” (p.30). The “sensing policy approach” states that policy makers must include “those most directly affected by issues arising in the determination of recommendations and policy” (Wiebe, 2019, p. 30). This aligns with my belief that Indigenous community members are “situated bodies of knowledge” that are experts in their owned lived experiences and have the solutions to their issues (Wiebe, 2019, p. 30). My co-creators were capable of advocating for their own health service needs because of their lived

experience as users of our public healthcare system, and allowing them to speak truth to power – the healthcare professionals in charge of policy – is the best way to affect change within that system.

### **2.1. Insights on the Methodology of Indigenous Digital Storytelling in Health Research (see Appendix F).**

From May to June 2019 I co-created two digital health stories with Indigenous women from the Women Warriors<sup>2</sup> programs in Lloydminster and Onion Lake Cree Nation (OLCN), on the border of Alberta and Saskatchewan. I relocated to Yellowknife for the months of July and August and co-created three digital stories with Indigenous women there. I conceived of this project as community based participatory action research carried out through the lens of Indigenous feminism, which center the participant as the person most knowledgeable about their own experiences (Green, 2017). The objectives of these health stories was to allow Indigenous women to share, with a medical audience<sup>3</sup>, their traditional knowledge and Indigenous healing practices, and to help them conceptualize and communicate about their own health stories and service needs. It also served to educate non-Indigenous peoples about traditional healing practices for different Indigenous groups bridging the gap between biomedical western medicine and traditional healing.

The Four R's of research — Respect, Relevance, Reciprocity, and Responsibility - guided my research process (Kirkness & Barnhardt as cited in Strega & Brown, 2015, p. 58). I call my research participants, co-creators and they have been involved in every step of this

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<sup>2</sup> Women Warriors is an Indigenous focused holistic health program aimed at improving Indigenous women's health outcomes. Shelley co-founded the program in 2015 in Lloydminster and it expanded to Onion Lake Cree Nation, on the border of Alberta and Saskatchewan and the City of Calgary in 2018-2019.

<sup>3</sup> The Alberta Indigenous Mentorship in Health Innovation (AIM-HI) network sponsored the Alberta portion of this research. This network is associated with the University of Calgary's Cumming School of Medicine and as part of Shelley's research dissemination she will present these stories to medical residents.

project including planning, creation, and knowledge translation, which are the central tenants of community based participatory action (CBPA) research. Before I started this research I prepared myself by examining my heart and asking myself if I was ready for the responsibility of a long-term commitment to my co-creators. The novel, *Sacred Instructions* by Sherri Mitchell (2018) states that being a creator comes with responsibility:

When we engage creation, we must be willing to be responsible for everything we create, knowing that the world is interconnected and that every thought, breath, and action influences the whole. This requires us to choose our creations consciously. When we ask for extreme wealth for ourselves, we may deprive another. When we ask for material items, we must be willing to bear the cost that is associated with them being made. This means we must ask ourselves – has life been harmed or served by my manifestations? (p. 141)

Furthermore, Indigenous academic, Wilson (2008) states that checking your intentions for the research and how they may impact the community is also essential to the research process:

The source of a research project is the heart and mind of the researcher, and “checking your heart” is a critical element in the research process. The researcher insures that there are no negative or selfish motives for doing the research, because that could bring suffering upon everyone in the community. A ‘good heart’ guarantees a good motive, and good motives benefit everyone involved. (p. 60)

My role in the process of creating these digital stories was to hold space for my co-creators.

Holding space means opening your heart and listening with compassion, and non-judgment. It meant offering silent strength to them during their outpouring of pain, grief, and trauma and not trying to fix them. I held the following quote in my heart during the process: “People start to heal the moment they feel heard” (Cheryl Richardson quote, Instagram, 2019).

This research took a physical, mental, spiritual and emotional toll on me. I had to refuel by running outside, pouring my grief out onto the land and the Great Slave Lake, and praying for guidance and strength. I felt a deep sense of responsibility as an Indigenous community member conducting health research on my traditional territory, which I believe is much different than for

a non-Indigenous researcher (Wilson, 2008; Smith, 1999; Kovach, 2009). I was responsible to my co-creators, to my community and to my family and ancestors (Wilson, 2008; Smith, 1999; Kovach, 2009).

The guidelines that I used to create these stories, based on the book, *Digital Storytelling: Capturing Lives, Creating Community* by Lambert (2013) were a 400 to 500-word count, a maximum of 12 photos and intimate one-on-one workshops with each co-creator. I hosted approximately four 2-hour sessions and each story took approximately 12 hours to complete. The first session was to explain the reason for of our research project, discuss consent and brainstorm health stories they were willing to share with a health care audience. The second session, usually in their home, was a form of narrative therapy that involved reflecting, sharing, venting and often crying about their experiences (Garcia, & Rossiter, 2010). I usually left some space – about 3 to 5 days – between sessions for co-creators to reflect and write their stories. During the third session I helped edit their stories, and we went line by line to choose pictures. Then I uploaded their photos on iMovie software and began the process of creating the video and adding special effects. The next session they recorded their vocals on my high quality microphone and picked their music from the website audioblocs.com or in Tanya’s case she recorded her own throat singing. The last session co-creators viewed their completed digital stories and we did final edits. I gave each co-creator a USB stick with their stories so they could share it with their friends and family (Lenette, 2017).

The relationship building process and trust between my digital storytelling co-creators and myself were central to this project (Wilson, 2008; Smith, 1999; Kovach, 2009; Iseke & Moore, 2011). I had previous relationships with Maxine and Beatrice because they had participated in Women Warriors, a holistic health program that I co-founded in 2015 in

Lloydminster. Due to the fact that we had a good level of rapport, they felt comfortable exploring the legacy of residential school in their lives and how it impacted their health.

For example, as part of her digital storytelling process Maxine asked me to go with her to the site of the residential school that her mother attended, St. Barnabas located on Onion Lake Cree Nation. We had a spiritual and healing experience during our visit. I was taking pictures of Maxine standing beside the foundation of the principal and teacher's residence when a Cree drummer started playing in the distance. It was as if the ancestors carried the song to us, "We survived and our culture remains".

Relationships building with Beatrice included taking me to a special place on her land that has a natural spring and telling me stories of her childhood. When she showed me the picture of her great grandparents and revealed that she was a third generation residential school survivor. I felt honoured to be able to share her story. I explained we would present the digital stories at a public event and she stated she did not want to be interrogated by the audience. I knew that in order for Beatrice to feel safe and keep our trust intact I had to be careful about how we set up public events.

In Yellowknife I had a summer student, Sheryl and as part of her learning outcomes we created her digital story. I made a mistake during our first session – we went too deep, too fast and the result was her being triggered on the first day of work (Hancox, 2012). I thought I could do the same process of sharing intimate stories on our first session, but I didn't have the foundation that I had with my previous two co-creators. Later that week I apologized to her and I told her that while I'm the researcher, I'm also learning this process. It's important to be mindful of where women are on their healing journeys before asking them to share their health stories, and to have a list for them of the mental health resources in their area.

Dorothy's story, which was the most traditional of all the stories, was also created in the most traditional method - orally. For two hours Sheryl and I listened to Dorothy while I wrote down, mostly verbatim what she said. Her entire story was created orally with back and forth verbal edits – she never touched a pen or keyboard to create her story. I regret not having enough time to record her story in her traditional language. Reciprocity and respect means recording stories in traditional languages so co-creators can share their stories with their community Elders (Wilson, 2008).

Tanya is an experienced writer and wrote her 500 words by herself and asked me to edit it. Tanya's story is a circular narrative style, and the timeline and kinship relations of her story jumps all over from past, present, and future. After I read it I asked her if she had issues with editors trying to make her stories linear, and she admitted not all editors know the culturally appropriate way to edit to her stories. It was my responsibility to understand and respect the non-linear formats of Indigenous stories and how to edit these stories without changing my co-creators authentic voice (Kovach, 2009).

