Defining Health from a Plains Cree Perspective

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Dedication

To the Creator; who continues to be my primary source of inspiration and motivation. This spiritual relationship has eased my path and inspired me to believe I could change my life for the better and make a difference for others.

To my mother, Celia BF Wapass-Clennell and my grandfather, Pete Wapass who had the foresight to value education and to encourage me to pursue further studies from an early age.

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Abstract

The current state of Aboriginal health is of national concern. Aboriginal people as a population do not have the same level of health as other Canadians. There has been a long history of providing health care based on Eurocentric (Western) ideology that has not taken into account Aboriginal peoples' perspective. There is limited research to provide insight toward understanding how Aboriginal people understand, define, and address their health concerns.

This study used the Kaupapa Maori Philosophy/Methodology to define health from a Plains Cree (Indigenous) perspective. A qualitative descriptive research study was done in Thunderchild First Nation. A combination of purposeful and convenience snowball sampling was utilized to select 14 participants to reach saturation. Semi-structured interviews were conducted with eleven open-ended questions to facilitate elaborations during the interviews. Thematic analysis was used to analyze the data, and then the data was categorized using the Medicine Wheel.

Four broad themes were derived from the data. Health was consistently described in relation to physical, emotional, intellectual (mental), and spiritual wellness. Collectively there does appear to be a holistic perception of health, similar to the teachings from the Medicine Wheel. Half of the participants described health from a holistic perspective and half described health using two of the four components of the Medicine Wheel: physical, emotional, intellectual (mental), and spiritual wellness. Pursuing and maintaining health included a combination of information and practices from both the Western and Traditional Indigenous world. Further collaboration and research is necessary to determine if the findings are similar among other Aboriginal Peoples' in Saskatchewan.

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CHAPTER ONE

INTRODUCTION TO THE STUDY

Background of the Problem

Throughout this research project the terms Aboriginal, Indigenous, First Nation, and Indian will be used interchangeably. The Department of Justice Canada (2006) states the "three groups of Aboriginal peoples defined in the Canadian Constitution are Indian, Métis and Inuit". Indian and Northern Affairs Canada (2004) state the Indian Act (1876) defines an Indian as " a person who, pursuant to this *Act,* is registered as an Indian or is entitled to be registered as an Indian" and is used to determine eligibility for government benefits (Status Indian). Non-status Indians are people who consider themselves Indians or members of a First Nation but the federal government does not recognize them as Status Indians (Health Canada, 2004). Health Canada (2004) states "Indian" is a "term that collectively describes all the Indigenous people in Canada who are not Inuit or Métis". Further, "in Canada, the term Indian has generally been replaced with the term First Nation" (Health Canada, 2004). MacKinnon (2005) notes, "First Nations are the largest of the three constitutionally recognized Aboriginal peoples in Canada" (S13). Health Canada (2004) clarifies "First Nation" as a "term that came into common usage in the 1970s to replace the word Indian…although the term First Nation is widely used, no legal definition exists". Merriam-Webster Online Dictionary (2006) defines Aboriginal as "being the first or earliest known of its kind present in a region"; and Indigenous as "having originated in and being produced, growing, living, or occurring naturally in a particular region or environment". Therefore First Nation and Indian are part of Indigenous. Willows (2005) states the "Inuit are culturally and linguistically distinct from First Nations and Métis". Also, "Métis is used broadly to describe people with mixed First Nations and European ancestry" (p. S32). With this as

background the researcher's preference is Aboriginal or Indigenous; however, the terminology is not consistent within the literature. Thus it is impossible to use only one term.

The current state of Aboriginal health is of national concern. Since the late nineteenth century, the federal government has worked to address the health needs of Aboriginal people. Although much progress has been made, Aboriginal people as a population do not have the same health status as other Canadians.

Among other health disparities, they have disproportionately high rates of injury, suicide, and diabetes (Health Canada, 2004). Health Canada shares the following statistics:

> Life expectancy for First Nations males (68.9 years) and females (76.6 years) is lower when compared to the Canadian population of males (76.3 years) and females (81.8 years). Endocrine and immune disorders (including death related to diabetes) are three to five times higher than that of the Canadian population. Death from injury and poisonings is 2.9 times higher than that for the Canadian population. The tuberculosis rate among First Nations was eight times higher than that for the Canadian population. The incidence rate for chlamydia was seven times higher in First Nations living on reserve than for all Canadians.

First Nations and Inuit Health Branch (2006) share the following statistics when comparing First Nation health to the rest of Canada. Arthritis or rheumatism is 36% higher, diabetes is 2.7 times higher, smoking is 2.1 times higher, contact with family doctor in the past 12 months is 21% lower. The life expectancy for both male and female remains the same as reported by Health Canada (2004). First Nation youth suicide (10 to 19 years) was 4.3 times higher than for Canada in 2000.

The First Nations Regional Longitudinal Health Survey (RHS) 2002/03 is a First Nations initiative, led by First Nations, to "support First Nations research capacity and control and provide scientifically and culturally validated information to support decision-making, planning, programming and advocacy with the ultimate goal of improving First Nations health" (National Aboriginal Health Organization, 2005, p. vi). This report was compiled after "22, 000 First Nations people were surveyed (adult, youth, and children) from 238 communities across Canada" (National Aboriginal Health Organization, 2005, p. vi). This report shares the most common health conditions in the communities surveyed: "heart disease, hypertension, arthritis/rheumatism, asthma, cancer, and diabetes" (National Aboriginal Health Organization, 2005, p. vii).

The following table shows the comparison between identified health issues in First Nation communities and the Canadian population.

Table 1: Health Conditions for Adults Reported by the RHS 2002/03

Condition	First Nation	General Population (Canadian)
Arthritis/rheumatism	25.3 %	19.1%
High blood pressure	20.4%	16.4%
Asthma	10.6%	7.8%
Heart disease	10.6%	7.8%
Injuries	Almost 3x higher	
Diabetes	14.5% (much higher)	
Smoking	Approximately 2x higher	
Disability	28.4%	25.8% *CCHS 19.3% *NPHS

*CCHS Canadian Community Health Survey
*NPHS National Population Health Survey

There is great concern regarding injuries in First Nations. RHS (2003/03) states:

> Injuries among First Nations People who are adults are almost three times the Canadian average; almost one third of the adults required treatment - twice the Canadian average;

one in twenty reported they had suffered at least one instance of violence in the previous year" (p. vii).

The RHS (2002/03) states, "injury is one of our leading causes of death, and is responsible for approximately one quarter of all deaths and over half the potential years of life lost" (p. 22). Further, RHS states, "in addition to death and disability, injuries (including those resulting from sexual violence) can lead to a variety of other health problems including depression, alcohol and substance abuse, eating and sleeping disorders, and HIV and other sexually transmitted diseases" (p. 22).

RHS (2002/03) states "injuries are caused by a variety of factors that include low socio-economic status, cultural norms that support violence to resolve conflict and rigid gender norms" (p. 22). At the individual level "there is evidence to suggest that injury risk is linked to income and education as well as alcohol and substance abuse" (p. 22). According to the RHS the most common causes of injuries among adults included "falls, sports injuries, incidents with motor vehicles (cars, snowmobiles, ATVs), and violence (family violence or other assault)" (p. 22).

Measuring the Potential Years of Life Lost (PYLL) shows causes of mortality. Health Canada (2004) suggests PYLL is a useful tool to identify deaths that could potentially be avoided, and to determine priorities for prevention and health promotion programs. Even a partial reduction in the injury death rates among First Nations would have a profound effect on premature death rates and on the health of the First Nation population in general.

The RHS (2002/03) also discussed concerns related to access and treatment to dental care. Access to dental care and treatment was identified as a concern as "just under half of the First Nations adults who reported they needed urgent dental treatment, said they had difficulties accessing Non-Insured Health Benefits" (p. vii).

