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Sexual Health: Engaging Urban Indigenous Youth.

by

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The undersigned certify that they have read, and recommended to the Faculty of Graduate Studies for acceptance, a thesis entitled “Sexual Health: Engaging Urban Indigenous Youth” submitted by Alanah Woodland in partial fulfillment of the requirements for the degree of Master of Science.

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Abstract

The disproportionately high prevalence of STIs among Indigenous youth, especially the increasing incidence of HIV/AIDS infection, is alarming and suggests that current measures are inadequate. A qualitative study that embraces Indigenous approaches to inquiry explores the sexual health perceptions and experiences of urban Indigenous youth. Semi-structured interviews were conducted with a non-probability sample of Indigenous youth aged 18 to 24. The primary outcomes are thematic descriptions of unique structural and social barriers to sexual health raised by Indigenous youth that include their insights into developing sexual health promotion programs relevant to urban Indigenous youth. It concludes with a comparison of the themes to the published literature concerning the sexual health concerns of Indigenous youth highlighting the unique experiences of racism, acculturation, and colonialism forwarded in discussion as critical barriers. The results necessitate a broad and multi-faceted ecological approach to meeting the sexual health needs of Indigenous youth.

Dedication

I would like to dedicate my work to Indigenous youth, especially those who graced me with their trust and enriched my life with their stories.

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I will tell you something about stories,

[he said]

They aren't just entertainment.

Don't be fooled.

They are all we have, you see,

All we have to fight off illness and death.

You don't have anything

if you don't have the stories.

-Leslie Marmon Silko, *Ceremony*

CHAPTER I: INTRODUCTION

The Researcher

I am an Indigenous woman. My father is N'kuktsa (Stl'atl'imx) with rumours of ties to other Indigenous peoples. My mother is Irish and English. As a youth, I struggled to find my identity living within a Caucasian family in Caucasian neighbourhoods. My childhood held moments of confusion as I dealt with the racism from both trusted and nameless faces. At the age of 12, for both personal and family reasons, I decided to leave my home and in doing so became a runaway, a drop out, and another statistic. For the next couple of years I chose to align myself with the troubled youth of the local First Nations communities and, through my experiences, I learned firsthand of all the lingering repercussions of colonialism. In this time, however, I also learned about the humour, the strength, and the unwritten proud and rich histories of the first peoples of the land now called Canada. On the periphery of my circle of friends I saw glimpses of healthy First Nations families immersed in their cultures and communities. It was during this tumultuous time that I began to accept my heritage, abandoning ignorance-induced shame to embrace knowledge and its successor, confidence.

Motivated to learn more about my history and myself, I continued to seek connections with various Indigenous communities, including my own. Through my homecoming to my Indigenous community and as a guest of Indigenous communities around the world, I have been privileged to feel welcomed into

many Indigenous communities. My connection to Indigenous communities underlies my commitment to the health of Indigenous peoples.

My interest in sexual health came about quite by accident but quickly revealed its importance. It began as a class project on HIV/AIDS and developed into a concern for the sexual health of Indigenous youth. Motivated by a dearth of literature addressing the sexual health of Indigenous youth, the absence of Indigenous methodologies in those few that existed, and the voices of several Indigenous people I met at an international AIDS conference, I embraced sexual health as work I would do for my thesis. My hope is that my work in sexual health will contribute to the larger efforts of those long committed to ensuring the healthy futures of Indigenous peoples.

Background

It is well documented that Indigenous people of Canada have a poorer health status than the general population of Canada. Long-term effects of colonialism and racism have resulted in inequities in income, education, social support, work environments and physical environments that perpetuate systematic health disparities (Adelson, 2005; Kelm, 1998; Royal Commission on Aboriginal Peoples, 1996b; Young, 2003). Waldram, Herring and Young (2006) offer the following: “Long considered to be the most disadvantaged group in an otherwise affluent society, Aboriginal people today paradoxically experience the kinds of

health problems most closely associated with poverty, problems linked to their historical position within the Canadian social system" (p. 3). The disparities of sexual health evident in sexual transmitted infection statistics are one example of health disparities. Statistics indicate that the number of lives affected by STIs is increasing. HIV, the human immunodeficiency virus, is the most notorious of the sexually transmitted infections and is a precursor to the fatal acquired auto immunodeficiency syndrome (AIDS) (Public Health Agency of Canada, 2004; Canadian Aboriginal AIDS Network, 2000; Health Canada, 2005). In 1998, 18.8% of positive HIV tests that reported ethnicity were within the Indigenous population. In 2003, the number increased to 25.3% (Public Health Agency of Canada, 2005). As the holders of the political, cultural, social, economic and reproductive future of Indigenous peoples the health of youth is of primary concern. Yet, youth represent 31% of positive HIV tests within the Indigenous population (Public Health Agency of Canada, 2005). These statistics may be inadequate since ethnicity is reported in only 27% of HIV tests (Public Health Agency of Canada, 2005) . Furthermore, statistics are arguably often culturally inappropriate (Smylie, Anderson, Ratima, Crengle, & Anderson, 2006). Still, the increasing incidence of HIV within this measurement system provides insight into an impending epidemic within Indigenous communities, especially among youth.

The research described in this thesis explored the sexual health perceptions and experiences of urban youth, who comprise approximately 50% of the Indigenous

youth in Canada. The research was conducted in a manner that embraced Indigenous research principles.

This chapter outlines the current literature on sexual health within the Indigenous population – focusing on youth. It highlights the paucity of literature and the need for a qualitative and Indigenous approach, and it continues on to describe the conceptual framework and strategies of inquiries that guided the research project.

Terminology

Indigenous People

Aboriginal is defined as “having existed in a region since the beginning; it is also often used when referring to Canada’s Indigenous peoples collectively (Pickett, Pritchard, & Leonesio, 2000). Canada’s original people have been assigned the label “Aboriginal” and have been categorized into legally defined subgroups: North American Indian (Status and non-status), Métis, and Inuit. However, despite these imposed groups, each subgroup represents diverse people differing in geography, social structures, language, and culture but who share histories of colonisation and complex relations with the government (Royal Commission on Aboriginal Peoples, 1996a; Frideres & Gadacz, 2005). Diversity is further increased when issues of identity enter the discussion. Identity, in particular Indigenous identity, is a complex and contentious issue (Peroff &

Wildcat, 2002; Weaver, 2001; Yellowbird, 1999). As such, individuals may choose to identify with any multitude of labels that have occurred since colonial contact or with their individual nation (e.g., Blackfoot). Some Indigenous people reject imposed labels such as Aboriginal and instead adopt the term Indigenous. As Smith (1999) explains, 'Indigenous people' is a relatively recent term which emerged in the 1970s out of the struggles primarily of the American Indian Movement (AIM), and the Canadian Indian Brotherhood. It is a term that internationalizes the experiences, the issues and the struggles of some of the world's colonized peoples" (p. 7). Jose R. Martinez Cobo, the Special Rapporteur of the Sub-Commission on Prevention of Discrimination and Protection of Minorities (1993), offers a working definition as follows:

> Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system.
>
> This historical continuity may consist of the continuation, for an extended period reaching into the present of one or more of the following factors:
>
> Occupation of ancestral lands, or at least of part of them;
>
> Common ancestry with the original occupants of these lands;

> Culture in general, or in specific manifestations (such as religion, living under a tribal system, membership of an Indigenous community, dress, means of livelihood, lifestyle, etc.);
>
> Language (whether used as the only language, as mother-tongue, as the habitual means of communication at home or in the family, or as the main, preferred, habitual, general or normal language);
>
> Residence on certain parts of the country, or in certain regions of the world;
>
> Other relevant factors.
>
> On an individual basis, an Indigenous person is one who belongs to these indigenous populations through self-identification as Indigenous (group consciousness) and is recognized and accepted by these populations as one of its members (acceptance by the group).This preserves for these communities the sovereign right and power to decide who belongs to them, without external interference (p. 7).

In this paper the term Indigenous will be used to refer to original peoples of Canada.

Sexual Health

Sexual health may be defined differently by communities, cultures, and individuals; however, the Pan American Health Organisation (PAHO), the World Health Organization (WHO) in collaboration with the World Association for Sexology (WSA) presented a united definition in their publication *Promotion of Sexual Health Recommendations for Action* (2000):

> Sexual health is the experience of the ongoing process of physical, psychological, and sociocultural well being related to sexuality. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. It is not merely the absence of dysfunction, disease and/or infirmity. For sexual health to be attained and maintained it is necessary that the sexual rights of all people be recognized and upheld (p. 6).

Literature Review

This review draws on the literature pertaining to understanding the sexual health of Indigenous peoples of Canada, particularly that of youth.

An analysis of the literature includes an overview of sexual health research concerning the Indigenous population, an exploration of the role of STIs, and an examination of the relationship between sexual health and STIs, barriers and facilitators. It concludes with a conceptual framework that guided the understanding of the factors affecting the sexual health of urban Indigenous youth for the project.

Existing Sexual Health Research

The review of existing literature on sexual health of Indigenous people was found to include two distinct types of literature speaking to the sexual health of

Indigenous youth. The first set of studies take a primarily positivist approach to examine and quantify the disease and dysfunction in the Indigenous population. Second set of studies employs both quantitative and qualitative methodologies incorporating non-positivist approaches to understand the sexual health needs of Indigenous peoples.

A recent study by Young (2003) reviews published peer reviewed literature from 1992 to 2001 focused on health of Indigenous peoples in Canada. In the 254 articles found, examined, and categorised, the research fails to include the Indigenous population as a whole: the Métis and urban population are both severely underrepresented; and key health issues such as rehabilitation, injuries, social determinants, and smoking are mostly ignored. Young's (2003) findings are also mirrored in the dearth of research focused on understanding the factors affecting the sexual health of Indigenous youth. A search[1] yielded only 14 relevant articles that address Indigenous peoples and sexual health. The majority of studies come from a positivist approach that highlights the quantitative aspects such as the prevalence or incidence of sexually transmitted disease. Although prevalence and incidence statistics contribute to understanding the magnitude of the sexually transmitted infection load, they lack the rich and dense data that

[1] I conducted a series of searches from January 2006 to March 2007 using Medline, PubMed, Wilson, Google scholar and Academic Premier databases using the following search criteria: sexual health; HIV; AIDS; sexually transmitted disease; Indigenous synonyms (Indian, native, aboriginal, Métis, and Inuit) and the dates 1992 –2007.

contributes to understanding the interwoven factors in the lived experience (including cultural and social factors) necessary to intervene with effective health promotion measures.

Of the documents found, only six focus on Indigenous youth. The first two include a study of Indigenous youth who inject drugs and a study of young men who have sex with men. Neither of these studies focuses on obtaining the youth perspective or Indigenous communities' perspectives. The remaining four studies that incorporate the voices of Indigenous communities are discussed.

Tenuous Connections (Ontario Federation of Indian Friendship Centres, 2002) is a comprehensive study that examines the relationship between sexual health and Indigenous teen pregnancy through focus groups, interviews, and questionnaires with the parents of the teens, front-line workers and grandmothers. The study focuses on topics related to pregnancy, such as sexual practices and contraception, but also includes broader topics like sexuality and sexual health. The study recognises the unique environments of urban centres and draws its sample from an urban Indigenous youth population. The report concludes with recommendations to address teen pregnancy and sexual health issues of urban Indigenous youth.

A US national study, *National Native American AIDS Prevention Center Needs Assessment: Focus Groups Series on Young Native Adults and Sexual Health*

(Satter, Zubiate, & Gatchell, 2003) used focus groups to assess the sexual health knowledge and needs of Indigenous youth of America. It included Indigenous youth from reserve, rural, and urban areas. The study asked seven questions in each of the focus groups to explore the following areas: age of first sexual intercourse; drug use; drug use and its relation to sex; violence; sexual identity; and sexual education.

An unpublished study was discovered in discussions with other academic researchers. The study "Strengthening and Building Sexual Health of Aboriginal Youth and Young Adults" (Hampton, Jeffrey, McWatters, & Farrell-Racette, 2004b) uses a mixture of qualitative and quantitative methods in collaboration with the community, to assess the sexual health knowledge and determine the sexual health needs of "invisible" Indigenous youth in Regina, Saskatchewan. The study focuses on understanding the barriers to sexual health services from both the providers and youth perspective.

The study "HIV Risk, Systematic Inequities and Aboriginal Youth: Widening the Circle for HIV Prevention Programming" (Larkin et al., 2007) was published during my data collection in April 2007. It focuses on an Indigenous participant subset from the larger study Gendering Adolescent AIDS Prevention (GAAP) project that uses focus groups in Toronto, Ontario to explore youth perceptions on HIV/AIDS. Larkin et al., (2007) explores and emphasises the marked differences between Indigenous and non-Indigenous participants' understanding

and perception of HIV/AIDS. They find that Indigenous youth solely demonstrated internalised racism in their transfer of fault to Indigenous communities. Additionally, they were unique in their identification effects of colonialism as factors in the prevalence HIV/AIDS in their communities.

The “Tenuous Connections “ (Ontario Federation of Indian Friendship Centres, 2002) study furthers the understanding of teen pregnancy and explores sexual behaviour among Indigenous youth in Ontario. Satter, Zubiate and Gatchell (2003) provide insight into sexuality, sexual behaviours, and sexual knowledge of Indigenous youth. Hampton, McWatters and Farell-Racette (2004b) and Tenuous Connections (Ontario Federation of Indian Friendship Centres, 2002) studies have incorporated the context and complexities of urban settings into their studies. This final study encourages us to incorporate and address larger societal and structural inequities including the role of colonialism in developing sexual health programs for all youth (Larkin et al., 2007). To our knowledge, no previous studies have been done with the Indigenous youth of Calgary. The research described in this thesis builds on the studies that incorporated Indigenous community perspectives, but it is clear that there is insufficient research to fully understand the sexual health needs of Indigenous youth in general, in Calgary or in other cities.