The five most important lessons that I learned from this research are:

- 1) My community-based participatory action approach was essential to the success of this project. My co-creators and I co-designed the direction of everything in this research, especially the community event in Yellowknife (Strega & Brown, 2015).
- 2) Maintaining trust between my co-creators and me involves a continual consent process. I keep them informed when I present their digital stories at events or academic conferences, and I invite them to attend as much as possible either through technology or in-person (Lenette, 2017).

3) Decolonized research meant paying my co-creators a week of living wages for their emotional labor and time. I also feel strongly that academic institutions that hold the funds need to understand decolonized research requires quick payment to everyone involved (Smith, 2008).

4) Capacity building for this project meant giving these women the opportunity to learn new skills such as digital storytelling, collaborating on the research, doing public engagement and speaking at our community event in Yellowknife and exposing them to media interviews (Smith, 2008).

5) The empowerment aspect of this research was giving the co-creators a platform to advocate for their own health and share stories that are relevant to their daily-lived experiences. An essential part of this process is the co-creators having an audience to share their stories with and receive feedback. This sharing is transformational for both the creators and the audience (Juppi, 2017).

There are several ways that I created a safe environment for these women to share their health stories. First, I was clear they had total control over every aspect of their stories. They chose every detail of their digital story including writing their first person narration, and picking out the personal photos and music that represented them and the story they wanted to tell. My role was to hold space for their stories, which meant listening with non-judgment, and offering support however they asked for it. Also, as an Indigenous researcher I understand that there are certain things, such as sacred dreams, that are not appropriate to include in my formal research findings, which I believe gave my co-creators the freedom to express their life experiences on a deep level because they knew I would not expose sacred information (Strega & Brown, 2015, p. 246). Moreover, I demonstrated that I valued these women's time, knowledge, and emotional

labor by paying living wages while we worked on their stories, which took approximately one week.

I incorporated an integrated knowledge translation plan that allowed the participants to share ideas and provide input about how to disseminate the research and their digital stories to the community. I also have a continual consent process with my participants and I keep them informed when I present their digital stories at academic conference or events. I will continue sharing with them how their stories are impacting the audience even after my formal research is done. I take direction from the project participant when they suggest spaces to share their digital health stories. For example, one of the participants emailed me to suggest we approach APTN to share the digital stories. I have since been in contact with a video journalist and we have future plans to meet and discuss this project. We are also considering creating an Indigenous knowledge translation workshop where we screen the digital stories with health care professionals, then host talking circles, and have a group discussion on reconciliation in healthcare. I am in the process of searching for academic or healthcare conferences that we can attend as presenters.

### **3. Indigenous Models of Determinants of Health – Proximal, Intermediate & Distal**

Indigenous peoples health disparities, in comparison to the general Canadian population, must be understood in relation to colonization and the larger historical, socioeconomic and political origins of their distress (Kirmayer & Valaskakis, 2009, p. 7). An important concept in explaining these origins is the social determinants of health. The World Health Organization (2019) website ([https://www.who.int/social\\_determinants/sdh\\_definition/en/](https://www.who.int/social_determinants/sdh_definition/en/)) defines social determinants of health (SDOH) as “the conditions in which people are born, grow, live, work and age [which are] shaped by the distribution of money, power and resources at global, national and

local levels.” Reading & Wien (2009) argue that Indigenous peoples social determinants of health are unique to them due to colonization, their concept of health as holistic (physical, spiritual, emotional and mental dimensions) and their interactions between life-stage health and social determinants (i.e. how poverty impacts life course trajectories) (p. 8). Reading & Wien (2009) adapted the SDOH to be culturally relevant to Indigenous peoples through the following categories: proximal determinants (e.g. health behaviours, physical and social environment), intermediate determinants (e.g. community infrastructure, resources, systems and capacities), and distal determinants (e.g. historic, political, social and economic contexts) (p. 7). Distal determinants of health, defined as the structural and systemic context or the “causes of causes” (Czyzewski, 2011, p.4) are considered the most influential on Indigenous peoples’ health “because they represent political, economic and social context that construct both intermediate and proximal determinants” (Reading & Wien, 2009, p. 22). Czyzewski (2011) states colonialism, a distal determinant, continues to shape “Indigenous/state/non-Indigenous relations and account for the public erasure of political and economic marginalization, and racism today” (p. 4). For healthcare providers, it is essential they educate themselves on “colonial discourse as a circumstance that determines Indigenous...health” thereby understanding how colonialism creates health inequities and adapting their attitudes and clinical practices when working with Indigenous patients (Czyzewski, 2011, p. 6)

### **3.1. The Legacy of Indian Residential School (IRS) & Indigenous Women’s Health<sup>4</sup>**

One of the main tools for colonial disruption of Indigenous communities was residential school because it severed family, culture, and language ties, along with community networks (Reading & Wien, 2009, p.23). As a result, Reading and Wien (2009) assert that residential

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<sup>4</sup> One of the five digital storytelling participants attended IRS, while four of the five participants had immediate family members that attended.

school attendance (either in person or by a close family member) influenced almost every one of the SDOH (p. 23). Our digital stories reinforce that residential school attendance negatively impacted the health of 4/5 of the participants. Furthermore, the digital stories explain how the legacy of residential schools and “intergenerational trauma<sup>5</sup>” continues to manifest in these women’s health (Czyzewski, 2011, p. 6). These digital stories are effective pedagogical tools for educating health care professionals on how health inequities experienced by Indigenous women are mainly a result of the legacy of residential school and SDOH. Featured below are the names and titles of the digital health stories<sup>6</sup> (see Table 1) and the impacts of residential school on their health and wellbeing (see Table 2).

Table 1: The Digital Health Stories Titles & Participant’s Self-Identification (see Appendix A - E for the transcripts of the digital stories).

A. Fragmented by Maxine Desjarlais	Self-identifies as Métis and was raised on Fishing Lake Métis Settlement.
B. Broken Trust by Beatrice Harper	Member of Onion Lake Cree Nation, Saskatchewan.
C. Secrets Revealed by Sheryl Liske	Member of Yellowknives Dene First Nations.
D. Living Our History by Dorothy Weyallon	Member of the Tłıchǝ Nation & a resident of Behchokò.
E. Tuq&urasiit by Tanya Roach	Yellowknife resident formerly from Rankin Inlet, Nunavut.

<sup>5</sup> Defined by Wesley-Esquimaux (2007) as the historical experiences of First Nations people(s), which disrupted the process of Indigenous cultural identity formation, [that] continue to resonate in the present, and the harm in the past that continues to manifest inter-generationally into the present. The psychological affect generated by centuries of cultural dislocation, forced assimilation and the Indian Residential Schools.

<sup>6</sup> These digital health stories can be viewed on the Women Warriors website: [www.womenwarriors.club](http://www.womenwarriors.club). Women Warriors logo, education course material, and the digital stories are the trademark of WOMEN WARRIORS.

Table 2: Digital Storytelling Transcripts - The Impacts of Residential School<sup>7</sup> (see Appendix A-E)

Isolation from family	<p>- My mother must have been so traumatized, the first night she had to stay in a strange place and no chance of seeing her mother for a very long time. What a shock for a young 4-year-old girl to be placed in the hands of strangers. She must of thought what is wrong with me? Why isn't my mother coming back to get me? Growing up in the residential school my mom would not have been treated as someone special, someone to be taken care of with love and compassion.</p> <p>-The boys and girls, including family members were separated and not allowed to speak to each other even during recess.</p>
Verbal/emotional/physical abuse	<p>- They [grandparents] were mistreated.</p> <p>- My mom was affected by her experiences at residential school. My mother would put up with abuse, she would say "Kiyam" (don't say anything).</p>

<sup>7</sup> Themes for this table are adapted from Reading & Wien (2009) Table 20: The Impacts of Residential Schools on First Nations Adults Living On Reserve 2002-2003, p. 23.