The statistics provide insight to the disparity and current state of Aboriginal health. The challenge is to effectively address and meet those needs in a timely manner. On September 30, 2002, the Governor General of Canada read the 2002 Speech From the Throne, to open a new session of Parliament. The Throne Speech, titled "The Canada We Want," laid out the government's objectives for the next year and beyond. This federal speech ensured Aboriginal Health will receive increased focus and action oriented attention (Liberal Throne Speech, 2002).

The Blueprint on Aboriginal Health (2005) is a ground-breaking initiative that is intended to bring about transformative change and set a national agenda in Aboriginal Health for the next decade. Its origins stem from an historic commitment announced during a Special Meeting in September 2004 by the First Ministers and the Leaders of the five national Aboriginal Organizations, including the Congress of Aboriginal Peoples (CAP), the Assembly of First Nations (AFN), the Inuit Tapiriit Kanatami, the Métis National Council, and the Native Women's Association of Canada. The Government of Canada, all provincial and territorial governments, and the five National Aboriginal Organizations have all agreed to work together to develop this Blueprint to assist Aboriginal peoples in attaining the same level of health, and the same quality in health care services, as that of other Canadians. This will be achieved by "improving access and quality of health services through comprehensive, wholistic and coordinated service provision by all parties to the Blueprint, and through concerted efforts on determinants of health" (Blueprint on Aboriginal Health, 2005).

The Blueprint is intended to guide future decision-making by all levels of government and the identified National Aboriginal Organizations, in achieving the stated vision of closing the gap between the health of the general Canadian population and Aboriginal peoples. However, since the document is a political commitment, and is not legally binding it is important to recognize

the Blueprint as a vision, and important starting point of collaboration between Indigenous and non-Indigenous leaders toward addressing the health disparities between general Canadians and Aboriginal peoples.

The government statements and recent research initiatives (by Indigenous peoples) express urgency, and concern; furthermore, they are action oriented toward addressing Indigenous health. Moreover, with the recent change in government philosophy toward addressing the health of Aboriginal peoples, perhaps the disparity of health between Canada's Aboriginal peoples and the remaining Canadians will be ameliorated.

In addition to understanding current government policy impacting Indigenous health, it is important to acknowledge the history and continued legacy colonialism has on Indigenous peoples. This phenomenon is not limited to Canada's Indigenous peoples but has occurred within Australia's Indigenous peoples (another settler colony of Britain). It is interesting to note similarities between the rapid decline in health of Indigenous peoples of Canada and Australia since European invasion. Hains (1993) states:

> Since the European invasion, the health status of the Aboriginal people [Australian], who were arguably one of the healthiest races in the world, has declined to such an extent that it is now on par with many people who live in third world countries (p. 128).

Franklin & White (1991) discuss the impact from European invasion in Australia and attribute the subsequent decline in the health of Aboriginal people to three reasons:

> First, the introduction of new diseases, second the forceful removal of their ancestral land, and third the substitution of a healthy lifestyle with a poor diet and living conditions. In addition there was physical confrontation, murder, and rape. The result has been, and continues to be, physical and psychological illness and spiritual despair (p. 129).

In order to provide effective health care to Aboriginal peoples in Canada, it is essential to understand current government policy, the impact and continued effects of colonization, and Indigenous peoples' current perception and definition of health.

In summary, there is an abundance of literature that describes the impact of government policy and colonization on Indigenous health. Conversely, there is limited awareness of how Aboriginal peoples understand and define health, and address their health concerns. Having this knowledge is an important first step in program planning for all areas of health and for delivering effective health care.

Research Problems

Professionals have been coming in as experts using Western tools to collect evidence on Aboriginal peoples and using Western interpretation of the data collected. The Western philosophy and the tools were developed, tested, and validated using a non-Aboriginal population (Ermine, Sinclair & Jeffrey, 2004; Schnarch, 2004). Effectiveness of this approach in addressing Aboriginal health issues is highly questionable and needs further investigation (Bartlett, 2005; Hakim & Wegmann, 2002; Peacock, 1996; Schnarch, 2004). Historically, research in Aboriginal communities has not been a positive experience, therefore creating additional challenges for research (Schnarch, 2004; Smith, 1999). Smylie, Kaplan-Myrth, Tait, Martin, Chartrand, Hogg, Tugwell, Valaskakis, and Macaulay (2004) state, "culturally appropriate and community-controlled collaborative research can create pathways that avoid the old pitfalls of health research in Aboriginal communities" (p. 215). Further "the theoretical and epistemological frameworks underlying Western scientific and Indigenous knowledge systems have fundamental differences. For these two systems to interface, knowledge translation methods for health science research must be specifically developed and evaluated within the context of

Aboriginal communities" (Smylie, Martin, Kaplan-Myrth, Steele, Tait, and Hogg, 2003, p. 142). Clearly, understanding the fundamental differences between Western and Indigenous knowledge systems is essential, as well as understanding how Indigenous peoples understand and define health, and address their health concerns in this contemporary setting. There are many tribal groups of Aboriginal peoples and this research will examine the perception of health from one group, the Plains Cree people in Saskatchewan.

Finally, there is a common perception that Aboriginal peoples view health from a holistic perspective (Adelson, 2005; Bartlett, 2005; Yee & Weaver, 1994). Holistic health/models address the emotional, mental, social, spiritual, as well as the physical needs (Walker & Irvine, 1997); take into account the psychological, spiritual, social, and physical needs of the patients and their families (Yi-Onn Leong, Onn-Kei Lee, Ng, Lee, Yue Koh, Yap, Guay, & Min Ng, 2004); and are the "balance of all facets of the person- the body, mind, and spirit" (Spector, 2002, p. 197). "Aboriginal populations commonly describe life as holistic and use the terms spiritual, emotional, physical, and mental (intellectual) to describe their perceptions of health and well-being" (Bartlett, 2005, p. S22). Further, Bartlett noted, "minimal academic exploration has been done to document this perception and the meaning of these terms with Aboriginal populations" (p. S22). The researcher wanted to explore and determine if these perceptions of holistic health are congruent with the perceptions of Plains Cree people in Thunderchild First Nation.

Research Questions

Smylie et al. (2004) affirms, "the gaps in current health information are a major barrier to the effective planning and implementation of health-care services within Aboriginal communities" (p. 212). The goal of this research is to provide a current overview of how

contemporary Plains Cree people perceive health. How do they define health? How do they address their health concerns? Where do they get their health information? How do they maintain health? What do they need to obtain optimal health? What are their perceived barriers in obtaining optimal health? Do they view health from a holistic perspective? Do they practice holistic health?

In addition, the relationship of health perceived and described by contemporary Plains Cree people and the World Health Organization's (WHO) definition of health will be explored. The World Health Organization's definition of health seemed to be a reasonable standard to use for comparison and discussion, as it is governed by 192 Member States through the World Health Assembly and accepted by health professionals internationally to provide standards of health care throughout the world (WHO, 2006).

Theoretical Framework

Given the history and context in which research has been traditionally conducted in Indigenous communities, it was of utmost importance to the researcher to be aligned with the changing philosophy and research practices being recommended and endorsed by Indigenous peoples. Smith (1999) shares "for Indigenous peoples who have been colonized the experience, and the discourse, about research are shared" (p. 1). Ermine et al. (2004) stated:

> Western knowledge, with its flagship of research, has often advanced into Indigenous Peoples' communities with little regard for the notions of Indigenous worldviews and self-determination in human development. As a result, the history of Westernization in virtually all locations of the globe reads like a script of relentless disruption and dispossession of Indigenous Peoples with the resulting common pattern of cultural and psychological discontinuity for many in the Indigenous community (p. 9).