Rates of STIs

STIs, especially HIV/AIDS, are a concern among Indigenous communities (Canadian Aboriginal AIDS Network, 2001; Canadian Aboriginal AIDS Network, 2001). HIV, much like other sexually transmitted infections, is not equally distributed; data suggest that Indigenous people are overrepresented with respect to HIV when compared to the general Canadian population (Canadian Aboriginal AIDS Network, 2000; Public Health Agency of Canada, 2005; Canadian Aboriginal AIDS Network, 2001; Canadian Aboriginal AIDS Network, 2001). Studies have shown that Indigenous youth are at greater risk of contracting STIs than other segments of the Indigenous population, as well as being at greater risk than non-Indigenous youth. Indigenous youth between 15 and 29 years old represent 31% of positive HIV tests within the Indigenous population (Public Health Agency of Canada, 2005). Indigenous peoples are also becoming infected with HIV at younger ages than in the non-Indigenous population (Public Health Agency of Canada, 2005; Canadian Aboriginal AIDS Network, 2000). The Indigenous youth reported to be at highest risk of contracting HIV are injection drug users; however, youth not involved in injection drug use nevertheless constitute a large proportion of the new HIV infections in Indigenous youth (Canadian Aboriginal AIDS Network, 2000; Public Health Agency of Canada, 2004). Although some of the statistics can be attributed to a younger demographic, in excess of 60% of the overall Indigenous population is

under 30 (Health Canada, 2004). Thus, there are obviously other factors affecting the sexual health of Indigenous youth.

Urban Indigenous Youth

The 2001 Canadian Census reported that greater than 49% of the identified Indigenous population live in urban areas. This number has risen to 54% in 2006 (Statistics Canada, 2002; Statistics Canada, 2008). Additionally, some of the population may move to an urban centre for short periods to pursue education, to find employment, or to access health services, yet may not indicate the urban centre as their place of residence. The Indigenous population in urban areas reflects the same youthful demographics found in the overall Indigenous population (Statistics Canada, 2008). Although the urban environment may offer more social and health services, it may pose deficiencies of a different nature affecting the health of Indigenous youth.

Wilson and Rosenberg (2002) speak to the negative emotional and psychological effects of decreased access to traditional activities, loss of identity, and separation from the land that overshadow the increased access to services and marginally improved socio-economic status of the urban Indigenous population. Indigenous youth in urban environments may have different factors contributing to their health than their counterparts living on reserve or rural Indigenous communities (Royal Commission on Aboriginal Peoples, 1996b). Furthermore,

the presence of services does not guarantee that Indigenous youth are accessing them. It is essential to listen to urban Indigenous youth (Ontario Federation of Indian Friendship Centres, 2002) and to explore their perceptions of what processes, systems and experiences contribute to their sexual health and to discover ways to support them through health promotion interventions.

Barriers and Facilitators of Sexual Health

Barriers

There are specific barriers to sexual health and unique risk factors for Indigenous youth, which may render them vulnerable to STIs and sexual health issues. These barriers may be found at the level of the individual, family, community or society and may be grounded in structural (historical, cultural, political or socio-economical) or social capital aspects of health.

As individuals, young people may have cognitive and developmental barriers to sexual health. Psychological and developmental theories suggest that youth may still be lacking the skills needed to make decisions, engage in negotiation, or problem solve to make healthy choices in regards to their sexuality (Gunatilake, 1998). Arnett (2000) asserts that youth through the ages 18 to 25, although technically adults, are still establishing their identities. Since, sexuality, gender identity, sexual preference, and self-image are in their formative stages, youth are more likely to be experimental (Gunatilake, 1998; Perrin, 2002).

The majority of the literature is focused on the individual behaviours and also the individual barriers as they pertain to sexual health, however, the social, cultural, historical , and political context must also be addressed (Larkin et al., 2007; Hampton et al., 2004b; Hampton, Bourassa, & McKay-McNabb, 2004a; Shoveller, Johnson, Langille, & Mitchell, 2004). Youth who experience sexual and physical violence are at greater risk of engaging in sexual risk taking behaviours. Voison (2005) conducted a study to assess the relationship between exposure to violence and HIV risk taking behaviours. The findings suggest that youth exposed to violence or sexual abuse, are more likely to engage in higher sexual risk taking behaviour. A history of colonialism which has resulted in high suicide rates, substance abuse, domestic violence and sexual abuse in Indigenous communities, suggests that Indigenous youth have more risk factors and fewer resources than non-Indigenous youth (Bartlett, 2003; Hampton et al., 2004a; Kirmayer, Simpson, & Cargo, 2003; Royal Commission on Aboriginal Peoples, 1996a; Trovato, 2001). The Alberta Alcohol and Drug Abuse Commission participants (2006) study of high school youth assessed risk and protective factors relevant to substance use in grade 7-12. The study cites an average of 7.1 risk factors in Indigenous participants compared to 5.5 in non-Indigenous.

Economic barriers, social issues, the residential school experiences of the parents, including sexual abuse, may render the home environment an unlikely

place to receive adequate information about sexual health. One author argued that Indigenous youth may be more apt to be in social and physical environments that restrict preventative care activities; they may not enjoy the social support to access the preventative services nor be part of an family or community that communicates messages about health (Benjamins, Kirby, & Bond Huie, 2004). As the lives of rural Indigenous youth develop, some are transitioning between on-reserve areas and urban areas while seeking employment or educational opportunities (Canadian Aboriginal AIDS Network, 2000), which may increase their risks as they move away from their social supports. Bartlett (2003) also argues that the "stress phenomenon" that comes from a continued history of living in cultural conflict and cultural oppression negatively contributes to health of Indigenous peoples. An urban environment with more interactions with non-Indigenous cultures may pose more opportunity for cultural conflicts. Hampton, McWatters and Farell-Racette (2004b) identified environmental factors, awareness of services, lack of appropriate services, and the sexual health knowledge of youth as barriers to the sexual health of Indigenous youth in Regina. The risk factors associated with being Indigenous, a youth, and urban are compounded in the lived experience of the urban Indigenous youth.

Facilitators

The extant literature does not focus on facilitators and protective factors of sexual health. However, education, involvement in cultural or mentoring programs, positive and supportive home environment and community with high levels of

self-determination have positive associations in other areas of health. The positive aspects of health determinants, such as advanced education, stable and satisfactory socio-economic positions that include income and employment, inclusive social environments, adequate housing and transportation, and access to health services, are recognised as protective factors (Shapcott M., 2004; Hutchinson & Stuart, 2004a). Recreation and community involvement are included, especially for youth in the Ryerson-Wellesley framework (Hutchinson & Stuart, 2004b). Recent literature has identified linkages between social capital and structural inequities emphasizing the importance of larger ecological factors in the health of Indigenous youth (Adelson, 2005; Ahern, Hendryx, & Siddharthan, 1996; Hampton et al., 2004a; Hendryx, Ahern, Lovrich, & McCurdy, 2002; Larkin et al., 2007).

Local control factors in addition to the restoration of cultural traditions are associated with positive health outcomes (Chandler & Lalonde, 1998; Kirmayer et al., 2003). Chandler and Lalonde (1998) highlight the importance of culture and local control to the well-being of youth in a study of suicide among British Columbia First Nations communities; an association was found between the presence of what they label as “cultural continuity”, and a lower suicide rate. Those communities with elements such as self-government, control over education and cultural facilities had significantly fewer suicides (Chandler et al., 1998). Kirmayer (2003) argued that these elements are more reflective of local control than of cultural continuance but agrees to the relationship to positive

health outcomes. Recently, Lalonde (2006) has forwarded culture continuance as a component of the collective resilience of Indigenous communities. Cultural continuance is identified as the process of establishing and maintaining a strong collective cultural identity. Lalonde argues that it positively affects Indigenous youths' cultural identity and acts as vehicle to foster their resilience. The study completed by Myers et al., (1999) conceives culture in terms of transmission of knowledge in the form of teaching and guidance as it pertains to sexual health. The studies by Chandler and Lalonde (1998) and Lalonde (2006) view cultural continuance in a context of community controlled structures wherein a community has the ability to influence its local environment and engage daily with elements of their own culture. Although the understanding of culture is variable between studies, as is its validity of application at the individual or community levels, there is consensus among the studies as to the benefits to Indigenous health.

Health Promotion

The Ottawa Charter for Health Promotion (1986) states "health promotion is the process of enabling people to increase control over, and to improve, their health." The vehicles for achieving the goals of health promotion are vast. They are often reflective of the Ottawa Charter's list of actions for health promotion, and they may include interventions on an individual, community or population level. Examples include addressing social determinants of health, developing personal

skills, health marketing, educational programs, policy change, creating the environment for health, and social activism. The types of health promotion discussed in the current literature regarding the sexual health of Indigenous youth is limited in scope; the studies found focus primarily on critiquing health marketing and educational programs. The limitations of the studies may reflect the limitations in the scope of health promotion measures currently employed to achieve sexual health of Indigenous youth or merely a limitation on the published literature. Regardless, indicators suggest that current sexual health promotion interventions are failing to reach urban Indigenous youth. Majumdar, Chambers and Roberts (2004) highlight the lack of appropriate and culturally relevant sexual health promotion strategies for Indigenous youth. A thorough study conducted by the Canadian Aboriginal AIDS Network (2004) found current HIV prevention messages are not directed and are not delivered in a culturally competent manner to Indigenous youth. The findings of Pedlow and Carey (2004) suggest current HIV prevention messages and sexual health initiatives may not be appropriate to the developmental age of youth. Clarke, Friedman and Hoffman-Goetz (2005) found English Indigenous-directed mass print media often included an aspect of culture and spirituality in its portrayal of people living with HIV/AIDS, but was most often not inclusive of the youth and women.

STI statistics and the literature both indicate Indigenous youth are at increased risk of HIV infection and other STIs; however, the current sexual health measures have thus proven insufficient to reach them. The works of Larkins et al. (2007)

and Hampton et al. (2004b) implicate larger contextual issues as critical factors in the sexual health of urban Indigenous youth. The dominant public health discourse of disease is insufficient and incomplete to address issues such as colonialism, culturally safe and cultural competent health care, and community healing.

Conceptual Framework

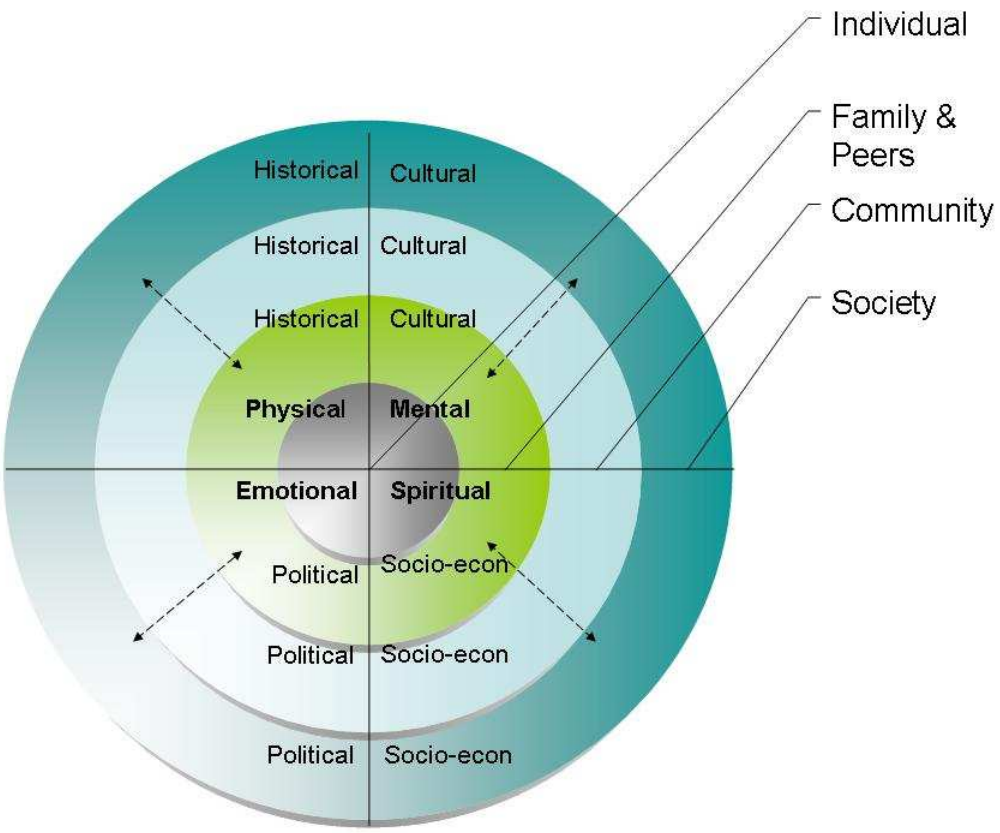

Figure 1: A Sexual Health Framework

The proposed sexual health framework recognizes that sexual health is influenced by the complex socio-ecological interactions that marry social strata such as peers, family, community and society with structural factors such as socio-economics, politics, culture and history.

My proposed framework graphically illustrated in Figure 1 is designed to guide an understanding of sexual health of urban Indigenous youth that incorporates a more ecological approach than traditional biomedical individualism (Fee & Krieger, 1993). The framework intertwines Bronfenbrenner's (1979) ecological model, the four components of health (mental, physical, emotional, and spiritual) commonly accepted by Indigenous communities (TenFingers, 2005), and Weenie's (1998) diagram illustrating the forces that shape a child. My model reflects a merging of Bronfenbrenner's(1979) and Weenies' (1998) models . Weenie's (1998) model offers the introduction of culture, history, politics and socio-economics as the critical aspects in the health and development of the indigenous child. She does not however approach her model from an ecological systems perspective. The absence of systems approach does not permit the consideration of the macro, meso and micro systems or provide the constructs to address the interactions between multiple layers of society (individual, family, community, society). Brofenbrenner's (1979) systems approach to health , however, doesn't focus on key and central aspects such as culture and politics but regards them as distal contributors in the peripheral macrosystem influencing overall health and development. Furthermore, Bronfenbrenner's (1979) model

more directly applies to a child living within a singular culture not recognizing that multiple opposing environmental factors may be at play within the developmental environment of a child. In my model, I align myself with Weenie (1998) in her assertion that culture, history, politics and socio-economics are the four critical determinants of health development of a child. However, I also introduce a focus on the interplay between the layers of society in those four specific critical elements within an ecological systems framework.

In Figure 1 each interlaid circular strata is a subsystem that begins with society and ends with individuals within the larger global environment. As conceptualized in Bronfenbrenner's theory (1979) this layering of circles illustrates that the sexual health of individuals is dependent on distal and proximal factors found in the family, community, society and vice-versa. The use of arrows in between the circles acknowledges the interplay or 'bi-directional influences' within health systems, (Bronfenbrenner, 1979) especially between individuals, families, communities and societies.

In alignment with Bronfenbrenner (1979) the centre of the framework is the individual and her interaction with her surroundings, however it adopts an Indigenous concept of health in its explicit inclusion of the spiritual, mental, emotional and physical aspects of health (Bronfenbrenner, 1979; TenFingers, 2005). These four aspects of health are a central tenet not only to the individual but radiate out to all other layers or subsystems of society.