Loss of cultural identity	<ul style="list-style-type: none"> <li>- The loss of culture, land, identity and language.</li> <li>- In foster care my relationship with my Inuit culture was severed.</li> </ul>
Separation from First Nations/Inuit community	<ul style="list-style-type: none"> <li>- As a child of a residential school survivor, I spent fifteen years in and out of foster care between Nunavut and the Northwest Territories.</li> </ul>
Loss of language	<ul style="list-style-type: none"> <li>- I know something traumatic happened in residential school that has blocked me from getting my language back.</li> <li>- Some people lost their language and culture due to colonization and residential school. It's sad when people don't have their language because there is emptiness in them.</li> </ul>
Lack of physical intimacy	<ul style="list-style-type: none"> <li>- Growing up there was no hugging or affection, or positive reinforcement, and they never said, "I love you." I know this lack of affection was a consequence of residential school and their separation from a loving family. They did not know how to be physically affectionate. There</li> </ul>

	<p>was no storytelling at bedtime, no touching – it felt like everything we did was physically separated. I never saw my grandparents hug, hold hands, or walk together. With the way my grandparents raised me with no touching or physical intimacy it made me very uncomfortable when a stranger touched me.</p>
Lateral violence	<p>-Because of the lateral violence committed on behalf of my peers I couldn't be myself, and being a people pleaser it really affected my well-being. I lost myself as a person and I didn't know who I was.</p>
Shame	<p>- When it came to physical ailments, such as a cold sore my mom would not want to be seen and she would say "I look so ugly." It seemed like she was ashamed of appearance.</p> <p>- I felt uncomfortable, violated, and ashamed.</p> <p>- It explained parts of me that I had been ashamed of.</p>

	<p>- A lot of aboriginal people came from a shame-based system that was taught to them in the residential schools.</p>
<p>Intergenerational trauma</p>	<p>- Being the first generation of a residential school survivor really messed me up. I carried the burden of hidden secrets and not being able to speak my truths from intergenerational trauma that contributed to my mental illness, which manifested as depression.</p> <p>- I came to realize that all the twisted emotions of negative thoughts, the lack of self-esteem, and feeling really low was from the hurt of intergenerational trauma</p> <p>- Due to Intergenerational trauma in my life, I would also experience abuse, family violence, sexual assault, family suicide, and alcoholism.</p> <p>- She [her mother] did not show a lot of affection. I did not receive a lot of nurturing by my mother when I became school age for example hugs, kisses and hearing my mom say” I love you”.</p>

Lack of empathy	<p>- My mother could not show empathy.</p> <p>One of the legacies of residential school is nobody addresses the feelings of the heart.</p> <p>I really struggled with empathy with my own children being able to hug them and identify emotions.</p>
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Intergenerational trauma is a theme in 4 out of 5 of the digital stories (Maxine, Beatrice, Sheryl, and Tanya) and reinforces Czyzewki's (2011) findings that "trauma embodied in parents or previous generations negatively impact people's lives and mental health today, indicative of colonialism's interpretation as a generator of certain types of disadvantages and unjust environments, thus capable of determining health" (p. 8). I will examine each of the stories in further detail in order to explore the impacts of residential school. Maxine's inability to have empathy for her children and a difficult time parenting her four children also coincides with the study by Bombay, Matheson, and Anisman (2009) that "cumulative trauma was a significant predictor of parental abuse potential" (as cited in Czyzewki's, 2011, p. 7). The same study also cites a "strong relationships between stressors and substance abuse," which may help to explain Maxine's history of substance abuse (ibid, p. 7). Beatrice's digital story demonstrates the psychological trauma of "touch" as a residential school survivor, and how her routine doctor's visit became a source of colonial power and oppression. Furthermore, she highlights the power imbalance between the physician and patient, and how stereotypes and/or racism reduced her ability to access quality health care. Sheryl's story is about the secrecy, on behalf of her residential school survivor parents, about their attendance and how it became a source of

psychological distress. As well, the lateral violence in her community, which can be understood as a byproduct of residential school when the “colonized become the colonizers” (NWAC, 2011) contributed to her clinical depression. Tanya’s story about her eczema and psoriasis diagnosis could be viewed as a physical manifestation of colonization. She felt uncomfortable in her own skin as a child of a white father and Inuk mother. The impact of residential school in her life was a total disconnection from her culture after being placed in foster care because her residential school survivor mother could not adequately care for her. This disconnection from family and community eventually impacted her mental health, and she was medicated with antidepressants.

Dorothy’s story is the outlier in relation to the other stories, even though her grandparents who raised her were also residential school survivors. Her story reaffirms an important social determinant of health for Indigenous peoples, which is access to their traditional land base. Bethune et al. (2018) state that “Indigenous peoples living in rural locations are more likely to report a positive self rating of self-reported health compared with those that live in more urban areas” and posits that the “environment may be more consistent with traditional indigenous lifestyles and individual living in rural regions are more likely to have a positive and strong sense of belonging and community” (p. 6). Dorothy shares how important the land and her community is for her health and wellness.

Dorothy is a member of the Tłı̨chǫ government - which negotiated the The Tłı̨chǫ Agreement in 2005 – the first combined comprehensive land claim and self-government agreement in the Northwest Territories, according to the Tłı̨chǫ government website (<https://www.tlicho.ca/government/our-story>). Reading & Wien (2009) state that “self determination” is the most important determinant of health for Indigenous peoples (p. 24). Dorothy’s strong cultural values and ties to her family and community may be attributed to the

self-determination of her First Nation. Furthermore, cultural continuity, defined by Reading & Wien (2009) as the “degree of social and cultural cohesion within a community” involves the following factors: “land title, self government, control of education, security and cultural facilities, and...control of the policies and practice of health and social programs” (p. 21). The Tłchq government have control of all these factors in their territory which creates a stronger cohesion in the community and less risk of suicide (Reading & Wien, 2009, p. 21) Furthermore, Dorothy also speaks her mother tongue and shares stories of “intergenerational connectedness” between herself, her grandparents, and her children, which also positively impacts her health (Reading & Wien, 2009, p. 21). Dorothy’s deep connection to her land, language, culture and community demonstrates the link between Indigenous social determinants of health and overall wellbeing.

### **3.2 Traditional Knowledge & Healing Practices**

Western health care service providers need to learn more about Indigenous knowledge, “specifically in areas of healing, medicines, and integration of Indigenous ways of knowing in biomedical health care” (Stewart & Mashford-Pringle, 2018, p. iv). These digital stories served the purpose of filling the gap in research on how health care providers can incorporate Indigenous knowledge and healing practices into patient care plans so that Indigenous women feel respected and can build safe health care relationships (Greenwood, et. al., 2018). Moreover, Kirmayer & Valaskakis (2009) state that Indigenous peoples know what is best for their holistic healing and that “the most important knowledge is already in the community” (p. 328). These digital stories allow Indigenous women to share how they incorporate traditional knowledge and healing practices into their daily lives, thereby allowing healthcare providers a better understanding of Indigenous women’s healing and holistic health (see Table 3).