According to the Ermine et al. (2004) Indigenous peoples are now "poised to assert the Indigenous perspective on research and reclaim a voice that contributes to the dismantling of an old order of research practice" (p. 9).

"Ownership, control, access, and possession (OCAP) of research activities and outcomes pertaining to Indigenous populations worldwide has become the trend" (Ermine et al. 2004, p. 34). Further, Ermine et al., affirmed OCAP is linked to the agenda of self-determination for Indigenous people because it serves to "guide the re-appropriation of the research activities and outcomes in research pertaining to Indigenous people and it provides the context within which the development of culturally relevant, Indigenous worldview based research paradigms are developing" (p. 34).

Considering the history of traditional Western approaches being utilized to conduct research in Indigenous communities, and the current literature clearly describing the experience as primarily negative, the researcher recognized the importance of using an Indigenous paradigm/methodology. The researcher's main concern was to ensure first and foremost Aboriginal people's voices would be priorized and that the research would be beneficial to the community. For this reason she chose to use Kaupapa Mäori methodology, which originated in New Zealand, as the process to initiate the research process and to collect the data.

It is important to note that this Indigenous framework may not use the term "methodology" as traditional western science has in the past and current literature. According to Gillis & Jackson (2002) there are six characteristics of qualitative research designs: multiple realities exist, the researcher is committed to identifying a perspective to understanding that will support the phenomena studied, the researcher is committed to the participants' points of view, inquiry is conducted in a way that does not disturb the natural context of the phenomena studied,

the researcher, as a participant-observer, is considered to be an insider, and finally the research report is written in a literary style rich with participants' comments. Kaupapa Maori Methodology shares and has incorporated all six of the characteristics of qualitative research designs. Given there are "no rigid rules for selecting a research design; rather, the researcher is guided by examining the research question, the purpose of the research, and his or her own philosophical approach to inquiry" (Gillis & Jackson, 2002, p. 92), the researcher chose to utilize an Indigenous philosophy and methodology to guide this research project. The researcher did evaluate the predominant philosophies and methodologies used in nursing research and had initially decided to use the "Health-World View", a conceptual orientation for investigating health offered by Reynolds-Turton (Reynolds-Turton, 1997). After considerable thought and evaluating her own philosophy regarding research and health, she decided to use the Kaupapa Maori Methodology to provide the framework to guide the research and to allow for wide latitude in possible findings. In order to remain true to the original authors, the Indigenous Maori, the researcher refers to the Kaupapa Maori in the same fashion, as a methodology.

There are five working principles of Kaupapa Maori Research that provide the basis for the methodology: the Principle of Whakapapa, the Principle of Te Reo, the Principle of Takianga Maori, the Principle of Rangatiratanga, and the Principle of Whanau (Smith, 1999).

The Principle of Whakapapa is defined as "a way of thinking, a way of learning, a way of storing knowledge, and a way of debating knowledge" (Smith, 1999, p. 7). There are three inter-related issues to this principle. First, this issue involves the way of thinking about Maori people in general. Smith states, "it is about having a deep and thorough understanding of Maori society" (p. 8). The second issue is recognition that Maori people may be participating in kinship-based groups when outside of their community. Thirdly, a "Maori researcher also has a whakapapa,

also belongs somewhere else…being a Maori researcher does not mean an absence of bias, it simply means that the potential for different kinds of biases need to be considered reflexively" (Smith, 1999, p. 8). Smith recommends that researchers "front up to the people…and position themselves publicly …in terms of their whakapapa" (p. 9).

The Principle of Te Reo is related to saving and revitalizing the Maori language. The "survival of Te Reo Maori is viewed as being absolutely crucial to the survival of Maori people" (Smith, 1999, p. 9). Maori language is important in a number of ways, "Maori worldviews are embedded in the language…the language, in this sense, is a window to ways of knowing the world…language is also a way of interacting with the world" (Smith, 1999, p. 9). Dissemination of research results is discussed under this principle. This principle includes "sharing knowledge and the results of research so people can become better informed and make better decisions", and this practice "has another consequence further down the track of promoting different forms of literature in Maori" (Smith, 1999, p. 10).

The Principle of Tikanga Maori, the third principle, is about "being able to operate inside the cultural system and make decisions and judgments about how to interpret what occurs" (Smith, 1999, p. 10). Smith discusses the direct implications for research:

> How the researchers enter the research community, how they negotiate their project aims and methods, how they conduct themselves as members of a research project and as individuals, and how they engage with the people, requires a wide range of cultural skills and sensitivities (p. 10).

Smith argues this is one of the reasons that "even Maori researchers need a mentor when they are entering the more formal domains of Maori communities" (p. 10).

The Principle of Rangatiratanga, the fourth principle, is "connected to the goal of control over one's life and cultural well being…involves control over decision-making processes" (Smith, 1999, p. 11). This principle is related to control over the agenda for research, addressing Maori concerns, and ensuring a collaborative research process between the Maori and the researcher.

The Principle of Whanau, the fifth principle, is concerned with social relations. In terms of research Smith (1999) shares the following:

> The Whanau principle is generally regarded as an organizational principle, a way of structuring supervision, of working collaboratively, of ensuring that a wide range of Maori concepts are discussed rigorously, and a way of connecting with specific communities and maintaining relationships with communities over many years…it includes all those roles that are technical roles…about mentoring and support (p. 12).

Smith (1999) states Kaupapa means "a plan, a philosophy, and a way to proceed…embedded …is a notion of acting strategically, of proceeding purposively" (p. 2). In addition, the Kaupapa Mäori methodology provided a culturally congruent approach to plan and conduct research with the Plains Cree in Thunderchild First Nation bringing their concerns and priorities from the margins to the center.

The Kaupapa Mäori methodology inherently "validates Mäori knowledge, Mäori ways of knowing and researching…asks questions of importance to Mäori" (Crengle, 2006). Using this Indigenous paradigm validates the legitimacy of Indigenous worldviews, culture, and language. Crengle (2006) discussed a unique characteristic of the Kaupapa Mäori methodology, it "rejects 'victim-blaming' theories and analytic frameworks…looks at environmental factors that influence outcomes rather than the 'problems' of the individual". The researcher took the

Kaupapa Mäori methodology which has been and continues to be used by the Maori (Indigenous peoples of New Zealand) and applied the gestalt of the methodology to the Plains Cree people of Thunderchild First Nation.

As the process evolved, and during the data analysis it quickly became apparent to the researcher that the Medicine Wheel (see Appendix L for a picture of the Medicine Wheel) was not only an appropriate tool to categorize the data but also a methodology in itself. The Medicine Wheel is "an Aboriginal framework in a visual shape of a circle divided into 4 quadrants; each quadrant represents a direction along with the teachings for that direction" (Roberts, 2005, p. 92). The Medicine Wheel is a process that can be applied to any situation or circumstance in life. Absolon (1993) shared the Medicine Wheel "encompasses many facets of creation and life's teachings" (p. 3). Roberts (2005) remarked "the Medicine Wheel is becoming a popular health-teaching model for a variety of disease entities such as diabetes and addictions" (p. 92). "Each of the diverse First Nations and Inuit cultures has its own way of presenting the ideas of the 'Medicine Wheel'" (Sevenson & Lafontaine, 2002/03, p. 190). This symbol, the Medicine Wheel, has different meanings and expressions for different First Nations, however, some of the principles of the Medicine Wheel are quite universal (Absolon, 1993; Sevenson & Lafontaine, 2002/03). Sevenson & Lafontaine (2002/03) affirm " that everything is related to everything else, that things cannot be understood outside of their context and interactions, and that there are four aspects to the human condition-the physical, the emotional, the mental and the spiritual" (p. 190). Sevenson & Lafontaine (2002/03) state their "description is taken largely from the plains First Nations but the major elements, although they may be expressed differently by other First Nation and Inuit people, are basic concepts similar to all" (p. 190).