In Weenie's (1998)*Sacred Circle Concept*, the diagram of *The Forces that Shape a Child* illustrates history, culture, social-economics, and politics as core influences in health and development. A parallel ideology is expressed in *The Way of the Pipe: Aboriginal Spirituality and Symbolic Healing* (Waldram, 1997b; Waldram, 1997a) where culture and history are viewed as key influences of health. Similarly, Anderson (2007) discusses the models of Turell and Mathers (2000) and Berkham and Glass (2000) in his assessment of their applicability to the social determinants of Indigenous health, and he highlights the necessity of the inclusion of both structural and social factors such as government policy, socio-economics, social capital and culture.

My framework asserts that health is both relationally and structurally dependent, and that social cohesion and societal structures are interrelated. The dependence of social cohesion demonstrated through each concentric circle of societal strata is coupled with structural factors: politics, socio-economics, culture and history. In the framework history, politics, culture and socio-economic status are core components of sexual health. As such, the framework includes the constructs culture, history and politics and socio-economic status in each stratum and the relationships between them as integral components. The distinct separation of culture, history, socio-economics, and politics in each stratum recognises that the relationships may be incongruent (<-,->) compatible(<-,<-) or competitive(-><-) .

Politics, in the sexual health framework includes both government and governance at all levels. For example it may include the role of community leadership, school board policy, or decisions and policies of national bodies such as the federal government. Historical components of health are present in each layer of society and cross layers to include the lifespan of the individuals, communities and society as a whole (Thurston & Vissandjee, 2005). Culture although arguably not well understood as a social determinant (Thurston et al., 2005), is included in the framework. Unlike other models where culture is ambiguous (Anderson, 2007), culture is integral to each layer of society to acknowledge the independent role of culture in the lives of individuals, families and communities but also to accentuate intersections that occur between each layer. The cultural components in and between each layer are present to illuminate the way the participants discuss and experienced the role of culture in sexual health. Socio-economic status is a well established determinant of health (Lipowicz, Koziel, Hulanicka, & Kowalisko, 2007; Hahn et al., 1995; Krieger, 1993; Krieger, Chen, & Selby, 2001); it affects the relationships between the individual, family, and community and is influenced by national and international policy (Labonte, 1998; Navarro & Shi, 2001). Each of culture, history, politics, and socio-economics exists independently within the framework, but these factors are likely to intersect and influence each other. The framework includes gender as a construct of culture, history, socio-economics and politics further shaped by the relationship and interactions between the layers of society. The framework is ideologically focused on culture, history, politics and socio-

economics in its use as a tool for the exploration of the factors influencing sexual health.

This adopted framework serves only to provide a structure to understand and organise the issues raised in the research. The perception and voice of the youth have precedence over the framework. As such, the youth and their experiences will direct the emphasis in the results on the micro, meso or macro level factors.

Summary of Literature Review

Statistics and the limited literature paint a bleak picture of sexual health within the Indigenous youth population; however, we must also take into consideration that a legacy exists where research focuses on the negative aspects of the health of Indigenous peoples (Kelm, 1998). A focus on disease and assumed deficiencies at the individual and community levels reinforces stereotypes and overlooks disparities (Reid, Robson, & Jones, 2000). This practice precludes the likelihood of the adoption of appropriate and necessary system level interventions. Hampton M. et al., (2004b) and Larkin et al., (2007) suggest that lived experience, sexual health perceptions, and subsequent sexual health needs may be different or, if similar, may need to be approached differently. There are known facilitators, as well as barriers, that influence sexual health in multiple levels of society yet little research was found that explored how Indigenous youth view their sexual health.

Research Question

Purpose

The research aims to explore the participants' primary sexual health concerns and their perceptions of the factors affecting the sexual health of urban Indigenous youth.

Research Questions

1. How do participants define sexual health?
2. Do urban Indigenous youth have sexual health concerns. If so, what are they?
3. What factors do participants perceive or experience as affecting the sexual health of urban Indigenous youth?
4. What do the participants express as the key sexual health issues of urban Indigenous youth?
5. What do participants perceive as the effect of being two-spirited on sexual health?
6. What do participants believe are the key components required for a sexual health promotion strategy that targets urban Indigenous youth?

CHAPTER II: STUDY DESIGN AND METHODS

This chapter of the thesis will discuss the chosen methodology, an Indigenous qualitative approach. The philosophical underpinnings of this approach are discussed first followed by sampling procedures and recruitment strategies, data collection methods, data analysis methods, validation and reliability strategies, and ethical considerations.

Indigenous Qualitative Methodology

I adopted an Indigenous approach in that I sought to follow the recommendations made by Indigenous communities and scholars in the design and use of qualitative methods, and in the use of Indigenous practices including following ethical principles. Qualitative methods of inquiry were used because, as Struthers (2001) argues, study methods which embrace narratives, oral tradition or phenomenology are more attuned to Indigenous epistemologies and more able to capture Indigenous lived experiences. The theories of qualitative research are in alignment with a philosophical constructionist foundation (Creswell, 2003). Constructivism asserts that reality is social constructed and is experienced differently by individuals; the individual is not merely a passive observer but is actively engaged in shaping her reality (Creswell, 2003). Furthermore, a qualitative study relies upon participants' experiences and perceptions to generate theories (Creswell, 2003).

Indigenous Research

Indigenous research has no single definition or set criteria but includes the adherence to ethical conduct, the use of culturally competent methods, the privileging of Indigenous voices, and the movement towards empowerment wherein the primary beneficiaries are Indigenous communities (Porsanger, 2004; Rigney, 1999; Smith, 1999; TenFingers, 2005; Wilson, 2003b). Rigney (1999) suggests that "Indigenous research is research by Indigenous Australians whose primary informants are Indigenous Australians and whose goals are to serve and inform the Indigenous struggle for self-determination" (p. 118). Smith (1999) proposes an Indigenous research model wherein all research is focused on moving to the ultimate goal of self determination through interconnected phases of survival, recovery and development by efforts directed at healing, decolonisation, transformation and mobilisation. Kaupapa Maori practices, the way in which a Maori researcher is wise to conduct herself, is outlined by Smith (1999) to include respect, listening, generosity, community presence, humility, caution and protection of a person's sacred power or essence. Steinhauer (2002) quotes Martin's list of the main components of Indigenous research which include the recognition of the Indigenous worldview, an inclusion of social, historical and political context, honouring the social and cultural attitudes and traditions, privileging Indigenous voice and experience, and identifying and re-focusing on issues of importance to Indigenous people. Dr. Marlene Brandt-Castellano gave a talk at University of Calgary in 2006 in which she asserted that all research with

Indigenous people needs to be respectful, responsible, relevant, and reciprocal; a premise paralleled in Steinhauer's (2002) paraphrasing the personal words of Weber-Pillwax, igniting researchers to ensure their research is guided by respect, reciprocity and relationality.

Indigenous research is often tasked with not only incorporating the appropriate Indigenous protocol but also maintaining a mindset that allows the merging of the Indigenous worldview with that of dominant society (Wilson, 2003b). For example, in earlier phases of Indigenous research, Wilson explains that Indigenous research is permitted to provide a voice and direction of Indigenous peoples but still must adhere to epistemology and methodology of dominant society to be recognised as valid. In efforts to be recognised as valid during its development, Indigenous research has borrowed arguments and methodology from feminist theory and methodology (Rigney, 1999; Wilson, 2003b). Although Indigenous peoples' concerns may be more of racism and colonialism than sexism (Rigney, 1999), the discourses merge in their focus on non-oppressive and inclusive methods. Ethical conduct is fundamental in Indigenous research; as such, it is rooted in respect, collaboration, collective and individual consent, relevance, and reciprocity (Brandt-Castellano, 2004; Canadian Institute for Health Research, 2005; Ten Fingers, 2005; Weber-Pillwax, 2001). The community is integral in the development of the question, the conduct of research, the analysis of the data, the dissemination of the knowledge gained (Ten Fingers, 2005) and the implementation of appropriate follow-up action. As

put forth by the various previously mentioned Indigenous scholars, Indigenous research is more than a prescribed methodology or rigid protocol, rather it is a way of interacting and engaging in a respectful and ethical manner that is ultimately focused on the needs and culture of the community.

As Ten Fingers (2005) writes, " In order to move beyond the legacy of colonialism and its effects on meaningful research, Indigenous methodologies must be utilised in all research involving indigenous people and our territories" (p. S62). Although not explicitly stated, this will include urban environments with a heterogeneous composition of Indigenous peoples. This study falls within what Wilson (2003b) refers to as the fourth stage of the Indigenist research paradigm wherein the research does not adhere to nor is it confined to any pre-existing or predefined methodology but rather focuses on developing a method and procedures appropriate to the community to answer or even develop the research question. The research described in this thesis was guided to respect the voices and the worldviews of the youth. It focuses on the empowerment of the Indigenous youth as individuals to explore their sexual health; to understand the factors affecting their sexual health; to identify and assert their sexual health concerns; and to provide an opportunity wherein the youths can identify directions for future research in a movement towards self-determination. It was research conducted in a manner that was ethical from the Indigenous communities' perspectives.

The study adhered to the following principles of research with Indigenous communities: a) collaboration-- which included seeking partnership with the Elbow River Healing Lodge; b) appropriate consent-seeking and consulting with community leaders; c) respecting the research participants and their ways of knowing; d) validating the research relevance by ensuring the research was of benefit to the larger community and worthwhile to the participants, and lastly; e) ensuring results and findings were followed through with responsible actions by the researchers (e.g., dissemination and knowledge exchange) (Piquemal, 2000; Brandt-Castellano, 2004; Canadian Institute for Health Research, 2005).

These axioms were adhered to as follows:

a) I formed a partnership with the Elbow River Healing Lodge, a local Indigenous health organisation; it provided professional services and the staff informed suitable patients of the study. The researcher talked to several staff about her study and its implication as well as provided a summary report.
b) I obtained consent from the Aboriginal Health Council as a form of collective community consent and was also open to receiving their direction during our meeting;
c) The focus of study was the experience and perceptions of the participants;
d) To respect gender differences, each participant was offered the choice of a female or male interviewer. I recruited an Indigenous male

undergraduate student who had some previous experience with qualitative interviews to be an alternate interviewer; however, no participant requested an alternate interviewer.

e) The study provided a safe place for Indigenous youth as individuals to reflect on the factors affecting their sexual health and to identify their sexual health concerns. The interviews were conducted in private rooms or in the participants' homes.

f) As an exploratory study the data may be of more theoretical than practical value; however, I have provided a verbal and written summary report to the Calgary Sexual Health Centre and I gave a follow-up presentation to the Calgary Aboriginal Health Council on Feb 20, 2008. I will continue to share summary reports with relevant Indigenous communities and health providers. The preliminary findings of the study were shared with the participants via email and participants were asked for input and concurrence. I hosted an informal follow-up forum on the sexual health of Indigenous youth with the support of the Mount Royal College Native Centre and Calgary Sexual Centre on Feb 13, 2008 to share results, explore future steps, and offer the opportunity for youth to have their sexual health questions answered (see Appendix B).

g) As the primary researcher, I entered the interviews with respect and a sense of responsibility. In most cases, a relationship emerged between the participant and me; my respect for the participant and sense of responsibility to them conveyed during my introduction of myself facilitated

our ability to engage in the conversation as equals. Furthermore, individual semi-structured interviews allowed participants to talk openly and freely and to focus on their concerns, rather than on the research questions per se.

Methods

Sampling

Youth aged 18 to 24 were eligible for participation in the study. Since there has been little research in this population, there was no basis for determining who should be included. Because we know that sexuality is a gendered experience, the sample was a balance of both sexes and included one youth who was two-spirited. This study began with recruitment of three interview participants, and the analysis of the subsequent interviews enabled decisions to ensure I included a mix of those who grew up primarily urban or primarily on reserve (i.e., theoretical sampling, Morse & Richards, 2002).

I recruited participants through existing community contacts and public notices posted in organisations (see Appendix C) where Indigenous youth were known to congregate. I met each organisational contact in person or emailed them the recruitment flyer. I was familiar with some of the initial contacts and participants.

Youth participants were asked to circulate information about the study to their peers. I attended events and community gatherings such as BBQ's, film screenings, and openings of Indigenous community facilities to provide information and engage in recruitment.

Participants were responsible for establishing first contact. The initial method of contact a participant used was treated as his or her preferred method of communication throughout the study to provide additional information on the study, set up meeting times or solicit feedback. The participants were contacted primarily in person or via email. The resulting sample is a non-probability sample obtained using criterion, opportunistic and snowball methodologies (Miles & Huberman, 1994; Mason, 1996).

Interview participants were given twenty-dollars to cover expenses associated with participation in the interview.

Sample Size

We recruited a total of nine Indigenous participants ranging from 19 to 24 years old who lived in Calgary. The sample size was based on the exploratory nature of the study and time and other resource limitations (Morse & Richards, 2002). Furthermore, experience has shown that eight to ten in-depth interviews will

provide rich data and that common themes will emerge (Graham & Thurston, 2005).

Data Generation

The primary method of data generation was the semi-structured interview. Semi-structured interviews were loosely guided by a set of open-ended questions and probes which closely paralleled the overarching research questions (see Appendix A).

In efforts to understand the participants, each was asked to provide the following demographic information as part of the interview: Indigenous identity, length of urban residence and age. The demographic information was recorded separately from their personal contact information and remains confidential. After the second interview, I decided to change the last question to something more concise as explaining the meaning of terms and obtaining clear responses had proven difficult. Interviews were conducted in either the homes of the participants or in a private space near to their place of school or work. Each interview was .75 to 1.5 hours in duration

Within 24 hours of each interview, field notes of the key concepts and themes heard were recorded or written, as well as any additional information that may

not have been captured by a recording, such as the body language of an individual. The recorded interviews and field notes were all treated as data.

Data Analysis

The approach used an iterative process. Data was analysed during the collection phase allowing for exploration of themes in subsequent interviews. The iterative analysis process included coding of sections of text, synthesis of codes into categories and then themes, and verification (Cropley, 2002). Once the themes were formed and concepts were sufficiently linked they were used to make interpretations (Creswell, 2003). The results section contains my interpretation of the interviews. Published literature, introduced in the discussion section, was drawn upon to aid in interpretation and corroboration of the data.