Table 3: Indigenous Women's Traditional Knowledge &amp; Healing Practices

Culture as healing	<ul style="list-style-type: none"> <li>- My first journey on a healing path, Trails of Our Ancestors [cultural event].</li> <li>- Practicing my culture keeps me healthy.</li> <li>- Healing for me is about nature, language, culture, and family.</li> <li>- Community events like hand games, drum dance, and community feasts are important.</li> </ul> <p>Practicing our culture brings healing to everyone</p> <ul style="list-style-type: none"> <li>- Now that I'm aware of the cultural power and conditions of Inuit names I accept my differences as a part of my family legacy.</li> </ul> <p>My health improved when I let go of the idea that my tendencies were not a betrayal to my own culture but a condition of my traditional name. Because of this, my eczema and psoriasis are under control and almost gone. Mending the connection with my culture has reconciled the relationship with the body that I've inherited from my ancestors.</p>
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<p>Holistic healing<sup>8</sup></p>	<ul style="list-style-type: none"> <li>- I had to learn how to heal from my traumas by faith in my Heavenly Father receiving his mercy and grace, my children, family, teachers, peers, counsellors, and education have contributed to my healing journey.</li> <li>- Telling my children helped me heal by speaking the truth.</li> <li>- It's hard work changing my thought patterns but through my healing work including, medication, counseling, journaling and focusing on myself I have found balance and gained confidence and strength. And forgiving yourself and others during the journey of depression is a huge part of the process of letting go and moving forward.</li> <li>- When I know there is something wrong with me – like feeling sad, stressed or depressed – I drive out to the middle of nowhere and I sit in nature. I talk to the</li> </ul>
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<sup>8</sup> Holistic healing incorporates physical, spiritual, emotional, and mental practices in order to seek balance.

	land, and I let the land take the negative energy out of me.
Connection between Elder teachings & good health	<p>-We need our Elders to teach us our way of life to regain our identity, retrace our path and develop skills required to be successful.</p> <p>-The Elders always say pay your respects before you take anything from the land.</p> <p>- I try to practice my culture as much as my ancestors did.</p>

#### 4. Knowledge Translation Events

Our Yellowknife event, Legacy: Indigenous Women’s Health Stories was held on August 15<sup>th</sup>, 2019 with approximately fifty-five in attendance. The event included a meal of bannock and chili, followed by welcoming remarks by Dr. Irlbacher – Fox, Scientific Director of Hotì ts'eeda, and Lesa Semmler, the Inuvialuit Regional Corporation representative of the Governing Council of Hotì ts'eeda Governing Council. The co-emcee of the event and community Elder, Gail Cyr shared, meaningful insights about Indigenous women’s health. I provided context for the screening of the stories by sharing the importance of storytelling and listening in Indigenous culture. It was my intention to create a decolonized space by asking those in attendance – both Indigenous and non-Indigenous people – to be responsible, reflexive listeners.<sup>9</sup>

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<sup>9</sup> Regan (2010) states that a responsible listener poses questions about the content of the information being presented, in addition to posing questions about our own questions. This type of self-reflexivity is essential to the reconciliation process as colonial-settlers examine their roles and responsibility in the process of colonization.

This community event featured a speaker's panel with all five digital storytelling participants. The panel discussed three questions: What was the impact of residential school on your physical, spiritual, mental, and emotional wellbeing? How did the process of digital storytelling affect you? What does good health mean to you from your own perspective? (Métis, Cree, Dene, Tłchq and Inuit)?

Prior to the event we collectively discussed what type of questions the panel felt comfortable answering and decided not to open the floor for questions and answers. I explained to the audience that it was my responsibility as the lead Principal Investigator of this research to keep my participants safe from colonial violence during their time with me. I explained that a seemingly innocent question might be perceived as impolite, cruel or violent. As well, there are very few spaces for Indigenous women only voices and decolonizing this space means Indigenous women's voices take precedence over everyone else's voices. This community event was about creating a space where Indigenous women felt empowered to advocate for themselves, and safe enough to be vulnerable as they shared their health stories.

## **5. Results & Conclusion**

There are several uses for digital storytelling in healthcare settings including educating health care professionals, and engaging them in critical reflection of their practice (Rieger, et.al. 2018). An important part of my research methodology is capturing the medical audiences' awareness of their own perceptions of Indigenous peoples' health, and reflecting on how they can incorporate information from the digital stories into their practice. I hosted a screening at the Stanton Territorial hospital that took place on August 8th and 9th, 2019. At the Stanton Territorial Hospital event there were fifteen employees, from a variety of backgrounds including

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Cultural sensitivity training often places Indigenous peoples as the focus of the training, when instead it should teach settlers to reflect on their own history, cultural practices, worldviews and values.

administration, registered nurses, respiratory therapists, medical interpreters, and members of the Aboriginal Wellness program. After screening the stories they were asked to provide feedback on a quality improvement evaluation that I provided. Their responses demonstrated that the digital stories served as a pedagogical tool for understanding the legacy of residential schools and increasing their cultural safety skills (see Table 4).

Table 4: Stanton Territorial Hospital Health Care Provider Evaluation Feedback (see Appendix G).

<p>Understanding the legacy of residential schools</p>	<ul style="list-style-type: none"> <li>- Better understanding of the lasting effects of residential schools on those who were forced to go to them.</li> <li>- Better understanding of multigenerational effects of residential schools and loss of culture suffered by Indigenous peoples.</li> <li>- Understanding the intergenerational impact of the suppression of physical &amp; emotional affection will help with better understanding in care situations.</li> <li>- Presentations are well paced visually compelling and really share well the person's difficult journey and the impact of their trauma.</li> </ul>
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<p>Understanding the diversity between each cultural group</p>	<p>- Understanding how differently Indigenous women approach health treatment is very important for health care providers.</p> <p>- These videos provide great visual and short story for health care professionals to gain a little perspective of the different personal stories of our Indigenous women. It's good to see and hear about the different cultures and experiences.</p>
<p>Increased cultural competency and cultural sensitivity</p>	<p>- Very good initiatives for new employees like me from another country to understand Indigenous culture.</p> <p>- Thank you for the opportunity to learn more and to improve my awareness and sensitivity.</p>

Digital health stories also have the potential to initiate community dialogue about issues that are of concern to the participants and the audience (Rieger, et.al. 2018). These digital health stories also served to open space for conversations about reconciliation in healthcare. Audience members at the Legacy event, which consisted of healthcare professionals, academics, post secondary students, government employees, non-profit executive directors, City of Yellowknife employees and Indigenous artists, healers, and Elders were asked to fill out a leaf for the “I Wish” Tree. They completed the sentence, “I wish health care providers would...” and hung

their leaves on an ornamental tree. This tree was representative of community connection and “growing” our ideas together to close the gaps in health disparities between Indigenous and non-Indigenous peoples. I intend to share the themes of the I Wish tree with health care professional when I screen the stories at various events (see Table 5). Sharing this community feedback may significantly decrease the time between knowledge generation and knowledge implementation by directly sharing grassroots ideas with healthcare professionals (Rieger, et.al. 2018).

Table 5: I Wish Tree Community Member Responses

Engage in deep listening	<ul style="list-style-type: none"> <li>- Had more time per patient to simply listen.</li> <li>- Stop rushing and LISTEN.</li> <li>- Listening and asking what is important to you?</li> <li>- Engaged in active and respectful listening.</li> <li>- Create the time and space for listening and being willing to talk about multiple issues and recognize complexity and interconnectedness.</li> <li>- Always listen first (really listen and learn and listen some more).</li> <li>- Engaged in active and respectful listening.</li> </ul>
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	<ul style="list-style-type: none"> <li>- Listen and check their prejudices and discrimination at the door.</li> <li>- Listen with patience and humility/not impatience and judgment.</li> </ul>
Practice cultural competency & cultural safety	<ul style="list-style-type: none"> <li>- Take cultural competency training as part of their formal education.</li> <li>- Take the initiative to become more aware of health inequities with Indigenous populations and take the time and effort to provide culturally safe care.</li> <li>- Educate themselves about cultural diversity. Listen. Provide holistic care.</li> <li>- To have the time as part of their workday to reflect on their responsibilities in cultural competency and develop specific methods and actions to achieve a culturally competent health system.</li> <li>- Care from a place of understanding rather than from a place of assumptions and bias.</li> <li>- Understand our cultural difference. Show more respect to our Elders.</li> <li>- Greet First Nations in their languages. To question their own learned perceptions. To</li> </ul>