Sevenson & Lafontaine (2002/03) assert the Medicine Wheel is "one of the basic symbols of the world view of First Nations …among many prairie First Nations" (p. 190). Reynolds (2006), an Elder from Beauval, Saskatchewan, states "the Medicine Wheel with the four directions emphasizes the concept of balance and equality…purpose is to show the interconnectedness of nature and our relationship as humans, to all of creation" (p.6). Reynolds continues, "it is a never ending cycle of beginning and ending, when we come to an end it is merely a new beginning" (p. 6). According to Sevenson & Lafontain (2002/03) the belief is:

> If a person is to be 'healthy' or achieve 'wellness' then each of the four aspects of their lives must be in balance…they must also achieve harmony…among all aspects of life, the individual, the living family, the community, nature (mother earth), and the Creator" (p. 190).

Absolon (1993) states:

> Typically, each direction is symbolized by a colour, and represents a season, a lifegiver, our positive and negative forces, our abilities, and many other aspects of creation. The center, where all four directions meet, is where our sacred fire burns. When we feed ourself with the positive and good medicines then our fire burns strong. When we allow the negative forces or bad medicines to feed us, our fire becomes weak (p.3)

Reynolds (2006) states, "the circle is you, the self". She continues, "our ceremonies which were given to us by the Creator, are our tools for our continued development as a person" (p. 7). Reynolds shares that the Medicine Wheel can be used to explore: the concept of self and connectedness; the four aspects of everyone's nature (mental, physical, emotional, and spiritual); the four stages of life; the concept of the four seasons; the concept of vision; concept of the four elements (air, earth, fire/sun, water); the concept of learning; the four races (Red, Yellow, Black,

and White); the concept of balance. Reynolds (2006) teaches, “people are one and the same as the universe”. Further, “we cannot separate ourselves from creation” and “if we are out of balance, then the universe is out of balance in relation to ourselves” (p. 21). She concludes her teachings about the Medicine Wheel by saying, “remember you are the center of the sacred circle (universe), and you direct your development which affects the growth of everything around you” (p. 22).

The Kaupapa Mäori philosophy was utilized to initiate the research process and to collect the data. The data was analyzed using thematic analysis and then categorized using the Medicine Wheel. Both of these methodologies are Indigenous and culturally congruent with the Plains Cree people of Thunderchild First Nation.

Nursing Theory for Research

Conducting effective and meaningful research with Aboriginal peoples and their communities requires integrity, commitment, and most importantly a caring researcher. The researcher has been practicing as a registered nurse for 21 years and utilized Jean Watson’s “Philosophy and Science of Caring”. This theoretical framework emphasizes honesty, empathy, and caring as the key components. Watson’s approach to nursing also includes acknowledging the “spiritual aspect of the patient and at the same time seeks to improve harmony within one’s self, others, and the environment” (Rexroth & Davidhizar, 2003, p. 299). Watson’s concept of caring “transcends cultural and global differences; she has observed that caring is communicated nonverbally in a language that transcends cultural diversities” (Rexroth & Davidhizar, 2003, p. 299). She states caring does not require verbal exchange. Watson (2005) states, “caring science offers a cosmology for science and humanity alike, moving us toward a deeper ethic of human belonging that affects all” (p. 304). Further, “caring science ethic is not only for sustaining

humanity, but also for sustaining the planet in which humans and all living things belong, reside, live, dwell, share, draw upon, come from, and return to in the sacred circle of birthing, living, dying, and rebirthing" (p. 305). Her holistic caring science is congruent with the teachings of the Medicine Wheel and culturally congruent with Plains Cree people.

This framework of caring guided the researcher's interaction with Chief and Council of Thunderchild First Nation, the Health Board, and participants involved in the research. The researcher as an Indigenous person acknowledges the importance of authentic caring and being aware of spiritual beliefs and practices when interacting with all peoples in a health care setting, especially Indigenous peoples.

Relevance and Significance of Research

Recognizing that Thunderchild is only one of many First Nation communities, this project is a beginning step toward understanding Aboriginal peoples, specifically the Plains Cree, perspective of health. The insight gathered from an Aboriginal (Plains Cree) perspective, identifying their current perception of health, health practices, health concerns, and perceived barriers to obtaining optimal health are essential, if not critical to plan effective health promotion (Bartlett, 2005; Hakim & Wegmann, 2002; Health Canada, 2004; Fishbein & Ajzen, 1975; Ermine et al., 2004) and modifying lifestyle. This study is a first step in that research.

Review of Literature

Very few studies have been completed to determine and to define health from a Canadian Aboriginal perspective, despite the increased awareness and interest over the past 15 years. The majority of studies published are related to specific health issues such as diabetes, sexually transmitted infections, HIV, cancer, and fetal alcohol spectrum disorder (FASD).

Two years ago when the researcher did a literature review there was limited current published research that defined health from a Canadian Aboriginal perspective; and the majority of available information was out of date and non-empirically based. Recently and after data collection this has changed; two new studies have been published by Roberts (2005) and Bartlett (2005) that define health from a Canadian Aboriginal perspective. The results of these studies were compared with the researcher's findings and presented in chapter four along with the discussion and recommendations.

To ensure a comprehensive search and provide an overview of health from an Aboriginal perspective, the following topics were included in the literature review: health, health practices, Aboriginal, attitude to health, knowledge, health behaviors, holistic health, health belief model, health promotion, culture, ethics, and research. Both research and non-research articles were included to provide a current overview of health defined from an Aboriginal perspective.

There were four main themes that emerged from the articles selected: describing knowledge and ways of knowing; how culture impacts health and health practices; concerns/definition of health; and recommendations, ethics, and integrity of research.

Knowledge and Ways of Knowing

Two authors (Reynolds-Turton, 1997; Bishop, 1998) acknowledge Aboriginal peoples have their own way to define knowledge and their unique perspectives in defining knowledge that impacts their perception of health and health practices. Reynolds-Turton (1997) states:

> Rather than imposing a Western biomedical perspective of health knowledge and beliefs on the study of an identifiable cultural group, it is of value to learn the distinctive ways of knowing about healthy living and contributing to health promotion from that group itself (p. 29).

In addition, Reynolds-Turton (1997) discusses the culturally specific ways of knowing about health described by Ojibwe people in her study: “stories from oral tradition, authoritative knowledge of elders, spiritual knowledge, ‘commonsense’ models of illness and health, and knowing oneself” (p. 31). Bishop (1998) states, “traditional research has misrepresented Maori understandings and ways of knowing by simplifying, conglomerating, and commodifying ‘Maori’ knowledge for ‘consumption’ by the colonizers. These processes have consequently misrepresented Maori experiences, thereby denying Maori authenticity and voice” (p. 200). Both authors recommend further research to effectively understand Aboriginal peoples’ ways of knowing and interpretations of health.