As outlined by Creswell (2003), the data was analysed in two iterations: concurrently with the data collection and a second time upon the completion of the final interview. It occurred in the following three steps: preparation, familiarising and coding. The data included the field notes, audio recording, transcripts, and the participants' post-interview feedback. The audio recordings were transcribed by a professional transcribe. Whole transcripts from the interviews were read and listened to several times to understand the data as a whole. Each transcript was read or listened to first literally, then interpretively and finally reflexively (Mason, 1996). A first set of indexing variables (open codes)

was extracted, often literally, from the transcribed text and used during the coding of the interviews. This set of indexing variables was later developed into a more defined list of categorical codes that aimed to join shared concepts of the open codes. In the analysis of individual interviews, patterns found in the data were joined together to form overlying themes, and themes and categories were used to interpret the data. Broad indexing variables were later generated to reflect interpretive themes that were categorised in alignment with the conceptual framework, dominant emerging themes and research question categories (Bogdan & Biklen, 1998; Mason, 1996; Patton, 2002). Visual aides such as concept maps and summary matrixes were used to interpret the data (Miles et al., 1994). The analysis process utilised the software package N6©.

Strategies for Validating Findings

To ensure the validity of the data, several of the research design strategies outlined by Creswell (2003) were employed. The study triangulated through the collection of different data types including individual interviews, literature exploration, and researcher field notes, which include the researcher's summary of ideas, opinions and feelings about the topics discussed. Committee members were used as secondary researchers to periodically cross check the themes and to discuss and reflect upon differences of interpretation. In alignment with Piquemal's (2000) third principle of ethical research with Indigenous people, participants received a summary of the preliminary results and were invited to

follow-up to confirm or elaborate on the interpretation. Additionally, scheduled meetings, phone calls and email with the thesis committee members were used as debriefing strategies.

Once categories were formed the framework and literature was used to guide the formation of the general themes, which outline the multiple societal barriers and facilitators of sexual health as experienced by the participants.

Dissemination

I shared the findings with Aboriginal Community Health Council, Elbow River Healing Lodge, Calgary Sexual Health Centre, and Indigenous youth. A follow-up presentation was delivered to the Aboriginal Community Health Council on Feb 20, 2008. Results and implications for practice were shared with the some staff of the Elbow River Healing Lodge. The final thesis and any subsequent publications will be forwarded to participants who requested to receive them. Publication will ensure that the results are available to a cross-section of Indigenous communities. The participants and the larger urban Indigenous youth community were invited to a follow-up youth forum on sexual health. The event was poorly attended; in fact, no youth of the target age attended the forum. This was despite the broad distribution of the event notice, which was distributed via email to more than 250 of the organisers' youth contacts. The forum included a customary meal and valuable prize giveaways. The results were discussed with

those in attendance, which included the staff of the Calgary Sexual Health Centre and MRC Native Centre staff, as well as some older students.

Ethical Considerations

The study adhered to the Tri-Council policy and received ethical approval from Conjoint Heath Research Ethics Board (Appendix D). It was conducted in the spirit of non-maleficence to the individual participants and Indigenous communities. As part of the recruitment procedure the participants were provided a background of the study. Each participant volunteered his or her oral and written informed consent. Each participant had the researchers' contact information and was able to withdraw from the study at any time.

The Elbow River Healing Lodge was available to provide access to professional services if the participants experienced any distress. An Elbow River Healing Lodge information brochure was given to the youth at the beginning or conclusion of the interview. In the case of a crisis situation, the interviewer had access to an emergency contact person through the Elbow River Healing Lodge.

Consent

The collective consent and protection of collective interests of the Indigenous community is a strong component of Indigenous research principles (Brandt-

Castellano, 2004; Piquemal, 2000; Piquemal, 2001). Standard consent literature recognises consent as continuously occurring at the onset and throughout the research process; however, Piquemal (2000) and the Canadian Institute of Health Research (CIHR) (2005) extend the consent requirements to include a balance of the rights of the individual with the collective well-being when conducting research with Indigenous peoples. Although the heterogeneous urban environment presents difficulties of assessing who is authorised to provide the collective consent, this study sought consent from both a collective body and the individual. First, as a representative group of the larger Aboriginal community in Calgary, collective consent was sought and obtained from Calgary Community Aboriginal Health Council (CCAHC) in February 2007. It is recognised that although the CCAHC is not necessarily directly connected to the participants or fully representative of the Indigenous communities of Calgary they could verify that the research was relevant, responsible, respectful and reciprocal, which can be accepted as the basic criteria of research with Indigenous communities. Second, to respect the right of the individual and adhere to standard ethical research practice written and informed consent was obtained from all participants.

Protection of Cultural Knowledge

As per Article 7 (Canadian Institute for Health Research, 2005) and Principles 4 & 5 (Brandt-Castellano, 2004), this study respected and endeavoured to protect

cultural knowledge. Although this study did not focus on obtaining traditional or cultural knowledge, it is acknowledged that this type of data may have been disclosed during data collection. As part of this study's protocol, if during an interview a participant shared a story or piece of information that had elements of traditional knowledge, he or she would have been asked after the interview about the nature of knowledge: including its origin, it owners, and whether or not the information should be shared openly. If such knowledge was disclosed, the ownership of said knowledge would remain with Indigenous people from which it was born. If necessary, the elders of the community from which the knowledge originated would have been contacted and consulted to determine how best to handle the data. It would not be publicly disclosed or published without the explicit prior consent of the owners of the knowledge and only where doing so would benefit the community and further promote the health of Indigenous youth. No traditional or cultural knowledge was disclosed that is not already published or openly discussed as common knowledge.

Privacy

Each participant received a unique identifier and alias. All data was identified using the unique identifier or alias. A minimum of personal and demographic information was collected: name, age, sex, Indigenous identity, length of residence in urban environment and contact information. Name and contact information were collected and kept separately from demographic information.

The participant's alias and unique identifier was combined with the other demographic information to create an overview of the participants. Interviews were all recorded; each recording was labelled with the unique identifier and alias. After the interviews were transcribed, the names of relatives were removed from the transcript to protect the participant's identity. As the participants' names were never used during the interview each participant was assigned an alias post-interview. The alias and unique identifier were linked with the individual participants in one electronic and one hardcopy (non-electronic) that will be kept in secure network area and locked space only accessible by the student researcher and supervisor; they will be destroyed after seven years.

CHAPTER III: RESULTS

Study Participants

While our sample included youth from a variety of backgrounds and experiences, the fiscal restraints and exploratory nature of this study limited our sample size to nine youth. Study participants included four females and five males aged 18 to 24 years. The participants all identified as Indigenous. All participants were engaged in post secondary education or employed. Although several of the youth were in romantic relationships, the participants were primarily single (never married) with only one participant married at the time of the interview. Most study participants reported living on reserve at one time in their life. Although not an explicit question, many participants disclosed their spiritual beliefs or religious upbringing: several were raised as Christians, one recently converted to Christianity, several followed Native Traditional spirituality, and the others did not state their belief systems. One participant had experienced an unplanned pregnancy during her adolescence. One male participant identified as two-spirited.

The results are structured to follow the research questions and provide example quotes designed to guide the understanding of the major findings. Other findings resulted when repeated dialogues indicated pervasive and contiguous themes in

the participants' responses regardless of the question; these findings of pervasive themes are also explored as part of the results.

I. How do urban Indigenous youth participants define sexual health?

What does health mean to you?

The first question was asked in order to understand parameters around the participants' understanding of health; the responses would provide a context to frame what sexual health means to them. The participants' initial responses varied between clinical and holistic viewpoints in the description of health. Eventually, as the discussion ensued, the majority of the participants' answers included mental, physical, emotional, and spiritual aspects of health. The participants articulated several recurring categories, the key ones being nutrition, self-care and respect.

> Food and nutrition, protein, carbohydrates, how you take care of your body, spiritually, physically, mentally, um, how you're supposed to take care of it.
>
> - Chad

Each of the categories applied not only to the participants individually but often also to the greater community. Three of the participants voiced their concern over the diets and nutrition of the children in their community. Two participants acknowledged the necessary and symbiotic relationship between individual and overall community health.

> Um, just how you take care of yourself ‘cause in order to make the community healthy, you got to make yourself healthy and how are we going to make the community healthy if us ourself ain’t healthy and that’s including physical, mental and spiritual. That’s the way I see things. - Bryan

There was general consensus that health is a complex entity that includes many aspects of life and societal systems.

> Um, it’s a wide range of stuff so it’s hospitals and clinics and things like that but it’s also prevention, um, education, learning about raising kids properly and, ah, nutrition. Um, yeah. I guess I think of health care in general. - Elisha

Two participants also immediately elaborated on the larger contextual aspects of health in their highlighting the global environment, the ecological environment and identity issues in forming one’s health.

> Health for me basically, well of course the physical part about it, you know a healthy body, healthy mind but basically it’s so much more to it like medicine and, um, you know and the environment. Yeah, just the whole and, and, and basically it’s, it’s such a global, um, meaning for me I guess. - Hope

What does sexual health mean to you?

Where most participants had little, if any, difficulty answering about their own understanding of health, the opposite was true in answering what sexual health signified to them. Initially questions were often met with silence or fluster. The subsequent answers of the participants describing what sexual health meant to

them were dominated by three themes: avoidance of disease and pregnancy; clinical reproductive teachings usually delivered in schools; and to a lesser degree, respect for oneself and one's partner.

The usual first response from the male participants was, "I don't know"; there was often hesitation in answering the question. When given time to think and elaborate, the male participants initially focused on avoidance of disease and unplanned pregnancy, and several moved on to include other aspects such as making choices, respecting oneself and respecting partners. "Being safe. Um, not try to do anything too questionable respecting the partner I guess and respecting yourself," explained Ray. Two participants included "being safe" as a primary component of sexual health. One male participant talked about the influence of mental health on the ability to make good sexual health decisions. The response of the two-spirited participant immediately included sexuality, sexual orientation and anatomy and was exceptional in its breadth of understanding.

> Sexual health? I think of, um, (long pause) wow, good question. I think of not just who you are sexually but everything to do with sex right? Um, your sexual orientation, um, your anatomy. - David

The female participants also focused on avoidance of disease and unplanned pregnancy but were also more apt to initially include respect, safety, smart choices, peer pressure, body image, relationships, and love. Respect was often

in terms of respect for oneself and protecting oneself not only physically but also spiritually. Elisha explains, “Ah, playing safe I guess and, um, if I thought about it, probably it also means not doing things that I know are going to damage my spirit as well.” Peer pressure was seen as a pressure to be on par with the level of sexual activity of other girls. One participant explained that girls, especially younger teens, would occasionally discuss sexual activity and compare levels of sexual experience. Two participants spoke of the pressure to have a boyfriend, and with the boyfriend came the pressure to be sexually active. The pressure to have a boyfriend was also linked to body image.

> Yeah. That and you know you just don’t want to be, like you know if you’re not sexually active, there’s something wrong with you. Um, you know the pressure to have a boyfriend. It’s just the whole pretty perspective too, right. Um, you gotta be you know, you have to have a boyfriend ‘cause if you’re not having a boyfriend, then that means you’re ugly. That you’re, there’s something wrong with you. - Hope

Both male and female participants spoke of personal safety, specifically of not being coerced into sexual situations. None of the participants spoke of healthy sexuality in the context of the question about the meaning of sexual health; however, one participant spoke later on in his interview of the difficulty of fostering an atmosphere that promotes healthy sexuality where there is hesitation in even broaching the subject.

> Sexual health like, I don’t know it’s just kind of weird. Like how do you portray a positive sexual[ly] health[y] being when it’s like, when, when sex is such a touchy subject right. - Ray

How you do think your peers (urban Indigenous youth in Calgary) think of sexual health?

Asking about their peers provided more insight into the participants' own views on sexual health and also into how they communicated about sexual health among their peers. The majority of the participants (n=7) did not think they shared the same views on sexual health as their peers. One participant thought he may think the same as some of his peers but not all. The remaining participant was uncomfortable speaking for other youth or assuming to know their viewpoint. Most participants explained that they did not normally engage in conversation about sexual health with their peers; if any conversation were to take place, it would of a joking or crude nature. In contrast, outside normal communication limits, one female participant explained that during a sexual health crisis one may confide in and seek support from a friend. In explaining how they saw the difference of their viewpoints, the majority of the participants thought that their peers may have less knowledge [of sexual health] and were more likely to be engaged in higher risk behaviour (i.e., promiscuity) than themselves. The participants demonstrated and expressed genuine concern for their peers.

II. Do urban Indigenous youth have sexual health concerns? If so, what are they?

Initially the participants' sexual health concerns superficially paralleled their views and description of sexual health; however, upon more thorough investigation of the interviews it was apparent that their concerns were more complex and broad.

What are the concerns?

All participants agreed that Indigenous youth have sexual health concerns. The majority (n=8) expressed concerns for Sexually Transmitted Infections (STIs), unplanned pregnancy and sexual abuse. Paramount in both its agreement between male and female participants and in its frequency of mention was the concern for the lack of sexual health knowledge among youth and the overall lack of communication about sexual health. There was participant consensus in concern for the lack of guidance they were receiving and the veil of silence that shrouds sexuality and sexual behaviour. Additionally, the lack of availability or awareness of sexual health services was raised as a connected concern.

The female participants also included issues in relating to their peers, partners and environment. Most female participants voiced concern for their peers and the emotional, mental or spiritual damage that can arise from sexual health issues. Some spoke to the challenge of dealing with peer pressure and living in a changing, more sexualized, environment. One female participant, a newly

converted Christian, spoke directly about morality and sex, including her disapproval of the media's portrayal of sex as a casual activity. Another expressed her distaste of the revealing and sexy attire of very young girls. The female participants were also more likely to make references to the emotional and mental aspects of sexual health concerns; respect was a central principle underlying their sexual health concerns. The meaning of respect included: respecting oneself enough to make wise choices, maintaining the community's respect, and men respecting women.

> Um, I think another concern is how guys, ah, do sleep around so much. Yeah. I think that's a concern. Um, because I find that I just find they don't respect them probably the woman that they're with. - Kari

The male participants were more focused on the repercussions of STIs and unwanted pregnancy. Two male participants expressed their frustration with the prevalence of absentee fathers in Indigenous communities and the overall effect of this on the health of the community. Interestingly, two of the male participants expressed concern for promiscuity. Three of the male participants brought up other health issues such as suicide, diabetes and nutrition.

Surprisingly, over half the participants did not initially raise sexual abuse or sexual violence as a sexual health issue. However, once probed, participants were shocked to realize that they had not raised the issue themselves and overwhelming agreed that it was a critical issue. Most said that they knew people

who were sexually abused and some said they had been sexually abused themselves. Participants expressed that sexual abuse was not spoken about among youth except occasionally when it was raised in situations where drugs or alcohol had been consumed.