	<p>prioritize Elders coming into the healthcare.</p> <p>- Spend time learning about the settler/colonial history to better understand the context of those who experienced it and were impacted by it. And then to hold up a mirror to themselves and explore their own relationship to power and privilege. How does that show up in their health provision?</p>
<p>Practice values of patience, humility, respect, reciprocity &amp; relationships</p>	<p>- Treat all patients with respect and dignity.</p> <p>- Treat all people with respect and equally.</p> <p>- Have humility and practice reciprocity when planning a person's care and include person in decisions.</p> <p>- Begin to understand that wellness and healing journey is a partnership!</p> <p>- To ask everyone how they can respect their culture. What practices they may do?</p>
<p>View health as holistic</p>	<p>- Understand that health care is more than about physical health.</p>
<p>Understand health in relation to the social determinants of health</p>	<p>- Universal access to free medication for anyone who identifies as Indigenous, especially for children. Priority given to</p>

	<p>Indigenous peoples for a regular family doctor over other people living in Yellowknife and fix the lack of family doctors. Offer evidence based approaches for increased access to all (i.e) advanced access.</p> <p>- See Indigenous women as whole women: multifaceted, resilient, dignified contributors to our society. To see health challenges as social barriers as mostly being a “function” of systemic violence and discrimination.</p>
Build long-term relationships	<p>- Specifically for smaller Indigenous communities that don’t have regular access to doctors and nurses to build long-term relationships with communities.</p>
Increase Indigenous healthcare professionals	<p>- Looked visibly Indigenous...like me!</p>

The Stanton Territorial Hospital and the Legacy event allowed Indigenous women the ability to showcase their resilience and strength and shift mainstream stereotypes and deficit-based stories towards asset-based stories about their health, communities, and culture. These events encouraged healthcare professionals to better understand Indigenous women’s unique

lived experiences and elicit cultural perspectives with respect to health issues, diagnosis, and treatments. A community member from the Legacy event stated she would be better able to respond to her Indigenous clients' needs in, "ways that are more meaningful and truly supportive" (email correspondence). Furthermore, the data directed me to focus my presentations to health care professionals on the seven themes I coded from the data (table 3). An important feature of Indigenous research, as discussed by Métis academic, Gaudry (as cited in Strega & Brown, 2015) is to be action-oriented and "produce a better life for community members, study participants, and Indigenous peoples in general (p. 257). It is through community engagement in the dissemination of the digital stories that allows for "Indigenous mobilization and creates a new space for Indigenous empowerment" (Gaudry, as cited in Strega & Brown, 2015, p. 257).

On September 29<sup>th</sup>, 2019 I screened our digital stories with residents enrolled in the University of Calgary, Cumming School of Medicine, General Internal Medicine program. After screening the stories the residents (n=8) were asked to complete a questionnaire<sup>10</sup> that I provided (see Table 6).

Table 6: Internal Medicine Retreat Questionnaire (See Appendix H).

<p>Question 1. Reflecting on the digital stories, what events or factors do Indigenous women face that contribute to the health challenges they experience?</p>	<p>-Psychological trauma, isolation and restrictions in residential school.</p> <p>-Significant generational trauma.</p> <p>Previous negative experiences with healthcare lead to future aversion of the system.</p>
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<sup>10</sup> The questionnaire was prepared by Dr. Rita Henderson, Assistant Professor, Models of Care Scientist, Departments of Family Medicine and Community Health Sciences & Dr. Cheryl Barnabe, Associate Professor, Departments of Medicine and Community Health Sciences, University of Calgary.

	<p>-Intergenerational trauma, residential schools, lack of physical/intimate relationships with family.</p> <p>-Intergenerational trauma, residential school experiences, lateral violence, stereotypes/racism, colonialism, mental health barriers, accessing culturally safe care.</p> <p>-Intergenerational trauma- the effect this experience had on people which had effected each subsequent generation.</p>
<p>a) Were any if these events or factors a surprise or new to you? If so, please explain.</p>	<p>-Did not have idea about the reality behind residential school and their impact on indigenous health.</p> <p>-The scope of generational trauma.</p> <p>-I wasn't familiar with the concept of intergenerational trauma.</p> <p>-I was not aware of the physical relationship aspect (lack of affection/touching).</p> <p>-No, I am Metis and work in Indigenous health research and clinical medicine.</p> <p>-No, I have previously had training with this and have worked extensively with Indigenous populations.</p>

<p>b) What events or factors do you feel you could address in your interactions with Indigenous patients? How would you do so?</p>	<ul style="list-style-type: none"> <li>-Be respectful and sensitive to the culture and not be judgmental based on any previous experience</li> <li>-Sensitivity.</li> <li>-Eliciting cultural perspective with respect to issues, diagnosis, treatments.</li> <li>-Awareness of answers to #1.(Intergenerational trauma, residential school, lack of physical/intimate relationships with family) Using respectful, non-intrusive language.</li> <li>-Providing safe care.</li> <li>-Asking about their background - asking how this has affected them.</li> </ul>
<p>c) Which of the stories resonated most with you?</p>	<ol style="list-style-type: none"> <li>1. Fragmented by Maxine - 3 respondents</li> <li>2. Broken Trust by Beatrice - 0 respondents</li> <li>3. Secrets Revealed by Sheryl - 1 respondent</li> <li>4. Living our History by Dorothy - 1 respondent</li> <li>5. Tuq&amp;urasiit by Tanya - 3 respondents</li> </ol>
<p>d) Why was this/these stor(ies) effective for understanding Indigenous women's health?</p>	<p>-Maxine's story is a direct consequence of the behavior, lack of love, and lack of emotions she experienced at her home. Tanya's story is</p>

	<p>just a reality of challenges people face dealing with two cultures.</p> <p>-Maxine's story the effect of lack of attachment - the impact.</p> <p>-They were very effective but Dorothy's story showed more success and more family and community, which I was able to identify with.</p> <p>-Very personal and clear story of effects through multi-generations of residential school.</p> <p>-Hearing first hand individual experiences are more effective than a didactic lecture/slideshows.</p>
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These responses demonstrated that the digital stories served as a pedagogical tool<sup>11</sup> for understanding of the legacy of residential schools and increasing their cultural competency and cultural safety with Indigenous patients. The last response stating that the digital stories were more effective than a didactic lecture speaks to the power of this methodology to form “empathetic connections” between the listener and the teller (Matthews & Sunderland, 2017, p. 68). It also speaks to the use of digital stories for “patient centered care” in health care settings, which serves to shift the narrative from a biomedical perspective to “treating people as individuals” (Matthews & Sunderland, 2017, p. 62). The power of these digital stories for health

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<sup>11</sup> Pedagogical tools are designed to convey important lessons and allow people to improve their understanding of a problem or undertaking.

care providers rests in validating Indigenous women's experiences and feeling empathy for how colonization, including residential school, has continued to impact their lives (Matthews & Sunderland, 2017, p. 62).

## **Conclusion**

Indigenous women's health stories can serve as a pedagogical tool to teach cultural safety in health care settings. Indigenous digital health stories inform solutions that are community-driven, culturally relevant to Indigenous peoples and based specifically in local knowledge. Indigenous women's digital health stories fill a gap in research on how health care providers can incorporate Indigenous knowledge and healing practices into patient care plans so that Indigenous women feel respected and can build safe health care relationships. Moreover, sharing Indigenous women's stories opens space for reconciliation in healthcare conversations, supporting collaboration to transform health care systems, policies, and practices to improve Indigenous women's health outcomes. These stories are an innovative way to decolonize health care, build relationships and trust with health care providers, and seek collaborative solutions to reconciliation in healthcare.