How Culture Impacts Health and Health Practices

The theme of culture and how culture impacts health and health practices is identified by numerous authors (Alaimo, 1999; Bartlett, 2005; Bishop, 1998; Cantore, 2001; Carlson & Chamberlain, 2004; Hains, 1993; Hakim & Wegmann, 2002; Morse, Young & Swartz, 1991; National Aboriginal Health Organization (NAHO), 2005/06; Sanchez, Plawecki & Plawecki, 1996; Shestowsky, 1995; Strickland, 1999; Reynolds-Turton, 1997; Waldram et al. 2006; Yee et al. 1994). These authors discuss the importance and value of understanding cultural differences and perspectives related to health and health beliefs to provide effective, culturally sensitive and competent programs to effectively meet the health needs of Aboriginal peoples. Interestingly, awareness of cultural beliefs impacting health practices has been acknowledged for at least twenty-five years in the literature. Baume, a Liberal Party Senator for New South Wales and Minister for Aboriginal Affairs, Minister Assisting the Minister for National Development and Energy (in Australia), advocated change to improve Aboriginal health. Baume (1981) acknowledged the only way to improve Aboriginal health “is by having Aboriginals and

Aboriginal communities identify with and promote them…involving Aboriginals in the planning and execution of their health programs…cultural beliefs must be taken into account in the design and implementation of health care programs" (p. 3). Upon examination of the available literature, it is apparent to the researcher the importance and necessity of taking culture into consideration to plan effective health promotion and intervention. Clearly, collaboration with Indigenous peoples is the most important component to ensure success.

Concerns/Definition of Health

Holistic health is a common concept that appears to be accepted and practiced in Indigenous communities and is very much related to their perception and practice of health (Morse, Young, & Swartz, 1991; Turton, 1997; Weaver, 2002; Wheatley, 1996). Turton's (1997) study revealed "health was promoted through balance of all aspects of being…the Ojibwe cultural image of balance is the medicine wheel. Within this wheel, each aspect of being is situated in perfect balance with all other aspects" (p. 34). Weaver (2002) describes wellness as a "holistic concept that encompasses all aspects of the individuals and communities including physical, mental, and spiritual dimensions. Balance among these different dimensions promotes both prevention and healing" (p. 1). Weaver continues, "the Medicine Wheel, a concept central to the cultures of many Native Nations, illustrates the importance of balance for wellness" (p. 1). Wheatley (1996) states, "Traditional American Indian health embodies a holistic health concept in which an individual has harmony with oneself, mind, body and spirit; with others; and with his or her surroundings or environment" (p. 48). Morse, Young & Swartz (1991) state:

> The sweat lodge has no parallel in Western culture which usually views physical health, mental health and spiritual health as different areas of life, each with its own set of beliefs, practices and practitioners. Because of this separation of the healing of the body, healing of

the mind, and healing of the spirit. Native people are frequently dissatisfied with the Western health care system (p. 1365).

Bartlett (2005) provided a synthesis of Métis women's perspectives on health and wellbeing "that provides a counterbalance to sometimes overwhelming negative descriptions" (p. S26). Bartlett's definition of health, "health is expressed as involving physical aspects of living, while well-being is holistic, integrated and includes the dimensions of spiritual, emotional, physical, and intellectual/mental aspects of human life" (p. S26). Robert's (2005) participants described health by "mithoyawin", this "means being in good health in all the four quadrants of the medicine wheel" (p. 94). Further, "the terms physical, mental, emotional and spiritual were mentioned …and all four need to be in balance for one to be in good health" (p. 94). In addition, Robert's participants "mentioned that good physical health entails eating right, exercising, being free of pain, and absence of disease or illness" (p. 94).

Bartlett (2005), a Métis physician, states, "Aboriginal populations commonly describe life as holistic and use the terms spiritual, emotional, physical, and mental (or intellectual) to describe their perception of health and well-being" (p. S22). Conversely, according to Bartlett "minimal academic exploration has been done to document this perception and the meaning of these terms with Aboriginal populations" (p. S22). She argues, "most health survey questions, even in Aboriginal-driven surveys, have not been validated for congruency with Aboriginal culture" (p. S22).

Recommendations, Ethics, and Integrity of Research

The history of research in Aboriginal communities has been a negative experience (Bishop, 1998; Ermine et al. (2004); Peacock, 1996; Schnarch, 2004; Severtson, Baumann & Will, 2002; Smith, 1999). Authors (Strickland, 1999; Weber-Pillwax, 2001) recommend the research

methods have to match the community. Additional authors (Bartlett, 2005; Baume, 1981; Ermine et al. (2004); Strickland, 1999; Reynolds-Turton, 1997; Weaver, 2002) state that for too long, others (outsiders) have defined tribal needs, conceptualized tribal problems, and used their theoretical models in implementing interventions.

However there is also recognition that change is imminent, a new era has started, and the spirit of self-determination is in the air. The process of research with Aboriginal peoples is moving towards a participatory approach (Bishop, 1998; Reynolds-Turton, 1997; Severtson, Baumann & Will, 2002; Strickland, 1999) that is oriented toward a reciprocal relationship that gives knowledge back to the community.

Consistency and Inconsistencies

All studies selected used qualitative methodology that has inherent limitations in the research design. The common limitations of the empirical studies selected are that the findings are specific to the unique group being studied; this is the nature of qualitative research. This indicates further research is necessary to explore local Aboriginal perceptions of health and health beliefs but is consistent with the idea that health is determined by local cultural group.

The various foci of the selected articles added understanding to the complexity and variety of factors involved and related to defining health from an Aboriginal perspective. Assessing and evaluating the studies that described knowledge and ways of knowing; how culture impacts health and health practices; concerns/definition of health; and recommendations, ethics, and integrity of research adds to understanding, and reiterates the need for further research.

Conclusions

There is consensus and support for further research into cultural beliefs about positive health outcomes and healthways rather than focusing on illness; this is congruent with the

cultural outlook of North American Aboriginal peoples (Reynolds-Turton, 1997; Weaver, 2002). It is acknowledged that all cultures have some forms, patterns, expressions, and structures of care to know, explain, and predict well being, health, or illness status. Health practices are influenced by cultural beliefs and by the way people interpret their health.

To date, the research done has been with small groups from a small percentage of Indigenous peoples worldwide. Current health promotion models and middle-range theories are being questioned in terms of applicability to Aboriginal peoples (Reynolds-Turton, 1997; Smylie et al., 2003). This is an area that needs to be further examined to develop appropriate paradigms, models, and theories to understand cultural beliefs and ways of knowing about health within Aboriginal peoples. There is published literature that supports using the Traditional Medicine Wheel for health promotion (Bartlett, 2005; Cantore, 2001) with Indigenous peoples.

There is consensus for further research to be done with the diverse cultures to generate a better understanding of their perception of health and to implement appropriate, culturally sensitive programs/interventions that are congruent with the Aboriginal peoples' philosophies and belief systems.

Researcher's Beliefs

It is essential before beginning qualitative investigations, the researcher engages in a process known as bracketing. Bracketing is "a cognitive process used by researchers to set aside one's biases and personal perspectives about the research topic" (Gillis & Jackson, 2002, p. 182). Its purpose is to make known what the researcher believes about the research topic so that the researcher can then approach the topic honestly. Before beginning the research process the researcher wrote her personal bias and assumptions regarding the research topic. Throughout the

research process she kept a journal regarding her personal thoughts and feelings about the research process.

Aboriginal health and health issues have been longstanding areas of concern both personally and professionally for the researcher. The researcher is a Band member of Thunderchild First Nation and she has been practicing as a Registered Nurse (RN) in a variety of health care settings since 1985. In her opinion:

- An incredible amount of resources has been directed toward Aboriginal health for many years; despite the resources provided, the health of Aboriginal peoples continues to improve at an unacceptably slow rate;
- Throughout her practice she noticed the health care provided in First Nation communities had the following in common: Medical Services Branch, National Health and Welfare (MSB) had determined the priorities and provided health care based on government priorities and these programs were universally applied in every community without consideration of the uniqueness of each community; consultation from the community has been a recent initiative that originated with transferring health from the government to the local band administration;
- Traditionally the services and resources have not been culturally appropriate;
- Most importantly, the community had minimal if any involvement in the issues being addressed as priorities in their communities;
- Essentially the focus has been on physical health without consideration for the mental, emotional, and spiritual wellness of the individuals in the communities;

- The statistics regarding Aboriginal health have been gathered by non-Aboriginal people and organizations and presented from a deficit base, the strengths and resilience has not been acknowledged;
- The statistics represent one aspect of Aboriginal health with an emphasis on the problems and do not include strengths and many of the resilient factors present in Aboriginal peoples and their communities;
- Statistics alone do not provide a complete representation of the current state of Aboriginal health and are not sufficient evidence on which to base effective intervention and health programming. The statistics are symptoms of deeper underlying issues that need to be self-identified and addressed;
- Western philosophy and perspectives have dominated the delivery of health services and programming in Aboriginal communities;
- Indigenous peoples have their traditional ways of knowing and defining health; this perspective has been long overlooked and in the opinion of the researcher is most relevant to provide effective programming and intervention. Programming needs to be congruent with the target audience's culture, priorities, and self identified areas of concern.