Are there any sexual health concerns of clear importance?

Although the participants directly responded with answers relating to dysfuction such as disease, unplanned pregnancy and sexual abuse, the overarching response throughout the interviews was the absence of communication. In the analysis of the interviews, it was clear that all participants experienced issues around communication; this was reinforced by direct reference to lack of sexual health communication by several participants. Communication issues between partners, peers, families, communities, and society were noted to be contributing to the detriment of sexual health of Indignenous youth.

Most of the participants had only received sexual health information via a single sexual health education class; two had received no sexual education at school. Only one participant had received significant sexual health information from a parent; his parent is a trained health professional. Notably, the same youth still maintained discomfort in talking to their his parent and said he would be unlikely to talk to them about sex or even ask them for assistance when it came to sexual health issues.

Are there sexual health concerns or benefits specific to living in a urban centre such as Calgary

The participants indicated the urban environment offered more resources but also posed unique risks. Although many of the participants cited more resources as a benefit of the urban environment, the majority were unable to provide examples of sexual health resources in Calgary. Some participants viewed the lack of family and community in the urban setting as an opportunity to be more anonymous and implied an increased likelihood to be more risky with their sexual behaviour. In opposition, it was lack of anonymity on reserve that could be problematic; some participants cited the lack of anonymity and probability of being related to the staff in community clinics as barriers to accessing sexual health services.

III. What do youth participants perceive as the role of being two-spirited in sexual health behaviour and sexual health?

Initial participants had limited response or difficulty understanding the questions about the intersections between sexual health and sexual identity, gender and sexual preference, and it was evident after the first three interviews that this set of questions was too confusing and complex. The reworked question that more simply asked: “What role does being two-spirited play in sexual health?” brought forth much richer data. The greatest breadth and depth of information came from

the five participants who have two-spirited family members, who have lived with a two-spirited roommate or who were two-spirited themselves.

Most responses focused on the unique challenges that faced two-spirited individuals. Participants indicated that in addition to the racial marginalization faced by Indigenous youth, two-spirited youth may face further marginalization by society and even their community because of their sexual orientation; according to the participants, a two-spirited youth on reserve may be ostracized by peers and family members rendering an environment of extreme isolation. Some participants who have had a close relationships with two-spirited persons thought being two-spirited could pose overall health issues – especially mental health issues. Interestingly, the two-spirited participant stated that he believes overall health is not affected by two-spirited status; he believes that only sexual health is affected by sexual orientation or sexual identity.

It was suggested by participants that many two-spirited youth living on reserve permanently immigrate to the cities to find support and two-spirited peers. The two-spirited participant found that the initial period after moving to the city is when two-spirited youth are engaged in the highest risk taking activity and equipped with the least amount of sexual health knowledge.

Although the physical acts of sex are agreed to be different, this was not seen to be an aspect affecting sexual health. Many of the participants thought a person's

sexual health was more dependent on overall personal health than on the sex of the person with whom you were having sexual relations. The implication in the responses was that if you were respectful of yourself and your partner you would do what is necessary to be healthy.

> And as for the sexual health part about that question is, is that it doesn't matter. It's still healthy. It's still not healthy. It depends upon who you are and it doesn't depend upon what you do. It depends upon who you are. - Bryan

All the non two-spirited participants were accepting of two-spirited youth and empathetic to their unique struggles. One participant spoke of historically different roles of two-spirited people, the previous accepted and even critical roles two-spirited men and women played in their societies.

IV. How do you think society could best serve urban Indigenous youth in meeting their sexual health needs?

Solutions proposed by participants move from those directed at the individual level onward through to the societal level. The participants explicitly proposed some solutions and others were embedded within the interviews.

Individual focused solutions were limited. Solutions to sexual health issues directed to the individual were focused on ensuring all youth have self-respect and pride, and the fostering of these qualities was implied to be the responsibility

of the family, community and greater society. There was, however, an individual responsibility to be a positive role model within your social networks. Several participants spoke of their self-imposed responsibility to be a role model or safe place for their younger cousins or siblings, although other participants were uncomfortable talking about sexual health with family members. Of note, there was no discussion encouraging educating youth about condoms and safe sex practices to change their individual sexual behaviour. Recurring themes in the interviews indicated that the participants perceived sexual health decisions to be made by the individual but also saw decisions impacted heavily by overall mental health, involvement in drugs and alcohol, access to sexual health services, sexual health education, fear of racism, and the community's health.

Most solutions proposed were interventions occurring at the family, community and societal level. In addition to the tangible suggestions to improve sexual health, many of the approaches from both male and female participants focused on building community cohesion, unity and pride. Some participants talked about creating an environment of caring and open communication.

Solutions included improving communication in both the family and the community. There was general consensus that opening the topic of sexual health for discussion would relieve the pressure of having to navigate toward information and understanding by themselves. It was suggested that communication could be formal or informal in nature. Elders, a health team and

peer educators were proposed as possible modes of delivery. Some participants believed that the delivery should be from a community member or a member of their cultural group while others thought the ethnicity of person was less important than their knowledge. Success of the programs or interventions was ascertained to be incumbent upon the trust relationship with the people and organisations delivering the interventions.

Family focused solutions included improving communication with parents and grandparents about sexual health, but this responsibility radiated out to include the whole community.

> It shouldn't. It shouldn't be something that you shouldn't talk about. You know it shouldn't be, it should be talked about everywhere, um, and I don't mean just in school you know. You shouldn't rely on your teacher to talk about it. Like a parent shouldn't rely on their teacher to give you, your child, um, everything they need to know about sex in school. I think it needs to come from home. I just think we need to, I don't know. I really don't know why but it really does bother me that it is not talked about in the homes and amongst Aboriginal people in general.
>
> - David

Community level interventions that were suggested included public performances in schools and at community halls. It was suggested sexual health programs could recruit musicians and actors to be role models and have them deliver sexual health messages through speaking engagements with youth and in print media (e.g., billboards). One participant suggested that a program was needed to

deal with the culture shock when arriving to school in the city; it was not stated explicitly that sexual health should be a part of such a program but was instead acknowledging the role culture shock played in overall health and decision making.

The request for elder involvement and overall elder guidance was prominent in the discussion of six participants, four males and two females who had primarily lived on reserve or moved between reserve and urban centres. Some participants also recognized that some elders had been sexually abused in residential schools and thus were not comfortable speaking about sexual health. Still, it was clear that elder leadership and involvement was part of most participants' culture and expected in other aspects of their life.

> And so when it comes to culture like you know just the men-mentality of the elders is like they don't really see that we need more knowledge, more education out there because when it comes to our culture we look to our elders for advice, their knowledge and, and when they're not exposing us to you know that it's okay for us to go to you know the clinics to ask about these things, we're really not led in the right way. They're kind of leaving that out I guess. – Hope

One participant explicitly and emphatically articulated the need for the end of sexual abuse. The topic was not immediately broached by other participants, but when asked about sexual abuse, most believed it negatively contributed to sexual health, in terms of self image and also the ability to make sexual health decisions.

Most of the participants spoke about specific gender based issues and differences required in interventions. Several participants thought that the separation of sexes during any sexual health education was necessary to create an open environment where individuals will feel able to learn and ask questions. One male participant thought it was more important to focus on intervening on behalf of young women since they carry the majority of the burden of unplanned pregnancy.

Some participants thought that the government was not in a position of trust given historical policies that resulted in sterilization and sexual abuse of Indigenous people. Participants often suggested the offered solutions needed to be community based and community controlled.

The prevailing answer from the participants was to use whatever means necessary to provide a safe place for youth to receive information, counsel and care on sexual health from trusted and knowledgeable people. A safe place was implied to be an environment free of judgment and racism.

VI. Thinking back a few years, do you think the sexual health needs of youth were different among your peers when you were younger? Do you think you would have answered the questions differently when you were younger?

During the second interview I asked the participant to reflect on her viewpoints on sexual health three to five years ago. Specifically, she was asked if she would have answered the questions differently and if there were different sexual concerns among her peers when she was younger. The valuable insight provided by the participant's rich response made this a central question in all subsequent interviews. Some participants, primarily those more than 20 years old, reflected upon a change that had occurred since their teens. The older participants said that when younger they either would not have participated in the study or would have answered completely differently, including being dishonest. Additionally, the older participants could see that they had matured: their view of sexual health had changed, they had more sexual health knowledge, and they had made changes in their sexual behaviours. Exploring the interviews, it is quickly apparent that the older participants are more reflective, thorough and open in their responses, which confirms their self-assessment of increased maturity.

Pervasive Themes

The following section explores the themes that pervade the data, thereby indicating their pertinence to understanding sexual health of Indigenous youth.

Communication

Communication was viewed as a significant barrier to sexual health. For the majority of the participants there were no substantive conversations about sexual health among peers, within their families or in their communities. School based sexual health programs, if delivered, were not well received and were argued to be delivered in a manner that prevented real discussion and learning. Shame and silence were associated with sexuality. Messages received from the larger society were limited to popular media trivializing and glamorizing sex or were in the form of statistics about diseases and dysfunction. The participants felt completely devoid of any reliable sources of information about sexual health or supports for sexual health.

Cultural, Modesty and Morality

The interaction with the participants revealed a shyness or quietness in talking about sexual health. This reluctance to discuss sexual health was evident even in the recruitment process; several people initially approached outright refused to talk about sexual health. This modesty was even more notable with the female participants. Modesty was even in the language used in the interviews; the

participants were careful not to use coarse language or profanities. If by accident they did swear, they apologised and asked if they could say it another way. One female participant spoke directly of the morality of sex and its relationship to spiritual health. Another female participant explained her position as “old fashioned”, meaning that she did not believe in having multiple sexual partners; she went on to speak of her concern for premarital sex and sex without thought to conceiving children. Several participants alluded to the immorality of promiscuity, but others were more apt to indicate its negative consequences from a mental and emotional health perspective. Western culture was often used to refer to judgement or expectations of non-Indigenous peoples, including judgment on sexual behaviours and sexual health norms within Indigenous communities. In reflecting historically, several participants spoke of the residential school, the government or church’s view and portrayal of Indigenous women as dirty. The participants themselves expressed disapproval and moral judgement of Indigenous communities and individuals too.

Access to Sexual Health Services and Health Education

It was evident that the majority of the participants did not have access to sexual health education or sexual health services. Their experience of having a lack of role models was demonstrated by their inability to discuss sexual health knowledge or demonstrate how they would impart it. Barriers to access were predominantly of three forms: privacy, racism and awareness. Access to sexual health care was primarily inhibited on reserve by privacy issues; participants

feared that their relatives may be working in the clinic or that people from the community may see them at the clinic. Access in the city was largely limited by a lack of awareness of what services are available and how to access them. Furthermore, it was clearly articulated that the threat of real or perceived racism prevented some of the participants from accessing sexual health services or seeking out sexual health education and equipment. Two female participants talked about accessing emergency sexual health services, such as the morning after pill, from drop-in clinics.

Community Breakdown

All participants talked of larger societal issues and their effect on overall health. This included the legacy of colonialism, including residential schools, poverty, drugs and alcohol, and disconnection and disharmony within communities. Some participants spoke of the breakdown in terms of an apathy within the community and the diminishment of communal support. There was also evidence of a generational gap, that is, the elders had become separated from the youth and their reality. As Hope explains, “Mhm, the only thing that comes to mind is I just see that there’s like a big gap [between the older generation and the younger generation].”

One participant spoke extensively and a few others alluded to the loss of cultural continuance. The participants spoke of the loss in terms of degradation of cultural systems, such as coming of age ceremonies and elder guidance on how to be an

adult. They also spoke to the social evidence of community breakdown such as alcoholism, drugs, suicides, and disharmony. Several participants related the issues within the Indigenous communities to historical racism and ongoing repression via the “Indian Act”. Others implicated a culture of poverty and difficult shared housing situations.

Racism

The dominance of racism as a theme was an unexpected result. Racism was discussed both directly and indirectly but never using the words racism or racist. I interpreted racism using a sociological based definition provided by Paradies (2005)[2], which categorises racism into three overlapping layers: internalised racism, interpersonal racism and systemic racism. Racial discrimination, one component of interpersonal racism, was discussed in terms of hearing negative attitudes toward Indigenous people, being seen as a stereotype, and enduring jokes and cynicism towards Indigenous peoples. In the following conversation, for example, a participant discussed coping with racial jokes and cynicism which I interpreted as attitude-based interpersonal racism.

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[2] Paradies (2005) describes racism as follows: “Thus racism, as a type of racialization, operates by increasing power differentials through either disadvantaging subordinate racial groups and/or by advantaging dominant racial groups. Adapting the framework used by Jones (2000), I define racism as occurring at three conceptual levels (which overlap in practice): (i) internalized racism—the incorporation of racist ideologies within an individual’s world view; (ii) interpersonal racism—racist interactions between people; and (iii) systemic/institutional racism—the racist production, control, and access to material, informational, and symbolic resources within society.” Pg.3

> It's like it just, I think it's harder for Native people 'cause we're still struggling with education and pretty much incorporating all our values into modern Western culture so I think, that's how I perceive anyways. I was raised in like, I have to say probably a good family but just very white influenced even though my Mom is very native and very intelligent for culture at the same time, it's just, growing up in like with all white people around you and me being just outside of that is just you look in and you want to be a part of it at the same time. You're not too sure what to do so when you see that [sexual behaviour and teenage pregnancy] and how people perceive that and then you go to the other community and see how they perceive what's going on and what they see, it just, you're like wow because I, I heard many like Native jokes and, and cynicism towards Native people and just, just like wow like where does this come from?-Ray

In the same passage, the participant stated "…we're still struggling with education and pretty much incorporating all our values in Western culture...", which also demonstrates the relationship between living within racialised environments and the resulting internalised racist ideologies but also alludes to a system of racism where one race must conform to another. Throughout the interviews internalised racism was prominent. Participants spoke of themselves and Indigenous communities struggling to conform to the dominant non-Indigenous culture and values. The participants were also largely aware of statistics portraying Indigenous peoples' health negatively. Interestingly, five participants talked of statistics and knew that Indigenous peoples of Canada were overrepresented in teenage pregnancy and STIs. In parallel, four [which may or may not include participants who talked of statistics] participants also stated that they did not want to be viewed as a statistic or a stereotype when it

came to teenage pregnancy, STIs, needing sexual health equipment, or being sexually abused.