This research suggests that the methodology of digital storytelling is adaptable in the following ways. It can facilitate a deeper level of self-expression for the participants, and empower them by sharing their health stories and advocating for their own service needs. Screening the digital stories with health care professionals can engage them to reflect on their own clinical practices, thereby increasing cultural safety in healthcare settings. In community settings, screening the digital health stories can open space for dialogue about reconciliation in healthcare and allow for community driven solutions that have the potential to be heard by those in decision making roles. Furthermore, digital storytelling facilitators can be trained in

Indigenous communities to create their own digital storytelling projects, thereby increasing community capacity and decolonization of healthcare. These stories can feature region-specific healing practices and can locate the barriers to quality care in each region.

Digital storytelling allows Indigenous women to share how colonization and the loss of cultural identity have negatively affected their health. At the same time, it highlights how Indigenous women have managed to maintain their holistic health practices and what that means for the health of their families and communities. The healthcare providers' feedback from the screenings suggests that they want more opportunities to connect with communities to better understand Indigenous worldviews and healing practices.

The most important aspect of this research has been the formation of empathetic connections between health care providers and Indigenous women's stories of cultural genocide such as the forced removal of Indigenous children to residential schools, and how it manifested in Indigenous peoples' physical, spiritual, mental and emotional health. Indigenous women's health stories are a form of reconciliation in healthcare because they assist medical professionals in understanding their own positionality and reflect on the ways they may disrupt the systemic racism embedded in our institutions.

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## APPENDICES

### Appendix A. Fragmented by Maxine

I am 52-year-old Aboriginal women and I had my first opportunity to visit the place where my mother was raised. It is crazy to think that it took me so long to see this place; I only live 30 minutes from the location. My mother grew up in a residential school and I had no idea where it was located. I was so ignorant of the way my mother grew up. She would only share a few stories about her childhood. One story she shared “I went to the residential school with my mom, they took me in gave me a bath and changed my clothes. When I came out my mom was still sitting there so I told her “I am ready to go now”, I didn’t realize that I had to stay, I thought I was only going there to get cleaned up.” My mom would have been approximately six years old. I cannot imagine the thoughts that went through my grandmother’s mind, she had no choice but to leave her sweet daughter there. The sadness, fear and grief must have been overwhelming and heart breaking. My mother must have been so traumatized, the first night she had to stay in

a strange place and no chance of seeing her mother for a very long time. What a shock for a young 4-year-old girl to be placed in the hands of strangers. She must of thought what is wrong with me? Why isn't my mother coming back to get me?

I grieve for my mom the losses that have never been spoken about, the loss of nurturing (hugs, kisses, conversations) dresses, hair combing, bath times, family times together, sibling ties, birthdays, celebrations, and traditions. The loss of culture, land, identity and language. Growing up in the residential school my mom would not have been treated as someone special, someone to be taken care of with love and compassion.

I remember my mom sharing a story when her son (my Brother) was in the hospital, she would not go visit him. She said, "it would be to hard on him when it was time for her leave". This was likely due to her experience when her mom was forced to leave her at the residential school and how hard it was on her. My mom contracted tuberculosis when she was in the residential school and was sent to a sanitarium. It must have been a very difficult time; her lungs were scarred and her emotional well being as well. I am not sure if her mom was able to visit her there; I don't believe so.

When it came to physical ailments, such as a cold sore my mom would not want to be seen and she would say "I look so ugly". My mom would never go to the hospital and I would watch her suffer. I came home from school with a sprang ankle and I showed her. She asked "you showed your foot to your teachers with that callous on your foot? It seemed like she was ashamed of appearance and could not show empathy. One of the legacies of residential school is nobody addresses the feelings of the heart. I really struggled with empathy with my own children being able to hug them and identify emotions.

In retrospect, my mom was affected by her experiences at residential school. My mother would put up with abuse, she would say “Kiyam” (don’t say anything). My mom did not express her emotions very often and she did not show a lot of affection. I did not receive a lot of nurturing by my mother when I became school age for example hugs, kisses and hearing my mom say” I love you”.

Due to intergenerational trauma in my life, I would also experience abuse, family violence, sexual assault, family suicide, and alcoholism. I had to learn how to heal from my traumas by faith in my Heavenly Father receiving his mercy and grace, my children, family, teachers, peers, counsellors, and education have contributed to my healing journey.

To health care professionals, I would ask that they would be more empathetic to aboriginal people. A lot of aboriginal people came from a shame-based system that was taught to them in the residential schools. A lot of aboriginal people will not seek medical help unless necessary. Sometimes, it is too late to receive medical treatment because they have waited too long. Which has caused aboriginal people to experience premature death.

## **Appendix B. Broken Trust by Beatrice**

I am a third generation residential school survivor. My late kokum and mooshum attended the same Roman Catholic residential school I did. The difference between our experiences is they were forced to stay at the school, whereas I was a day student. My late kokum would tell me that they were not allowed to speak Cree and they were mistreated. The boys and girls, including family members were separated and not allowed to speak to each other even during recess. I attended residential school for five years and moved on to Chief Taylor in grade 4 which opened in 1973. Similar to my grandparents I spoke fluent Cree before I went to kindergarten and I lost my language because the priests and nuns didn't allow us to speak our language. When I went to university I tried to learn Cree again, but I still can't speak it, although I can understand when people speak it. I feel angry and disappointed that I can't speak my

language. I know something traumatic happened in residential school that has blocked me from getting my language back.

My grandparents raised me and growing up there was no hugging or affection, or positive reinforcement, and they never said, “I love you.” I know this lack of affection was a consequence of residential school and their separation from a loving family. They did not know how to be physically affectionate. There was no storytelling at bedtime, no touching – it felt like everything we did was physically separated. I never saw my grandparents hug, hold hands, or walk together.

With this experience of how my grandparents raised me with no touching or physical intimacy it made me very uncomfortable when a stranger touched me. I experienced a traumatic incident with a doctor when I went for my first prenatal checkup. I was waiting in the examining room, and the doctor entered and explained I had to undress and he wanted to check for breast cancer. I never questioned him because it was my first time doing a prenatal checkup. I undressed and he examined me, without asking for permission to touch me, or offer an explanation about why I needed a breast exam. I was young and I didn’t know, but I felt very uncomfortable, violated, and ashamed. After he was done I put my clothes back on and walked straight out without making an appointment with the receptionist. On my way home on the bus I felt like I was sexually assaulted and I started to think that what he did to me was wrong. I thought about advocating for myself, but I felt like I wasn’t going to be heard. I thought to myself, who is going to believe a First Nations woman with no status living on social assistance, which made me look like a stereotype, verses a professional doctor?

I have five daughters, and they are all aware of this incident, which has helped me heal by speaking the truth. As a First Nations woman I tell my daughters to bring someone with them to doctor’s appointments to be a witness in case they are mistreated.

### **Appendix C. Secrets Revealed by Sheryl**

Being the first generation of a residential school survivor really messed me up. I carried the burden of hidden secrets and not being able to speak my truths from intergenerational trauma that contributed to my mental illness, which manifested as depression.

My battle with depression started at 18 years old and I did not know what it was or how to fix it. I came to realize that all the twisted emotions of negative thoughts, the lack of self-esteem, and feeling really low was from the hurt of intergenerational trauma and lateral violence in my community. Because of the lateral violence committed on behalf of my peers I couldn't be myself, and being a people pleaser it really affected my well-being. I lost myself as a person and I didn't know who I was. At first it did not seem like depression. It seemed more like confusion,

anger, sadness, grief, stupidity, and annoyance. It was all bundled into one big ball and each ball would grow over time, and then explode into outbursts of crying, screams, and disappointment.

I made an appointment with a physician and expressed the hurt of emotions that I was dealing with and how difficult it was for me to cope. The physician diagnosed me as clinically depressed, and prescribed counseling and medication to ease the hurtful pain. The years of lateral violence I was subject to, which became negative thoughts of not liking or loving myself, not being good enough, and putting myself down repeatedly were disrupted by the counselling and medication.