The researcher acknowledges she has personal bias and interest in this research project related to being Indigenous, a Band member of the Thunderchild First Nation, and a registered nurse (RN) who has practiced since 1985. As a result of her background she has developed and established personal beliefs and perspective as to how Aboriginal health could be improved. In order to remain true to the data she recorded her personal beliefs prior to initiating the research project and kept a journal throughout the process to record her thoughts and feelings about the

data collected. In addition, she outlined the process of data collection and analysis to remain true to the data.

CHAPTER TWO

METHODOLOGY

Description of Research Design

The researcher could have used either quantitative or qualitative methodology to conduct this research project. Quantitative research "seeks to quantify, or reflect with numbers, observations about human behaviour" (Gillis & Jackson, 2002, p. 712). Qualitative research "uses concepts, classifications, and attempts to interpret human behaviour that reflects not only the analyst's views but the views of the people whose behaviour is being described; the emphasis is on verbal descriptions as opposed to numerical ones" (Gillis & Jackson, 2002, p. 712). According to Gillis & Jackson, "if you decide to explore a phenomenon that is not well understood and has had little empirical investigation, you will most likely use a descriptive research design" (p. 92). Given the paucity of literature available describing health from an Indigenous perspective, and because the nature of the questions asked was related to the nature of human experience, the researcher chose to use a descriptive (qualitative) research design.

As more research is done from an Aboriginal perspective and with Aboriginal populations, a possible outcome could be to develop quantitative measures that could be utilized with larger populations and the findings could be transferable to larger groups of Indigenous peoples. Using quantitative measure would increase the ability to test for generalizability and transferability of the research findings.

This qualitative descriptive study will attempt to understand and describe subjective meaning of health and health practices from the participant's perspective by beginning with an analysis of the pure descriptive narratives shared by the participants.

Research Setting

The research project was done in Thunderchild First Nation, located by Turtleford, Saskatchewan. The community has a rich and diverse population of Plains Cree people, with many of the community members being fluent in both Cree and English. The researcher chose this setting because she wanted to go home and work in her community with people who have common cultural customs, traditions, and beliefs as her, the investigator. The investigator anticipated she would understand and integrate the data more accurately because she shared a similar paradigm as the participants. In addition to being a band member of the Thunderchild First Nation and a long-time resident of the area she anticipated to be readily accepted by the participants; and this proved to be true throughout the research project. The researcher gratefully acknowledges the acceptance and eagerness the participants shared their perceptions and beliefs about health. Being a nurse was definitely an asset, as people are generally accustomed and comfortable discussing health with health professionals.

Thunderchild First Nation is approximately 230 kilometers west of Prince Albert along highway #3 and 113 kilometers northwest of North Battleford. This reserve came about after Chief Peyasiw-awasis' headmen signed an adhesion to Treaty number six in August 1879 at Sounding lake (Thunderchild First Nation, 2006).

This reserve has a population of 1,868 of which 630 of these people reside on the reserve (Thunderchild First Nation, 2006). Indian and Northern Affairs Canada (INAC) (2005) had different statistics regarding registered band members, “the First Nation has a total population of 2,014 registered members, with 1,007 people resident on-reserve”. The closest emergency health services, including hospital services, are located in Turtleford, approximately 12 miles from the community.

Health Services (2006) funding in Thunderchild First Nation is received from First Nations and Inuit Health Branch (FNIHB) of Health Canada under two separate agreements: a Health Transfer Agreement and a Consolidated Contribution Agreement. This funding is dedicated to providing on-reserve programs and services to Thunderchild Band Members residing on Thunderchild lands.

The Director of the Thunderchild Human Services Corporation is responsible for the overall operation of the Thunderchild Human Services Corporation, including the departments and programs of the Health, Home and Community Care, Social Development, Justice, Daycare, HeadStart, and Youth/ Sport/ Culture/ Recreation. Key functions include program planning, accountability, supervision, and leadership to the Board of Directors and staff, and administration of the annual operating budget of $3 million (Thunderchild First Nation, 2006).

Health Programs and initiatives include: Community Health Nursing, Health Education (CHR), Community Wellness (NNADAP and Mental Health), Medical Transportation, Drinking Water Safety Program, Aboriginal Diabetes Initiative, Prenatal Nutrition Program, Health Information System, and a Dental Therapy program (contracted service). Home and Community Care is funded jointly by Indian Northern Affairs Canada (INAC) and FNIHB, and with their own reporting requirements. First Nations and Inuit Home and Community Care policies guide program delivery for Nursing/Coordination/Assessment and Home Health Aides. The Board of Directors is exploring the feasibility of developing an Adult Care Facility on Thunderchild and has set aside funding for a Feasibility Study (Thunderchild First Nation, 2006).

Research Participants

A combination of purposive and convenience snowball sampling was utilized. Purposive sampling or purposeful sampling is when “the researcher ‘hand-picks’ (Fain, 2004, p. 116) or

"individuals are selected to participate … based on their first-hand experience with a culture … or phenomenon of interest" (Speziale & Carpenter, 2003, p. 24). Convenience sampling, sometimes called accidental or nonrandom sampling, "is the collection of data from subjects…readily available or easily accessible to the researcher" (Fain, p. 112). Snowball sampling "relies on previously identified members of a group to identify other members of a population" (Fain, p. 113). The researcher wanted to ensure Elders would be involved in the study so she actively recruited their participation (purposeful sampling) by asking the Chief and Council of Thunderchild First Nation and the Health Board to identify and encourage Elders to participate in the study. In addition, the researcher relied on participants to identify others who might be interested in participating (snowball sampling) and encouraged the participants to invite others to participate. In fact, this process worked so well the researcher did not have any difficulty finding Elders and community members to participate.

Recruitment was done by word of mouth, posters (see appendix A), and presentations (see appendix B) to Chief and Council and the Health Board to ensure reaching interested participants. The researcher only talked to people who contacted her and requested to participate. This process ensured confidentiality of the participants interested or involved in the study. A total of 14 participants participated from the Thunderchild First Nation community.

Inclusion Criteria

The criteria for being considered an Elder varies from community to community (Elder B. Wapass, personal communication, December 12, 2004). For this study, Elder was defined as:

1. Band member of Thunderchild First Nation, living on or off reserve AND
2. Greater than 50 years of age AND
3. Identified by Chief and Council or other members of the community AND

4. Interested in participating in this project

The criteria for remaining participants included:

1. Band member of Thunderchild First Nation, living on or off reserve AND
2. Greater than 18 years of age AND
3. Interested in participating in this project

Participants who contacted the researcher and participants who participated, were given a letter (see Appendix C) outlining the purpose of the study, expectations, and contact information to reach the researcher and supervisor. In addition, a copy of the letter was given to Chief and Council of Thunderchild First Nation, and the Health Board.