> The, like one that really stand out for me are, um, the rise of you know unwanted pregnancies, um, amongst Aboriginal youth and, um, I don't know the stats exactly and I know that when it comes to stats, Aboriginals and First Nation, First Nations, just everybody in general, um, that fit under The Indian Act like Métis and Inuit and First Nations, I think we're over represented, um, hugely and so when it comes to stats, it's like oh my God! You know I remember reading, these people came to where I work and they were doing stats on you know HIV and STIs and you know how important it is to educate yourselves and da-da-da-da-da-da and when it came, it, oh one that always stood up, stood out was the Aboriginal component of it right. It was huge. Like the numbers were huge and I remember just freaking out.
>
> - David

A reluctance to go to health care providers, to ask for help, to seek guidance was described by participants as fuelled by the belief that if they did they would be seen as a stereotype. When asked for solutions, one participant spoke of building a sexual team, and when asked who would be on the team, she explained:

> It, to me that wouldn't really matter but I guess you would have to have some Aboriginal 'cause once again you know confiding, you'd want you know, if I was sixteen, I probably would have confided in another girl who was around my age or a bit older and who was Aboriginal because you know it's, um, it's growing up on the Rez you know, you just have this, you just don't want other places to kind of think down 'cause you know 'cause you just you know 'cause you're already living in a stereotype so you just don't want to I guess have others think that you are the stereotype.
>
> - Hope

I interpreted indicators of more systemic racism when conversations turned to issues with the Indian Act, sterilization of Indigenous women, residential school, reservation life including issues of housing and food security, all of which I linked to laws, policies and institutionalised inequities. Further to the conversations that provided direct linkages to systemic racism, I viewed the prominence of internalised racism as evidence of how a system of racism is propagated and internalised.

The government-imposed version of Indigenous identity was internalised by several of the participants. That there was the adoption of the externally constructed and legalised identity was crystallised when one participant spoke to the sexual health issues as they applied to Indigenous peoples. He began by talking of the different groups of Indigenous peoples separately and then concluded by referencing all of those who are covered by the Indian Act. One participant spoke extensively to his experience with racism from his peers; he spoke to how non-Indigenous viewpoints influenced his own. His desire to be a part of the community was interlaced with feeling like an outsider. In his experience, as he matured he no longer accepted the racism toward Indigenous people and chose to sever ties with friends.

Interconnectedness

There was an ongoing theme of interconnectedness among the participants' responses. Each recognized that their health and the health of their community were co-dependent. They recognized that individual health is highly dependent on the health of the community, but most participants saw themselves as part of that community and with membership it was their responsibility to uphold themselves to a standard of conduct. Health was described in a largely relationship context. The relationship you have with yourself determines the manner in which you treat others and so forth. Bryan articulated his view of health and its dependencies clearly; he began with physical health and personal success and moved to the environment in which that takes place:

> Salads. Like proper eating, um, exercise, um, gold medals. I'll just say [health is] about taking care of yourself mentally, ah, physically, spiritually. That's what health to me is and to always be clean eh with yourself, with your, with your mind, always think clean thoughts and spirituality you do what you can eh. …Just 'cause we were raised right eh. These, those are some of the issues and just cultural awareness and stuff like that. Like spirituality. Our spirituality kind of coincides with our beliefs, our, um, values, the way we hold ourselves, the way we carry ourselves and I think that has, has something to do with health issues too 'cause the way we carry ourselves, is the way we help others too. Like how we carry ourselves determines on how healthy we are. That's the way I see it like little things build up to the big things.
>
> - Bryan

CHAPTER IV: DISCUSSION

The purpose of the study was to explore the sexual health perceptions and experiences of Indigenous youth in Calgary in an effort to understand their sexual health concerns and how to better meet their sexual health needs. Through a series of in-depth interviews with nine Indigenous youth and impromptu informal discussions with people I met in my journey, I came to understand that most sexual health research, sexual health policy and sexual health programs inadequately address the sexual health issues of Indigenous youth.

My Experience With the Research Project

Each interview began with an introduction of me: my identity, my Indigenous origins, my intent, and my commitment. I treated the interviews as an exchange. The intention was to encourage each participant to learn about who I am and to establish a connection between us, thereby assuring the participants of my sincerity and beginning a relationship of trust and responsibility. This part of the process was critical in establishing trust in a field (i.e., research) that holds little trust in most Indigenous communities.

Recruitment began easily; the first six interviews came quickly. I had pride in what I was doing and felt I was on the right path. I think this optimism and eagerness translated to my interactions with the youth. Getting the last three

interviews required hours of work, trying not only to engage the community but to find the evasive "community" of youth. During this difficult time, I began to doubt the research project's necessity and to become inwardly critical of the process. I regretted that as a student entrenched in the expectations of an academic institution and limited by artificial timelines I had been the initiator of the research project. I began to debate whether sexual health, given all the other issues discussed in literature and evident on city streets, was worthy of the time and effort the Indigenous communities would need to afford it. With this internal dialogue of scepticism, I had a harder time approaching people and interrupting people from their daily lives to bother them with what I now saw as my 'little' study. After the seventh interview I met a young woman who was working with a corporate sponsor to find out what the health needs were of youth at a particular institution and then work to provide programs to meet them: it seemed like an ideal that I had not afforded myself in my haste to begin. Shortly after, I met a woman who through her connection in the urban Indigenous community and connection to sexual health programs provided a much needed moment of unintended encouragement. Her enthusiasm for my project reassured me of its importance and also directed me toward the path where I would find my last participants.

After spending some time with the youth, really listening to them and then going over the participant interview transcripts, reading them in their entirety and breaking down the first few into categories and ideas, I began to feel what the

youth were communicating. With each subsequent interview, the review and analysis of the themes became much more cohesive and aligned: each dialogue reflecting elements of the others. Despite the youths' varied backgrounds and ages, each voice resonated the voice of the last while still adding its own unique perspective.

Seeing the richness of the data, I temporarily became lost in it. I needed to return to it with focused questions in mind to really find the answers and in doing so forfeit some of the other aspects of the lives of Indigenous youth that were interlaced in the data. Once I had found my answers to each research question and identified key themes related to the questions, the overarching philosophy of interconnectedness allowed me to understand the data in its entirety and see it reflect the my conceptualized ecological framework of sexual health.

In the end, the study incited self-exploration, not only of my sexual health but also how my beliefs were shaped and formed and how my own health was affected throughout my life by issues similar to those found in the study . The period of the research project was interwoven with personal loss and health issues which led to several stalled stages when I had to process my own thoughts of the data, the relevance and significance of the study, and my own role in the study and then continue when I was ready. The responsibility to bring forth action and my own perceived powerlessness often brought on the doldrums of writing; the writing seemed insignificant and inappropriate to the problems at

hand. I had to decide that despite the study's likely insignificance and its simplicity I had a responsibility to Indigenous youth to take whatever action I was able.

Reflections on Interactions With the Youth

The research literature and the media are overwrought with messages declaring the tragic deficiencies and pathologies of Indigenous peoples and the threat they impose to the security and health of Canadians (Harding, 2006; Hawaleshka, 2003; Sinclair, 2003). Indigenous youth do not escape this widely perpetrated message. From these repetitive messages form the stereotype of Indigenous youth as unhealthy, substance abusing, suicidal, drop-outs struggling to survive, and engaged in criminal activities. Indeed, my own thesis topic was shaped by escalating prevalence and incidence of sexually transmitted infections among Indigenous youth in Canada. However, the insights provided by the participants suggested that the worrying statistics are not mere reflection of sexual health deficiencies of Indigenous youth but rather a confirmation of the broader disparities affecting overall health and access to health services.

Resilience is often explained as the ability to manage and continue in a positive way in the face of adversity (Luthar , Cicchetti, & Becker, 2000; Rolf, 1999). It is widely accepted that Indigenous youth face more risk factors than non-Indigenous youth and may have less protective factors, and this therefore implies

that in order to manage their lives in this environment Indigenous youth must be resilient (Adelson, 2005; Hawaleshka, 2003; Salee, Newhouse, & Levesque, 2006). While some of the participants had experienced the issues reflected in the literature, such as unplanned pregnancy, suicide attempts, sexual abuse, and justice system entanglements, they were all managing their lives. In fact, in many cases the participants stated their motivation to participate in the study to be the concern they had for their peers and future generations and their desire to incite change. Although initial investigations of resilience sought to understand sources of resilience within an individual, most recent literature adopts a broader understanding of resilience that looks at systems and processes of resilience fostered by interactions within levels of society and the structure therein that provide the foundations on which to build health (Lalonde, 2006). However, resilience within the Indigenous context is a contentious issue thought to continue the fallacy of racially defined abilities or inabilities to cope within the system of colonisation and oppression (Lavallee & Clearsky, 2006).

Rather than speak to their resilience, I will say the youth with whom I spoke demonstrated remarkable conscience of health and community. These youth are not the exception; Salee et al. (2006), Ponting and Voyageur (2005) and Wuttunee (2004) also found instances of healing and social and economic progress within Indigenous communities. Although this study did not intend to investigate the participants' sources of strength, the literature and the interaction

with the participants suggest that some of the answers may be found in their membership with an Indigenous community.

The participants were recruited using snowball and opportunistic techniques, with the result that all but one of the youth were involved or affiliated with an Indigenous organization or association. Cultural identity and social capital have been embraced as factors contributing to the health of Indigenous people (Chandler et al., 1998; Kirmayer et al., 2003; Rowe, 2006; Wilson, 2003a; Wilson, 2004). The youths' connection to Indigenous communities may be a contributor to the development of a positive cultural identity (Riecken, Scott, & Tanaka, 2006). Similarly, it may assist in the development process of forming a link between their social and cultural environment and their own individual identities (Cote, 1996). Furthermore, the development of relationships in these Indigenous organisations may act as social support for the youth and mitigate the effects of other ecological factors (Riecken et al., 2006; Shoveller et al., 2004; Shoveller, Johnson, Prkachin, & Patrick, 2007; Richmond, 2007; Richmond, Ross, & Egeland, 2007). A more comprehensive exploration of the facilitators of health, especially examining the lives and supports of Indigenous youth who are managing their lives, would be beneficial to understanding how to meet the needs of all Indigenous youth.

Theoretical Journey

Knowledge

The academic cannons' acceptance of Indigenous epistemology and ontology is in its infancy. It has only been in the last few years that major research institutes such as the Canadian Institutes of Health Research have adopted ethical guidelines that formally acknowledge Indigenous epistemologies and corresponding methodologies. Indigenous epistemologies are Indigenous peoples' cultural groups' ways of thinking, learning, conceptualizing, and validating knowledge based in their traditional knowledge and culture (Gegeo and Watson-Gegeo, 2002). Capp and Jorgensen (1977) elucidate the difference between Indigenous Knowledge (also known as Traditional Knowledge) and Western Knowledge in the following excerpt:

> Traditional Knowledge is generally transmitted orally and experientially, and not written. It is learned through hands-on experience and not taught in abstracted context. It is holistic, non-linear, and not reductionist in approach. It is qualitative and in the intuitive thinking mode, and not quantitative or in the analytical thinking mode. Instead of relying on explicit hypotheses, theories, and laws, it relies on spiritual, cumulative, and collective knowledge that is annually interpreted. Traditional Knowledge tries to understand systems as whole and not isolate the interacting parts. Pg. 37

In modern times, Indigenous scholars have adapted and imposed the following overarching strategic requirements to be considered within the paradigm of

Indigenist research: focus on resistance, privilege of the Indigenous voices, and adherence to political integrity (Rigney, 1999). West (1998) and Foley (2002) have forwarded Indigenous positions on knowledge creation which assert that the assurance of community ownership of knowledge, direct benefit to the community, leadership of an Indigenous researcher, and use of a traditional language for primary recording are a set of valid processes that constitute the components of Indigenist research methodology. Both the strategies and processes are rooted in Indigenous epistemology. I am more aligned with Indigenous epistemologies and methodologies; however, as a student at a "Western" academic institution I have had to struggle with balancing the often opposing epistemologies of "Western" and "Indigenous". In choosing a methodology, I rooted myself in conducting ethical and culturally appropriate Indigenist research and then chose several of the well-established qualitative data collection and analysis methods. I discovered an ethically rooted Indigenous methodology did not easily connect to a specific "Western" methodology but reflected elements of Phenomenology, Interpretative Ethnography and Narrative.

The methodology, methods and results of my study were validated and accepted through collective bodies by members of the Indigenous communities; this is not always sufficient for a Eurocentric academy. In the Western paradigm methodologies and methods of knowledge generation must be validated by academia in journals and publications. Throughout the writing process I struggled with the notion of exclusive ownership of knowledge and presumption

that knowledge can only exist and be advanced through the written text of journals of the privileged. I know that I bring many facets of myself into the research including : my energy, my spirit, my history, my bias, and my expectations. I also bring with me the same facets of my communities and my families. I bring with me my ancestors and their knowledge. I bring with me the experiences and knowledge that have been shared with me by the people I've informally engaged in conversations as a part of this research. I can not adequately acknowledge and credit the many intangible sources of the knowledge that contributed to my understanding of the sexual health of Indigenous youth.

What I Would Have Changed

In future research projects of a similar subject matter, I would consider two alterations to the research design. First, I would adopt a research design that allowed the participants full membership in the research process and its outcomes. Second, I would potentially include an equal number of non-Indigenous participants in the project for comparison and to allow for participants to explore and understand each other's realities.

During the recruitment process, I had an independent group withdraw their interest in participation following the discussion where I disclosed the limitations of my ethics protocol. I think they perceived the limitations as a waiver of their ability to be active participants in the process and as a result they no longer

wanted to engage. They have not confirmed this speculation on my part. This experience demonstrated the difficulty of adapting academic institutional requirements to the flexibility needed to work with the Indigenous communities; when working with Indigenous communities and adopting an approach that encourages community collaboration throughout the process it is difficult to assess future requirements or protocols of research before one can actively engage in them. In hindsight, I think the most suitable approach for the study would be to utilise participatory action research methodologies.

During the final writing phase of this chapter, I discovered a thesis that asks very similar questions exploring sexual health perceptions, sexual identity development and sexual health concerns of ten non-Indigenous youth (18 to 24 years) living in Saskatchewan (Taylor, 2004). Originally, I thought it appropriate to only look at the experience of the Indigenous youth, however, reflecting upon Taylor's study I found the process of identifying and analyzing the differences remarkably insightful. The parallels and deviations between our studies will be discussed later. My approach, my concerns and my corresponding questions originated from a different ontology than Taylor's study; there may have been value in comparing the responses of Indigenous and non-Indigenous youth who had been presented with the same research questions by the same researcher. Bringing the two groups together at some point in the project may have also allowed for cross-cultural learning. However, the value in comparing the two studies approached from different ontology motivated to answer similar questions

offered its own insights. Additionally, it allowed me to more clearly recognise the bias of my own perspective throughout the research process.