At the beginning of my treatment the medication did not seem like a good idea. I didn't know if it would cure me, or help the pain, or help the thoughts. I felt the stigma of being on medication for depression as a First Nations woman. The medication did help melt the pain away, build my self – confidence, and become more positive. Throughout my young adult life I was on and off the medication – sometimes I didn't need them because I found a balance within myself. And during dark times I needed them again because my coping skills were not as strong.

In my young adult life I have seen four psychologists and been on and off medication four times. Now on this journey of mental health I am better able to identify the dark times and through cognitive behavioral therapy I am able to switch my negative thoughts to more positive thoughts. It's hard work changing my thought patterns but through my healing work including, medication, counseling, journaling and focusing on myself I have found balance and gained confidence and strength.

It's up to you to make that decision to ask for help. You may feel awkward at first because it's new and you are not comfortable. The physicians and the medication are there to help you. Also, take the first steps to getting to know yourself and acknowledge your feelings.

I'm still a work in progress and I still have good days and bad days. All of this healing took a long time – basically half of my life. And forgiving yourself and others during the journey of depression is a huge part of the process of letting go and moving forward.

#### **Appendix D. Living Our History by Dorothy**

My name is Dorothy Weyallon and I come from the Tłıchǫ region in the Northwest Territories. Tłıchǫ people are composed of four communities - Behchoko, Gameti, Whati, and Wekweti.

My grandparents raised me and when I was 15 years old I took my first journey on a healing path, Trails of Our Ancestors. Every year our people travel by canoe or boat to the Tłıchǫ Annual gathering. This trip is considered to be a vision to re-trace our past and see it through the eyes of our elders. We need our elders to teach us our way of life to regain our identity, retrace our path and develop skills required to be successful.

My Grandfather invited me on my first Trails of Our Ancestors journey along with his friend, and my 10-year-old nephew, Melvin and Melvin's friend. Our first trip was 2-3 days by

boat to Whati. My nephew got sick on the first night so I informed my grandfather and he said we needed to go on the land to get medicine. Before we took the medicine from the land Melvin had to do an offering, and say a little prayer for a fast recovery and healing. My grandfather and Melvin disappeared into the bush and came back with spruce cones. My grandfather and his friend boiled the cones on an open fire. Once it was done they filtered out the cones and Melvin drank two doses of the medicine, and the next morning he was healed. The Elders always say pay your respects before you take anything from the land. Also, give a reason why you want healing from the land. We always make an offering such as tobacco, food or wooden matchsticks. If you don't pay your respects the medicine will not work.

Another teaching my Grandfather gifted me on this trip was about going to new places. If you go to a place you haven't been before – a new area on the land or new waters - you have to make an offering. He said, “My girl, you haven't been to this area before. Go pick a branch off the tree and pay your respects to the water. You need to ask for a safe journey including calm waters, no wind, and no interactions with the animals.”

I try to practice my culture as much as my ancestors did. Some people lost their language and culture due to colonization and residential school, but I grew up speaking my mother tongue, Tłchq. I practice my traditions in every season and I teach my children as much as I can about our land, language, and culture. Practicing my culture keeps me healthy. I am proud of where I come from, especially being able to speak my own language. It's sad when people don't have their language because there is emptiness in them. Our Elders have taught us you need to be “strong like two people” by keeping our traditions and language and speaking English and understanding Western ways.

Healing for me is about nature, language, culture, and family. When I know there is something wrong with me – like feeling sad, stressed or depressed – I drive out to the middle of nowhere and I sit in nature. I talk to the land, and I let the land take the negative energy out of me. I understand that everyone doesn't do healing like me, which is why community events like hand games, drum dance, and community feasts are important. Practicing our culture brings healing to everyone.

### **Appendix E. Tuq&urausiit by Tanya**

My entire life I have been alienated from my maternal Inuit family for being different. My grandmother, who was born in a tent on the land outside of Rankin Inlet, came from a generation where White people brought trouble to the Arctic. I was looked down upon because I had a white father. I was raised in a bilingual home with both Inuktitut and English, but I was more fluent in English. As a child, I was a vegetarian in a meat-eating culture, lactose intolerant, sensitive to processed foods, and I developed eczema and psoriasis at nine years old.

As a child of a residential school survivor, I spent fifteen years in and out of foster care between Nunavut and the Northwest Territories. In foster care my relationship with my Inuit culture was severed. My psoriasis, eczema and depression flared throughout high school and into

early adulthood. I was medicated with an antidepressant from twenty to twenty seven years old. When I was twenty eight a turning point took place in my life when I learned an important cultural teaching. It explained parts of me that I had been ashamed of.

In Inuit culture the naming system is important and highly regarded. Newborn babies are given names of the deceased to keep the spirit of them alive. Through the power of the name the newborn baby will be bestowed with some power and characteristics of the deceased person. The individuals of the community address the young child in relation to the previous name keeper.

When I was born my mother named me after her father, Equak Niviatsiak so she and her siblings addressed me as, “Dad.” My grandfather was a traditional nomadic hunter that was relocated to the town of Rankin Inlet in the 1950’s. He died from lung cancer two years before I was born. Through his fight with cancer he faced the challenge of miscommunication with healthcare professionals as a unilingual Inuktitut speaker. He was left with one lung and with his condition he was no longer able to digest meat. He told my Mother before passing that the person named after him would speak English over Inuktitut to communicate with the changing world, they would not eat meat and they would not smoke or drink.

Up until I learned the importance and effect of the naming system, I believed it was my own peculiarities that separated me from my culture. As though my subconscious had chosen colonial culture over my maternal culture causing discomfort in my own skin. Now that I’m aware of the cultural power and conditions of Inuit names I accept my differences as a part of my family legacy. My health improved when I let go of the idea that my tendencies were not a betrayal to my own culture but a condition of my traditional name. Because of this, my eczema and psoriasis are under control and almost gone. Mending the connection with my culture has reconciled the relationship with the body that I’ve inherited from my ancestors.

### **Appendix F. The Methodology of Digital Storytelling in Health Research by Shelley**

From May to June 2019 I co-created two digital health stories with Indigenous women from Lloydminster and Onion Lake Cree Nation. I relocated to Yellowknife for the months of July and August and co-created three digital stories. The objectives of these digital health stories were to allow Indigenous women to share their traditional knowledge, and healing practices in their daily lives and conceptualize their own health care stories and service needs to a medical audience. The Four R's of research — Respect, Relevance, Reciprocity, and Responsibility - guided my research process. I call my research participants, co-creators, and they have been involved in every step of this project including planning, creation, and knowledge translation.

Before I started this research I prepared myself by examining my heart and asking myself if I was ready for the responsibility of a long-term commitment to my co-creators. Indigenous academic, Wilson states:

The source of a research project is the heart and mind of the researcher, and “checking your heart” is a critical element in the research process. The researcher insures that there are no negative or selfish motives for doing the research, because that could bring suffering upon everyone in the community. A ‘good heart’ guarantees a good motive, and good motives benefit everyone involved” (p. 60).

My role in the process of creating these digital stories was to hold space for my co-creators. Holding space means opening your heart and listening with compassion, and non-judgment. It meant offering silent strength to them during their outpouring of pain, grief, and trauma and not trying to fix them. I held this quote in my heart during the process, “people start to heal the moment they feel heard.”

This research took a physical, mental, spiritual and emotional toll on me. I had to refuel by running outside, pouring my grief out onto the land and the Great Slave Lake, and praying for guidance and strength. I felt a deep sense of responsibility as an Indigenous community member conducting health research on my traditional territory, which I believe is much different than for a non-Indigenous researcher. I was responsible to my co-creators, to my community and to my family and ancestors.