Ethical Considerations and Consent

Prior approval was obtained from the Thunderchild Band (see Appendix D for a copy of the consent, Band Council Resolution (BCR)) and the University of Saskatchewan Behavioural Research Ethics Board (see Appendix E and F) before initiating the research project. The researcher presented the proposed research project to the Chief and Council and included their letter of approval in the submission to the University of Saskatchewan Ethics Committee.

The researcher obtained verbal and written consent according to University of Saskatchewan Behavioral Research Ethics Board (2003) and the cultural protocol in Thunderchild First Nation. This process ensured the participants were informed about the procedure and purpose of the research project in an ethical and culturally appropriate manner. A translator (of the participants' choice) was offered prior to obtaining consent and before proceeding with the interview. Participants were provided with copies of the consent (Appendix G), data/transcript release form (Appendix H), a letter describing the study (Appendix C), and contact information for both the researcher and supervisor.

Participants were assigned a code number to be used on the data collected during the interview. The master list with the real names, code numbers, and addresses was kept secure and only accessible by the researcher. With obtained consent, audiotapes were used during the interview process. The audiotapes and transcriptions were kept in a locked cabinet, restricting access to the information to the researcher and her supervisor. As per University of Saskatchewan protocol, the faculty supervisor will keep all original data for five years. After the initial interviews were completed, the researcher met with 10 of the 14 participants to provide an opportunity for further feedback and clarification of the data collected. Three of the remaining follow up interviews were conducted on the telephone and the other one was done by email and a follow up telephone conversation. Two of these four participants lived in Alberta (one had moved after the initial interview) and the two remaining participants preferred to provide their feedback using the telephone. With three of the participants the researcher read the original transcript over the telephone and mailed a copy afterward to their specified address. With one participant the researcher emailed per their request a copy of the transcript and followed up with a telephone conversation.

Semi Structured Interview

There were eleven open-ended questions, with four supplemental questions to facilitate elaboration and to guide the interview process. Participants were encouraged to talk and converse without any limitations imposed by the researcher. The open-ended questions were used to understand the individual's perceptions of: health, health maintenance and health practices, health practices of ancestors, and perceived barriers from obtaining optimal health. Seven of the interview questions were designed by a survey team who conducted a comparative evaluation of the perceptions of health of Elders of different multicultural backgrounds in Texas (Hakim &

Wegmann, 2002) (see Appendix I for a copy of the original seven questions from Hakim & Wegmann's study). A letter was sent to Helen Hakim to request permission to use their questionnaire (see Appendix J). Permission to use their questionnaire was granted (see Appendix J). The remaining questions were developed in collaboration by the researcher and her supervisor, Dr. Lynnette Leeseberg Stamler (see Appendix K for a complete copy of the questionnaire and the demographic questions). The questions used to guide and facilitate the interview were:

1. Tell me what health means to you?
2. What does being healthy mean to you?
3. What is a healthy person like to you or look like to you?
    A. Do you think you are a healthy person?
    B. What makes you a healthy or unhealthy person?
    C. What means you're healthy? Or when a person says you are healthy, what does that mean?
4. How do you keep yourself healthy?
    A. Checkups?
5. What do you do differently from your ancestors to stay healthy?
6. What do you do when you are sick?
7. Who do you talk to first when you are sick?
8. Where do you get your health information?
9. Have your feelings about health changed in the last 5 years?
10. When you thought about this interview is there anything you hoped I would ask but didn't?
11. Picture yourself being the healthiest possibly you can imagine. What would have to happen

for you to achieve that?

Data Collection/Procedure

Data used for this project were collected through personal interviews. Participants were assigned a code number, a letter with information about the purpose of the study, and contact information to reach the researcher and supervisor. The researcher met a second time with ten of the fourteen participants to obtain feedback and to clarify the data collected during the initial interview. Participants were provided with the opportunity to read the transcript from the initial interview and to add or delete information as they wished. Participants had signed a transcript release form along with the consent form. The remaining participants, as previously described, discussed their initial interview with the researcher over the telephone. In these cases, the researcher read the transcript to the participants, and in one case emailed a copy of the transcript and followed up with a telephone conversation.

After the data was collected and analyzed, the information and themes were presented to the Administration of Thunderchild First Nation. This meeting provided an opportunity for the administration of the Thunderchild Band to ask questions or to express any concerns they had about the information gathered and how it will be disseminated.

Data Management

The information recorded and notes taken during the interview were stored and managed in the researcher's personal computer. The hard copies of the data were kept locked in a filing cabinet in the researcher's office. The interviews were transcribed, and the notes that were taken during the interview were added beneath each question. Each interview was identified by a code number and coded manually. During the second interview participants had an opportunity to discuss their answers and could make any changes or additions to their responses during the

initial interview. Their changes and/or clarifications were documented in a light blue font to assist the researcher in identifying new information gleaned from the second interview.

Data Analysis

The audiotapes from the interviews were transcribed and recorded using Microsoft word. The verbatim data were recorded, entered, and analyzed manually. The data were analyzed using thematic analysis, as "thematic analysis focuses on identifiable themes and patterns of living and/or behavior" (Aronson, 1994). A file was created for each question, and each participant's response for each question was put into the respective file. The responses for each question were entered in the computer with the direct quotes and with the participant code number. After each individual response was coded the researcher, using thematic analysis, eventually collapsed the data into major themes that emerged from the data collected. Theoretical saturation was reached by the time 14 interviews had been conducted. Speziale & Carpenter (2003) define saturation as "when no new themes or essences have emerged from the participants and the data are repeating" (p. 68).

Process to Collapse Codes

To ensure consistent coding of the data, the researcher used the Traditional Medicine Wheel (see Appendix L) to organize the consistent themes that were emerging from the data collected. Initially, when the researcher was evaluating the literature to assist with separating and categorizing emotional and mental (intellectual) factors described by the participants, she was unable to find clear distinctions. Fortunately, the Medicine Wheel clearly distinguished between mental (intellectual) and emotional factors making it a logical tool, with the added benefit of being a culturally appropriate and accepted model within Indigenous communities.

Operational Techniques Supporting the Rigor of the Research

The first step to coding the data involved reading the participants' transcripts numerous times. According to Speziale & Carpenter (2003) the goal "of rigor in qualitative research is to accurately represent study participants' experiences" (p. 38). During the research process, the researcher considered the factors necessary to establish trustworthiness of findings: credibility, dependability, confirmability, and transferability (Guba & Lincoln, 1985; McDougall, 2000).

Credibility.

Ensuring credibility requires that the findings are accurate descriptions or interpretations of the lived experience (Guba & Lincoln, 1985). McDougall (2000) defines credibility as "the people studied find the produced account to be true" (p. 722). After the transcription was completed from the initial interview, the researcher provided an opportunity for the participants to elaborate, clarify, and to confirm the accuracy of the transcription. Any changes in the follow up interview were added to the original transcript in a different font color. This was to assist the researcher to identify new information obtained from the second meeting. For the data analysis the researcher used direct quotes from the data collected. This process ensured interpretation from the data and not from the researcher's personal experience.

Further, as part of "member checks" the findings were presented to the Thunderchild First Nation Administration. The "purpose of this exercise [member checks] is to have those people who have lived the described experiences validate that the reported findings represent their experiences" (Streubert & Carpenter, 1999, p. 29). Even though the Thunderchild First Nation Administration was not part of the study, they would have met the criteria to participate. The members present nodded their heads in approval when the researcher presented the overview and findings from the study.