Strengths and Weaknesses

The qualitative methodology underpinned with phenomenological philosophy was well aligned to the purpose of understanding the relatively unexplored subject of sexual health from the perspective of Indigenous youth. It is evident in the richness of the data and the depth by which I was able to answer my research questions that the overall process provided knowledge that is transferable to practice, policy and future research. It worked well because it privileged the voice of the youth; the open-ended questions allowed for a broad spectrum of answers; and the interviews set as conversations between two equals promoted learning, sharing and healing.

I was aware that ensuring a minimum of only one participant who identified as two-spirited was insufficient to fully understand the sexual health perceptions and concerns of two-spirited Indigenous youth. However, despite its inadequacy, I thought it was of significant importance to ensure the inclusion of at least one two-spirited youth and also to ask questions of all the participants about their perceptions about the link between sexual health and being two-spirited. Although not complete, there is sufficient data to inform and guide future research and provide interim information for current and developing programs.

Participant Bias

All the participants were either working or pursuing post secondary education. It could be argued that the experiences of these youth are not reflective of most Indigenous youth, especially those facing complex personal and socio-economic issues. Additionally, it could be argued that the participants are separated from Indigenous youth with issues of alcoholism, drug abuse, legal issues, homelessness, and poverty. Although the youth included in the study were all coping and managing their lives well, it would be naïve to assume that they are not exposed and most plausibly related to those who are not coping as well. Furthermore, some of the participants spoke to previous experiences with unplanned pregnancy, substance abuse and interactions with the justice system. If any bias is evident, it is an economic bias; as students and young professionals they may have more financial resources at their disposal and be less likely to discuss economic barriers than Indigenous youth with less financial means. Another possible bias arises from the recruitment process which primarily engaged youth through connections to an Indigenous organisation and may have resulted in participants with more social supports and stronger cultural identity than other Indigenous youths (Chandler et al., 1998; Lalonde, 2006; Riecken et al., 2006; Wilson, 2004; Shoveller et al., 2004).

Parallels and Deviations in Research Findings

The ontological differences between Taylor (2004) and I, and possibly between the groups of youth participants, likely resulted in responses whose undertones either aligned with the individual experience or the collective experience; her results and discussion accentuates an individual experience of sexual health within a social context whereas the Indigenous youth in my study spoke of collective experiences within a social context and drew upon personal knowledge to illustrate their stories. Despite ontological differences, the comparison between these studies highlights similarities in key themes, such as the request for the promotion of sexuality as positive, the obsession with the avoidance of disease and unplanned pregnancy, the difficult navigation of gender roles, and the evolution of the foci of sexual health with maturation. However, substantial difference in matters which have recently been forwarded as the Indigenous social determinants of health, such as history, colonialism and racism, (Carson, Dunbar, Chenhall, & Baile, 2007), were pervasive themes evident only within the discussions with Indigenous youth. The following section explores the parallels and deviations between the two studies, drawing in additional literature as necessary to understand them.

Parallels

Maturation

Consistent with the literature on adolescent development (Arnett, 2000), both groups spoke to the changes of sexual health concerns and sexual behaviours as they matured. Although the participants in Taylor's study were more likely to talk about the stages of their development, both groups spoke of the movement from the discovery stage towards the importance of intimate and committed relationships.

Gender

Both sets of participants are dealing with societal pressures and discovering their gender roles. Females in both studies talked more than males about emotional aspects of sexual health, something which is also evident in the literature (Tolman, Striepe, & Harmon, 2003), although the Indigenous males appeared to speak more of the interaction between mental health and sexual health than non-Indigenous youth males. The males in both groups were likely to speak more openly about sexual health and the females were more reserved. Of interest, the two-spirited Indigenous male was the most educated about sexual health, its definitions, its context and the broadness of its scope, although he did not necessarily apply this knowledge to his own life. Taylor examined the process by which males and females talk about prevention and found females more likely to engage in preventative reproductive and sexual health care. Unlike Taylor's study, neither sex of the Indigenous youth spoke of accessing health services

other than in a crisis situation (i.e., a disease was evident or pregnancy probable). Interestingly, Taylor found consistency with the literature when males in her study felt pressure to be sexually active; in contrast, only Indigenous females spoke of peer pressure to be sexually active. It is possible that gender roles for Indigenous youth are dissimilar to those for non-Indigenous youth.

Communication

In the two studies, the common sources of sexual health information and influence were media, peers, parents, and school. Indigenous youth articulated extended family, community and society as additional sources. Communication was a marked topic of interest for both sets of participants; however, there were different foci of communication. In Taylor's study the youth were primarily concerned with communication with sexual health educators, their sexual partners and their parents. In contrast, the Indigenous youths' concern extended to and focused on communication with their families and communities, and Indigenous communities in particular.

Media

Youth from both studies lived in an urban Canadian setting and were likely influenced by similar media. Similar to Taylor's and related research (Ansuini, Fiddler-Woite, & Woite, 1996; Clarke, Friedman, & Hoffman-Goetz, 2005; Delgado & Austin, 2007; Skinner, Biscope, Poland, & Goldberg, 2003), the Indigenous youth spoke of media contributing both positively and negatively to

their understanding of sexual health. Both groups spoke of being inundated with the message of casual sex without consequence in movies, TV and music, which was in opposition to sexual health promotion messages from brochures, pamphlet and posters. The conflicting messages between popular culture and health promotion media may cause confusion.

Peers

Whereas the non-Indigenous youth identified peers as their primary source of sexual health information, Indigenous youth were much less likely to talk to their peers about sexuality. Most Indigenous youth said their exchanges about sexual health were limited to jokes or possibly providing support to a friend in a sexual health crisis.

School

The majority of the youth in both studies cited school as the primary source of sexual education. However, three Indigenous youth, who had received their high school education on reserve, stated that they received no or minimal sexual education.

Parents

In Taylor's study some youth spoke to parental silence and discouragement of conversation about sexual health, especially physical aspects of sexuality, while others spoke of an open communication environment where both physical and

emotional aspects of sexuality were broached with parents. In contrast, only one of the Indigenous youth spoke of his parents speaking to him about sexual health.

Victorian Values and the Pathologizing of Sex

Sexuality and its norms are shaped by multiple processes and exist within a context of societal norms. The current culture of shame, imbalanced focus on negative consequence, and absence of positive sexual health is a barrier to the sexual health of Indigenous youth. Although many studies indicate that youth are getting the message attributing negative consequences to sexual activity, the results of our studies indicate they are not receiving the supporting message about how to be sexually healthy (Hampton et al., 2004b; Myers, Bullock, Calzavara, Cockerill, & Marshall, 1997; Ontario Federation of Indian Friendship Centres, 2002; Satter et al., 2003; Shoveller et al., 2004). Youth responses in our studies were entrenched in the discourse of disease and dysfunction; both sets of participants articulated sexual health definitions that excluded sexual intimacy and pleasure. As Taylor suggests, it is possible that the scope of sexual health definition has been truncated by the sexual education in schools, but it may also be that positive sexuality is not embraced within a societal culture of silence and shame.

When looking historically, the literature points to very different ideas of sexuality and sexual health between Indigenous peoples and Europeans (Newhouse,

1998). Although each Indigenous nation has its own culture and history around sexuality and sexual health, the literature suggests that sexual behaviour was previously governed by community well-being and spiritual well-being rather than limited by the constructs of Christian marriage and the prohibition of behaviours associated with Victorian values (Newhouse, 1998; Anonymous, 2002). Additionally, in many nations, gender and gender roles were diverse (Anonymous, 2002; Jacobs, Thomas, & Lang, 1997). A historical account suggests sex was once viewed as “Magic and Joy” (Newhouse, 1998), which sharply contrasts to the messages of disease, dysfunction and shame that the Indigenous youth are receiving today. It is likely through the process of acculturation and colonization that the youth have adopted some of the dominant culture’s Victorian values, resulting in an artificial culture of modesty consumed with ideas of sexual disease and dysfunction.

Deviations

The deviations between the two studies accentuated what are described as upstream and midstream, or macro and meso, factors (Berkham & Glass, 2000; Turrell & Mathers, 2000) experienced differently by the Indigenous youth participants. History, culture, and racism were key disparate themes that emerged from comparing the two studies.

History

The conversations with Indigenous youth were unique in their cognitive proximity to the horrors of history; most participants made references to historical atrocities committed in residential schools and to Indigenous women. Several youth in my study implicated the long-term effects of colonialism, such as ongoing issues with alcohol and drug abuse, poverty and sexual abuse; this mimics the findings of Larkin et al. (2007) where the Indigenous youth spoke of historical, societal and structural factors that influenced the prevalence of HIV/AIDS in Indigenous communities. Historical accounts, especially those related to colonialism, were not limited to sexual health but extended to large scale health issues that affected their whole communities. Similar conversations were not a part of Taylor's study.

Racism

Throughout the interviews, I heard experiences of personal, structural and societal racism, and even evidence of internalized racism. These findings are congruent with a continued history of racism towards Indigenous peoples that has resulted in an oppressive climate where Indigenous youth experience societal, structural and personal racism. From an individual perspective the ongoing experience of racism and marginalisation has been argued to be a contributor to negative health outcomes through biological and psychological stressors (Brunner, Shipley, Blane, Smith, & Marmot, 1999; Krieger & Sidney, 1996; Krieger & Smith, 2000; Marmot & Brunner, 2001; Paradies, 2006). More

damaging is the racism that underlies the justification of structural and social inequities that contribute to disparate health outcomes of a population (Krieger, Chen, Waterman, Rehkopf, & Subramanian, 2005; Paradies, 2006; Subramanian, Chen, Rehkopf, Waterman, & Krieger, 2005). The Indigenous youths' narratives referenced the impacts of the Indian act, residential schools and differential health care access, which are examples of racist policies and structures that impact their lives.

Freire (2002) argues that oppressed people internalize the negative images of themselves which silences and immobilizes them. This was evident in the articulated reluctance of the Indigenous youth to seek health care for fear of being seen as a stereotype, which is an example of both the lack of assurance of culturally competent care and internalised racism. It is apparent that racism is a critical aspect of Indigenous health and therefore of the sexual health of Indigenous youth. In sharp contrast, the "relatively privileged", "heterosexual" and probably Caucasian youth of Taylor's study reported no issues associated with racism. In response to the data indicating that many of the Indigenous youths' experiences were entrenched with racism, I amended my conceptual model to include race as a social construct formed within the societal systems that are interlaced with history, culture, politics, and socio-economics.

Acculturation

The Indigenous youths' narratives include loss of intergenerational communication, cultural identity issues and change in cultural practices, which clearly indicate youth are navigating the waters of acculturation with little guidance. They felt culturally misaligned not only with their parents, as in the case of the youth in Taylor's study, but also with society in general. Cultures are agreed to be dynamic and changing; however, the rapid change of culture, behaviour, beliefs, and values heavily influenced by a contact with a second, dominant culture is often described as acculturation (Bartlett, 2003; Redfield, Linton, & Herskovits, 1936). Acculturation issues such as cultural identity and cultural difference are argued to have an impact on health (Bartlett, 2003; Hampton et al., 2004a). The impacts of cultural difference, cultural identity and cultural change are reflected in the discussions with Indigenous youth wherein they lament the necessity of Indigenous peoples' adaptation to another culture, the experiences of social and cultural exclusion, and the difficulties with their own Indigenous identity, as well as the absence of intergenerational transmission of sexual health knowledge. Bartlett (2003) clearly states the importance of culture and the role of historical and current acculturation as a stressor in the health of Indigenous peoples; the stress that arises from cultural conflict is arguably linked to coping mechanisms such as substance abuse, suicide and violence (Bartlett, 2003; Hampton et al., 2004a; Young, 2003). The Indigenous youths' frustrations with cultural and racial discrimination, pressure to conform to the dominant culture, and the breakdown of intergenerational transmission of sexual health

knowledge reinforce the current literature's acknowledgement of the role of acculturation in the sexual health of Indigenous youth.

Interconnectedness

The most defining difference between the youth in the two groups was an aspect of their worldview: a collective versus the individual ontology. The Indigenous youth projected collectively and interconnectedness in the content of their dialogues and in the choice of language. Eight of the youth spoke of themselves in terms of community and spoke of issues from the perspective of community and society. They frequently talked in terms of "we" and "us" but were also careful to clarify that they were only speaking for themselves and their experience. Health and therefore sexual health was not described solely as an individual behaviour but took into account the community and society; your place in the community and your responsibility to it were key elements. This interconnectedness and responsibility to community may prove to be a valuable asset in sexual health programs that focus on promoting positive sexuality.

Rural

The rural environment within Canada's health care system was not addressed in Taylor's study; all of her participants were urban based at the time of the interviews. Many of the Indigenous youth in my study had lived in rural environments where access to health services was limited and issues of privacy and confidentiality were reported barriers to access.

Theoretical Frameworks

There has been a debate as to which of many distal and proximal factors are the causes of ill health, which often comes to individual versus social factors. In general, the recent social epidemiological literature prefers broader macro and meso factors of health to individual factors. Among those who focus on social factors there are three distinct foci: psycho-social, social production of disease and eco-social (Anderson, 2007; Krieger, 2001a). A psycho-social perspective sees the causes of ill health as primarily related the psycho-social stressors associated with a perception of inequity and inferiority; thus, those adopting the perspective focus their efforts on the development of social capital through modification or reinforcement of social processes to alleviate health issues (Anderson, 2007). Another focus is on the unequal distribution of materials and political economic power (structural biases) supporting inequality as the causes of ill health (Lynch, Smith, Kaplan, & House, 2000; Turrell et al., 2000). The final focus I will introduce is eco-social, the one with which my model was most closely aligned, and it approaches the causes of illness from a non-linear perspective. It seeks to understand the origins of illness from a whole system perspective incorporating contextual factors, individual factors and environmental factors, and the relationships between them rather than identifying causal pathways (Krieger, 1994; Krieger, 2001b; McLaren & Hawe, 2005; VanLeeuwen, Waltner-Toews, Abernathy, & Smit,

1999; Yamada & Palmer, 2007). The research questions in this study were designed to solicit answers not about the youths' individual experiences but their experience as members of an Indigenous youth subculture. The questions were not designed to focus on the psycho-social or neo-materialistic issues, but both emerged from the data.