The guidelines that I used to create these stories were a 400 to 500-word count, a maximum of 12 photos and intimate one-on-one workshops with each co-creator. I hosted approximately four 2-hour sessions and each story took approximately 12 hours to complete. The first session was to explain the purpose of our research project, discuss consent, and brainstorm

health stories the co-creators were willing to share with a health care audience. The second session, usually in their home, was a form of narrative therapy that involved reflecting, sharing, venting and often crying about their experiences. I usually left some space – about 3 to 5 days – between sessions for co-creators to reflect and write their stories. In the third session I helped edit their stories, and we went line by line to choose pictures. Then I uploaded their photos on iMovie software and began the process of creating the video and adding special effects. The next session they recorded their vocals on my high quality mic and picked their music from the website audioblocs.com or in Tanya’s case she recorded her own throat singing. During the last session co-creators viewed their completed digital stories and we did last edits. I gave each co-creator a USB stick with their stories so they could share it with their friends and family.

The relationship building process and trust between my digital storytelling co-creators and myself were central to this project. I had previous relationships with Maxine and Beatrice because they had participated in Women Warriors, a holistic health program that I co-founded in 2015 in Lloydminster. Due to the fact that we had a good level of trust established, they felt comfortable exploring the legacy of residential school in their lives and how it impacted their health. They both agreed that had an outsider and non-Indigenous researcher approached them to do the same, they would not have participated or gone to the depths of exploration that we did.

For example, as part of her digital storytelling process Maxine asked me to go with her to the site of the residential school that her mother attended, St. Barnabas located on Onion Lake Cree Nation. We had a spiritual and healing experience during our visit. I was taking pictures of Maxine standing beside the foundation of the principal and teacher’s residence when a Cree drummer started playing in the distance. It was as if the ancestors carried the song to us, “We survived and our culture remains.”

Relationship building with Beatrice included taking me to a special place on her land that has a natural spring and telling me stories of her childhood. When she showed me the picture of her great grandparents and revealed that she was a third generation residential school survivor I felt honoured to be able to share her story. I explained we would present the digital stories at a public event and she stated she did not want to be interrogated by the audience. I knew that in order for Beatrice to feel safe and keep our trust intact I had to be careful about how we set up public events.

In Yellowknife I had a summer student, Sheryl and as part of her learning outcomes we created her digital story. I made a mistake during our first session – we went too deep, too fast and the result was her being triggered on the first day of work. I thought I could do the same process of sharing intimate stories on our first session, but I didn't have the foundation that I had with my previous two co-creators. Later that week I apologized to her and I told her that while I'm the researcher, I'm also learning this process. It's important to be mindful of where women are on their healing journeys before asking them to share their health stories, and to have a list for them of the mental health resources in their area.

Dorothy's story, which was the most traditional of all the stories, was also created in the most traditional method - orally. For two hours Sheryl and I listened to Dorothy while I wrote down, mostly verbatim what she said. Her entire story was created orally with back and forth verbal edits – she never touched a pen or keyboard to create her story. I regret is not having enough time to record her story in her traditional language. Reciprocity and respect means recording stories in traditional languages so co-creators can share their stories with their community Elders.

Tanya is an experienced writer and wrote her 500 words by herself and asked me to edit it. Tanya's story is a circular narrative style, and the timeline and kinship relations of her story jumps all over from past, present, and future. After I read it I asked her if she had issues with editors trying to make her stories linear, and she admitted not all editors know the culturally appropriate way to edit to her stories. It was my responsibility to understand and respect the non-linear formats of Indigenous stories and how to edit these stories without changing my co-creators authentic voice.

The five most important lessons that I learned from this research are:

- 1) My community-based participatory action approach was essential to the success of this project. My co-creators and I co-designed the direction of everything in this research, especially the community event in Yellowknife.
- 2) Maintaining trust between my co-creators and I involves a continual consent process. I keep them informed when I present their digital stories at events or academic conferences, and I invite them to attend as much as possible either through technology or in-person.
- 3) Decolonized research meant paying my co-creators a week of living wages for their emotional labor and time. I also feel strongly that academic institutions that hold the funds need to understand decolonized research requires quick payment to everyone involved.
- 4) Capacity building for this project meant giving these women the opportunity to learn new skills such as digital storytelling, collaborating on the research, doing public engagement and speaking at our community event in Yellowknife and exposing them to media interviews.
- 5) The empowerment aspect of this research was giving the co-creators a platform to advocate for their own health and share stories that are relevant to their daily-lived experiences. An

essential part of this process is the co-creators having an audience to share their stories with and receiving feedback. This sharing is transformational for both the creators and the audience.

Indigenous women's health stories can serve as a pedagogical tool to teach cultural safety in health care settings; their stories inform solutions that are community-driven, culturally relevant to First Nations, Metis and Inuit peoples and based in local knowledge. It is an opportunity for Indigenous women to shift mainstream stereotypes and deficit-based stories towards asset-based stories about their health, communities, and culture. Moreover, these stories open space for reconciliation in healthcare conversations, and how we can work together to transform health care systems, policies, and practices to improve Indigenous people's health outcomes.

## Appendix G. Stanton Territorial Hospital Health Care Provider Quality Improvement Evaluation

### Do you identify as Indigenous?

*Indigenous in this context may refer to being a descendant of First inhabitants of any region who claim historical continuity with pre-colonial and/or pre-settler societies, and form non-dominant groups in the society where they live. This question invites your self-identification. Yes/no*

If yes, what Indigenous identification to you claim? (For example- Metis, Inuit, First Nation)

### Please rate how you feel about the following statements:

Social Cultural Confidence in Care Scale	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
<b>General</b>					
1. I am satisfied with my Indigenous patients' clinical outcomes.					
2. My level of confidence is high with regards to providing care to Indigenous patients.					
3. I modify my care approach when working with Indigenous patients.					
<b>Social Factors</b>					

4. When treating Indigenous patients, I routinely and specifically enquire about <i>socioeconomic</i> conditions? (e.g. income, employment, education, food security, transportation, housing, access to services)					
5. I explore with patients how <i>stress, trauma, and recurrent adverse life experiences</i> have potential impacts on their disease outcomes.					
6. I advocate for social resources that are key for my Indigenous patients.					
<b>Culturally Informed</b>					
7. I am knowledgeable about Indigenous healing traditions.					
8. *I am skilled at eliciting patients' use of and preferences for culture-based healing methods.					
9. *I am skilled at providing culturally sensitive patient education and interventions.					
<b>Facilitating Relationships</b>					
10. *I am aware of my own cultural and professional identities.					
11. I am an effective communicator with Indigenous patients.					
12. I employ cultural factors in my approach to building a therapeutic relationship with Indigenous patients.					
<b>Addressing Inequity</b>					
13. *I am knowledgeable of the impact of racism and prejudice in healthcare experienced by Indigenous populations.					
14. *I am aware of my own stereotypes of Indigenous peoples.					
15. I have an understanding of colonization and its impact on Indigenous health outcomes.					

**Comments:**

**Appendix H. General Internal Medicine Retreat Questionnaire**

Reflecting on Digital Stories & potential for change in practice:

1. Reflecting on the digital stories, what events or factors do Indigenous women face that contribute to the health challenges they experience?
  - a) Were any of these events or factors a surprise or new to you? If so, please explain.
  - b) What events or factors do you feel you could address in your interactions with Indigenous patients? How would you do so?
  - c) How did you address these events or factors in your practice before you viewed the digital stories?

2. Which of the stories resonated most with you?

- 1) Fragmented by Maxine
- 2) Broken Trust by Beatrice
- 3) Secrets Revealed by Sheryl
- 4) Living Our History by Dorothy
- 5) Tuq&urasiit by Tanya.

a) Why was this/these stor(ies) effective for understanding Indigenous women's health?

b) Was there any specific information in the presentation or digital stories that made you reflect on your attitudes, choices, and understandings towards adopting clinical and service practices that are culturally safe? If so, please explain.