Models in the social and health sciences are pictorial representations of an interpretation of a collection of research findings; they are often used to understand how social processes and structural factors influence health. Taylor's (2004) study resulted in the "Overview of a Theory - Influences on Sexual Health and Decision Making" model and accompanying theory while my analysis was guided but not restricted by my initial conceptual framework. It is apparent the model Taylor developed is well suited to her data; it conveys the individually-focused experiences articulated by her participants. Through examining the key elements in Taylor's model depicting the processes and factors influencing sexual health, it is apparent that her data produced a model with a distinctly "individual" perspective despite her acknowledgment of social factors in her introduction, whereas my data and guiding framework produced a broader picture of the sexual health of Indigenous youth. The tendency not to focus on social, structural or environmental factors in Taylor's study may account for the absence of gay, lesbian, bisexual, trans-gendered, or two-spirited participants in her discussion around their sexual health needs. Interestingly, the experiences of her participants are encapsulated within the Indigenous youth experience and the

conceptual model I used. Taylor's model, however, is insufficient to understand the unique experiences of Indigenous youth.

The experience of the youth supports the literature implicating macro and meso factors of significant influence on the health of Indigenous youth; sexual health of Indigenous youth is reliant on material structures, psycho-social factors and the relationship between them (Anderson, 2007; Berkham et al., 2000; Shoveller et al., 2004; Turrell et al., 2000). In my analysis I found that the processes and structures in the community and society levels of the conceptual model namely the role of history, culture and politics within the lived experiences of Indigenous communities. It is not only the relationships among the factors within one quadrant but the interrelationship among quadrants: the history, the culture, the politics, and socio-economic relationships. For example, the lack of communication about sexual health can be attributed to a multitude of factors within the systems: historical sexual abuse in residential schools, continued sexual abuse in communities, a historical culture of modesty, culturally inappropriate sexual education in the schools, the adoption of Victorian values through the influence of the church and non-Indigenous Canadian society, and the breakdown of intergenerational communication. My conceptual model acknowledges the intertwining distal and proximal processes, the political, cultural, historical and socio-economics structures and the social relationships that systematically affect sexual health of Indigenous youth. These are evident in the use of repeating quadrants and connective concentric circles.

In re-examining my conceptual model, I found that the data would support an almost identical model with exception of the socio-economic quadrant. Socio-economics was not as strongly supported by the data. This may have been a result of participants with higher socio-economic status or may elucidate the pre-eminent importance of history, culture, politics, and racism.

Curiously, in most social epidemiological models “culture” is often ambiguous and its relationship to health understated (Anderson, 2007). My conceptual model recognizes its central role in the sexual health of Indigenous youth. The ill effects of continued forced acculturation and the difficulty of access to culturally competent and culturally safe health care all indicate its critical role in the systems that influence sexual health.

The negative experiences associated with racism, acculturation and colonialism were forwarded in discussion with the youth as critical barriers to the health of Indigenous youth; whereas, social networks, culturally competent care, open communication, and a culture of interconnectedness are implicated as possible contributors to positive sexual health outcomes. The strength of my conceptual model lies in its ecological approach that incorporates psycho-social, structural, contextual, and relational factors in the systems experienced by the participants.

In beginning with a conceptual model, I recognized that I must exercise caution to ensure that the model did not drive the analysis. In my interpretation of the data, the conceptual model was found to be closely aligned to the results; however, deviations that emerged from data warranted model modification or justification. Responding to data that indicated many of the youths' experiences were entrenched with racism, I amended my conceptual model to include race as a social construct formed within the societal systems that are interlaced with history, culture, politics, and socio-economics. Furthermore in conversations with the youth, I recognized that socio-economics was not equal in its prominence as culture, politics and history, and therefore I needed to provide a plausible explanation as to why. Lastly, given my ecological ontology, it is possible that it is the only way I could see the data; another researcher with another position may interpret the data differently.

Implications

In proposing solutions, some suggestions from the participants were well rounded and complete while others offered insight to system deficiencies. Youth may not have the sufficient knowledge or resources to independently construct or implement solutions; however, they have an understanding of their own needs and should be integral to any decision making and planning processes.

Programs and organisations that foster cultural identity and social connections may serve to support the Indigenous youth in developing positive identities and reducing internalised racism.

Since almost none of the youth had knowledge of sexual health services available in the Calgary, the marketing is clearly ineffective or inadequate. Service providers need to ensure their programs are highly visible and highly accessible.

The role of racism is dominant in all aspects of Indigenous health. Policies and programs designed to eradicate racism are essential to improving the health of Indigenous youth. Additionally, ensuring access to culturally competent and culturally safe sexual health information and health care may reduce the barriers of cultural difference and racism. Furthermore, this environment may also serve as a safe place to seek healing for those affected by sexual abuse.

As a highly mobile population, first transitions between reserve and urban centres are critical points to the health of many Indigenous youth. Policies and programs should be developed in post secondary institutions and community organizations that support the sexual health and mental health of youth through the transitions.

A shift from a discourse of disease and dysfunction to healthy sexuality is necessary in sexual health promotion and sexual health research to encourage a culture of open dialogue where youth have the resources to learn how to keep themselves healthy. Incorporation of the worldviews of Indigenous youth that often include a sense of interconnectedness and an accompanying responsibility to community may serve to ameliorate positive sexual health promotion and sexual health education.

Healing must continue within Indigenous communities, and between Indigenous communities and non-Indigenous communities. A renegotiated relationship of Indigenous people with the Canadian government and Canadian society is necessary to ensure that Indigenous peoples have the sufficient resources, both social and material, that form healthy systems from which healthy youth can develop.

Conclusion

Those who aim to intervene to the betterment of the sexual health of Indigenous youth must adopt a broad and multi-faceted ecological approach. We must continue to move beyond the idea of individual choice in sexual health matters to an ecological framework that includes the cultures, histories, politics, and socio-economics that define the health experience of Indigenous youth.

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APPENDIX A – GUIDING QUESTIONS

Introductions: Researcher to introduce themselves and their background.

Background and Demographics

How long have you lived in Calgary?

Have you always lived in an urban centre?

Where are you from? How do you identify as an Aboriginal person?

I. How do urban Aboriginal youth participants define sexual health?

What do you think of when I say health?

What is included in health?

How would you explain health?

What do you think of when I say sexual health?

What is included in sexual health?

How would you explain sexual health?

How you do think your peers (urban Aboriginal youth in Calgary) think of sexual health?

II. Do urban Aboriginal youth have sexual health concerns? If so, what are they?

Do you think there are sexual health concerns that face Aboriginal youth?

What are the concerns?

Do you think that there any that are of clear importance?

III. What do youth participants perceive or experience as affecting the sexual health of urban Aboriginal youth?

Do you think that there are sexual health concerns specific to living in a city such as Calgary?

Are sexual health issues different in the city than those of Aboriginal youth who live in rural areas or on reserve?

IV. (INITIAL) What do youth participants perceive as the role of gender identity, sexual identity and sexual preference in sexual health behaviour and sexual health?

What do you think the role of:

gender identity,

sexual identity, and

sexual preference

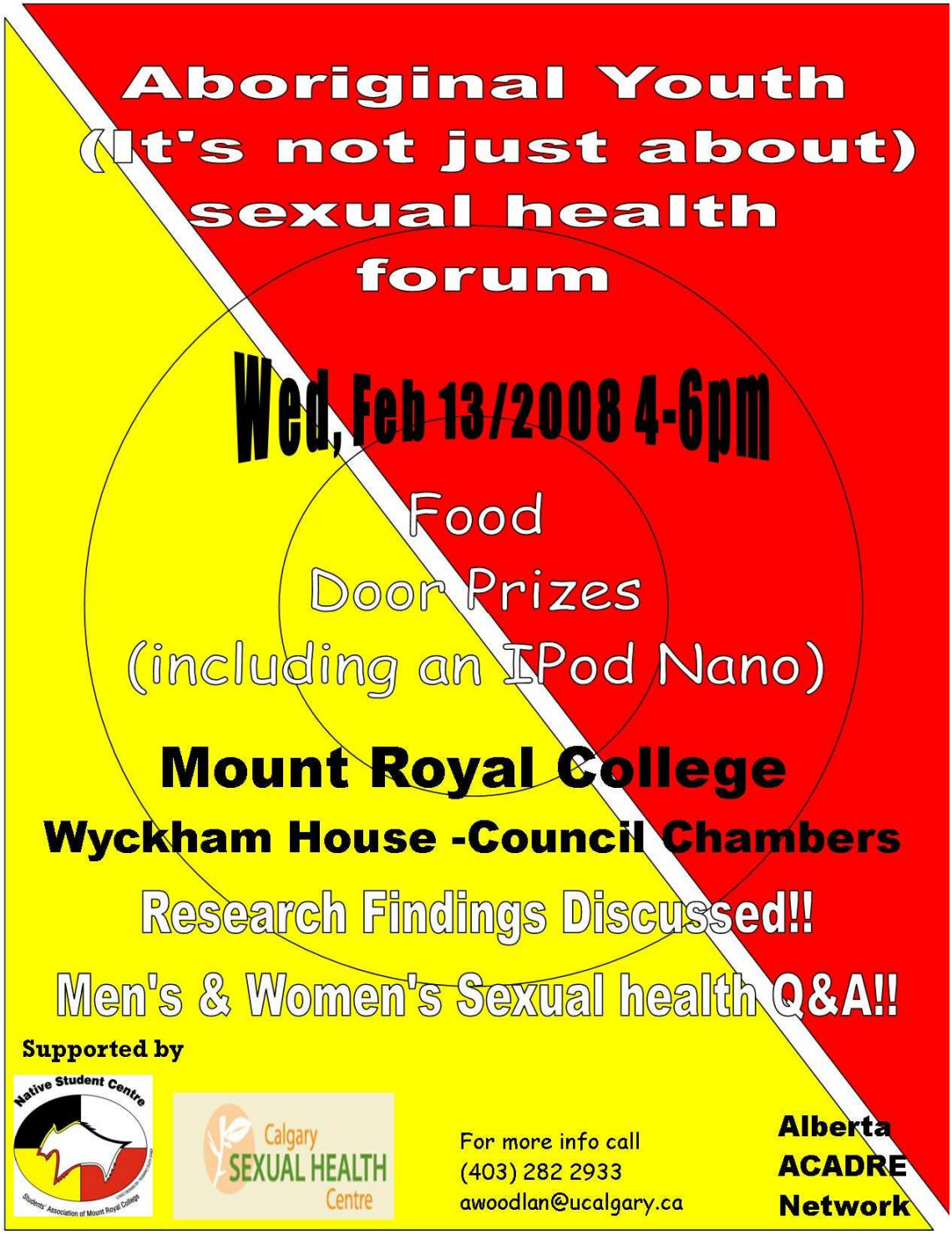
is in sexual health behaviour and sexual health of Aboriginal youth?

IV. (FINAL) What do youth participants perceive the role of being two-spirted is on sexual health?

V. How do you think society could best serve urban Aboriginal youth in meeting their sexual health needs?

VI. Thinking back a few years, do you think the sexual health needs of youth were different among your peers when you were younger? Do you think you would have answered the questions differently when you were younger?

APPENDIX B – YOUTH FORUM POSTER



APPENDIX C – YOUTH RECRUITMENT POSTER

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

Principles Investigators: Dr. Billie Thurston, Alanah Woodland
Department of Community Health Sciences, University of Calgary

ABORIGINAL PARTICIPANTS AGE 18 –24 WANTED: Share your views and personal experiences regarding sexual health and sexual health promotion.

Background

We would like to hear about your personal experiences, ideas, and thoughts on the sexual health. If you agree to participate you will be asked to share your perceptions on sexual identity, sexual behaviour, body image, and sexually transmitted diseases. You will be asked to explain the role of sexual health in your life and share your sexual health concerns. You will be asked to about the importance of sexual health in your life and identify the various aspects of your life which contribute to your sexual health. Lastly you will be asked about how the Aboriginal youth community can be best served through sexual health promotion programs. The information from the study will be used to better understand the sexual health of urban Aboriginal youth that will help will help direct the focus of future research and be useful in developing sexual health programs to serve Aboriginal youth.

Compensation

All participants will receive a $20 to cover expenses for participating in a 1 to 1.5 hour individual interview.

Restrictions

Participants must be between 18 and 24 years of age and must reside in Calgary

Contact:

For more information on how to become a participant in this study, please contact Alanah Woodland at (403) 282-2933 or awoodlan@ucalgary.ca.

APPENDIX D – ETHICS APPROVAL

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

OFFICE OF MEDICAL BIOETHICS
Room 93, Heritage Medical Research Bldg
3330 Hospital Drive NW
Calgary, AB, Canada T2N 4N1
Telephone: (403) 220-7990
Fax: (403) 283-8524
Email: omb@ucalgary.ca

2007-03-01

Dr. Wilfreda E. Thurston
Community Health Sciences
University of Calgary
Calgary,Alberta

Dear Dr. Thurston:

RE: Sexual Health: Engaging Urban Aboriginal Youth

Ethics ID: E-20706

Student: Ms. Alanah Woodland

The above-noted proposal including the Consent Form (Version 1.1 dated January 31, 2007), Poster , Interview Question Guide , Letters (Approval of Proposal dated Jan 8, 2007), and Protocol (January 2007) has been submitted for Board review and found to be ethically acceptable.

Please note that this approval is subject to the following conditions:
(1) appropriate procedures for consent for access to identified health information have been approved;
(2) a copy of the informed consent form must have been given to each research subject. if required for this study;
(3) a Progress Report must be submitted by **March 01, 2008**. containing the following information:

i) the number of subjects recruited;
ii) a description of any protocol modification;
iii) any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
iv) a summary of any recent literature, finding, or other relevant information, especially information about risks associated with the research;
v) a copy of the current informed consent form;
vi) the expected date of termination of this project.

4) a Final Report must be submitted at the termination of the project.

Please note that you have been named as the principal collaborator on this study because students are not permitted to serve as principal investigators. Please accept the Board's best wishes for success in your research.
Yours sincerely,

Glenys Godlovitch, BA(Hons), LLB, PhD
Chair, Conjoint Health Research Ethics Board

GG/emcg
c.c. Adult Research Committee Dr. T. Noseworthy (information) Research Services Ms. Alanah Woodland (Student)
Office of Information & Privacy Commissioner