In addition, the analysis of the findings was discussed with the researcher's supervisor, and she went over each of the drafts done by the researcher. This process is referred to as interpretative confirmation and adds to the credibility of the findings (Patton, 2002). In addition to adding to the credibility of the findings, it was an opportunity for the researcher as an Aboriginal person to discuss the interpretation of the data with a non-Aboriginal person**.** This process ensured interpretation from the data and not from the researcher's personal experience**.** Gillis & Jackson (2002) refer to this process as "collaborative research…having other investigators verify the effectiveness of data collection procedures, the comprehensibility of descriptions, the inclusivity of samples, and the logic of arguments" (p. 216). Gillis & Jackson state "collaborative research also improves the credibility and believability of results" (p. 216).

Dependability.

Speziale & Carpenter (2003) state, "dependability is a criterion met once researchers have demonstrated the credibility of the findings" (p. 38). McDougall (2000) defines dependability as "represents commitment to consistency" (p. 722). Gillis & Jackson (2002) state dependability "refers to both the stability and the trackability of changes in the data over time and conditions…this is determined by an audit trail" (p. 216).

As part of the audit trail the researcher took field notes during the interview to increase the accuracy of the transcription and interpretation of the interview. While taking notes the researcher added her own perceptions of the nonverbal communication and documented when participants laughed or paused for a significant amount of time. Taking notes was an additional precaution in case of mechanical failure of the recorder. These notes were included as part of the final transcription and for the data analysis. After the transcription was completed, the researcher provided an opportunity for each participant to review the transcript and to modify, edit, or

remove any comments they had made during the initial interview. All changes or additions made during the follow up interview were coded in a different color, so the researcher could easily identify new information gleaned from the follow-up interview. Further, the researcher included all the data collected during the project, and the data that did not fit into the identified themes was discussed in the summary after each question. Including the unique perspectives is part of descriptive research and adds to the truthfulness of the data presentation.

Given the researcher analyzed the data manually, it was imperative to use a systematic framework to categorize the data in a meaningful and consistent manner for accuracy and to maintain an audit trail. Thematic analysis was used to analyze the data. The researcher made a file for each of the questions asked during the interview, and the participants' responses were put in the corresponding file of the question. On the back of each response the research wrote the participant's code number. After the major themes were identified the researcher looked for a process/methodology to organize the data. To ensure and maintain an accurate audit trail, the researcher utilized the Medicine Wheel to categorize the data collected. The Medicine Wheel clearly described the differences between physical, mental (intellectual), emotional, and spiritual factors. Using this framework and the definitions provided by Mussell (2005) provided a solid and consistent foundation for the researcher to evaluate the data collected. This was particularly important in the instances where a comment could have been categorized into more than one category. In these cases the researcher provided a rationale for how she categorized these comments.

Confirmability.

McDougall (2000) defines confirmability as "relates to whether the analysis is 'grounded in the data' and whether inferences based on the data are logical" (p. 722). Gillis & Jackson

(2002) define confirmability as “objectivity of the data” (p. 216). To “assess confirmability, the audit trail is used …the researcher must be explicit about how personal biases, assumptions, and values may have come into play in the study” (Gillis & Jackson, 2002, p. 216). The researcher described the audit trail under dependability. The researcher did acknowledger her biases and assumptions in the first chapter.

As part of ensuring confirmability, the researcher used direct quotes from the participants. Further, the researcher used thematic analysis to analysis the data and than categorized the data according to the four components of the Medicine Wheel: physical, mental (intellectual), emotional, and spiritual factors. Using the Medicine Wheel and its clearly defined criteria allows for other researchers to follow the decision path this researcher made, and ideally arrive at the same or comparable findings, given the same information (researcher’s data, perspective, and situation). In addition, the researcher discussed the transcripts with her supervisor and the supervisor read every draft of the data analysis done by the researcher.

Transferability.

Gillis & Jackson (2002) define transferability as being “concerned with the generalizability or fittingness of study findings to other settings, populations, and contexts” (p. 216). Fittingness is a term used to “demonstrate the probability that the research findings have meaning to others in similar situations” (Speziale & Carpenter, 2003, p. 362). McDougall (2000) states, “applicability in the form of transferability, which may be possible if enough ‘thick description’ is available about concepts to be able to make a reasoned judgement about the degree of transferability possible” (p. 722).

The researcher presented the findings to the Thunderchild First Nation Administration and the Health Board to obtain feedback to demonstrate fittingness. This is another method to

determine if the findings are relevant to an audience in similar circumstances (transferability). Confirmation is obtained by the audience nodding their heads in approval or by verbal acknowledgment in response to the themes presented (Patton, 2002). The Thunderchild First Nation Administration and the Health Board nodded their heads in approval and verbalized their agreement to the researcher at the meeting. Their responses were discussed under dissemination of findings.

According to authors (Gillis & Jackson, 2002; Speziale & Carpenter, 2003; McDougall; 2000) the researcher has demonstrated adherence to the operational techniques supporting the rigor for qualitative research.

Dissemination of Findings

The findings and recommendations were shared with the Chief and Council of Thunderchild First Nation and the Health Board before being disseminated elsewhere. The researcher met with Thunderchild First Nation Administration on November 10, 2006 at the Saskatoon Inn, in Saskatoon to provide an overview of the research project (see Appendix M) to provide an opportunity for them to discuss their concerns or questions related to the research, and to discuss dissemination of the information. All five members of Thunderchild Administration were receptive and supportive of the project and the intended process of dissemination. Several members voiced their appreciation for the collaborative approach of the research; the communication before, during and after the project with the researcher, the wellness based versus illness based research; and the respect for their cultural protocol.

One of the members felt there should be information in the research project that addressed racism; he stated, “the stress of being Native was never addressed”. He shared “when a baby is born Native they are already stressed”. The researcher did share with this member that

two of the participants in the study did share their experiences and concerns related to racism in one of the questions, and their comments were presented along with their other comments. However, since racism was only mentioned by two participants, the researcher did not identify racism as a common theme, resulting in no further discussion about racism. This is not to deny or to minimize racism, however, the data collected in this study did not identify racism as a common theme.

There was discussion about the Medicine Wheel and its origins. One member stated, “it has been used for so long, and shared by so many Aboriginal people it would be difficult to accurately determine where it came from first”. He continued to say that there was a Keeper of the Medicine Wheel in our community (Thunderchild) and she would be able to speak more accurately about the teachings, origin, and certainly share a Plains Cree perspective.

Overall, the meeting was positive, the Administration was enthusiastic and engaged throughout the presentation and the discussion. They are looking forward to receiving the specific recommendations from the participants in their community, and eventually having a copy of the thesis. The researcher explained she intends to publish first and then will present a copy of the thesis to the Thunderchild Band Administration. The Administration understands, accepts, and agrees with the process.

The researcher met with the Health Board December 7, 2006 to share the results from the research project (see Appendix M). The Health Board was pleased with the process of the research project and appreciated the researcher meeting with them to discuss the results and the dissemination process. Each of the Health Board Members had an opportunity to briefly scan the draft of the thesis during the presentation and to ask questions. Further, the Health Board

Members expressed their anticipation of having a copy of the thesis and expressed a willingness to work with the researcher for her next research project.

CHAPTER THREE

RESEARCH FINDINGS/RESULTS

This chapter will present the research findings starting with a description of the participants followed by the data. The data will be discussed according to the eleven study questions. Each question will be discussed separately. A discussion of the themes, verbatim descriptors, and a summary will be presented for each question. Since this is a descriptive study, all the data gathered will be presented. Some of the responses may not fit with the identified themes so these responses will be shared in the summary for each question.

For the majority of the questions the participants often discussed health in relation to a state of physical, mental (intellectual), emotional, and spiritual wellness. To consistently categorize the participants' descriptors the researcher initially separated the data by using the definitions for physical, mental (intellectual), emotional, and spiritual wellness from the Merriam Webster On-line Dictionary (2006) and in the end used the Medicine Wheel to determine the final categorization of the data. The definitions of these terms from the Merriam Webster Dictionary were consistent with those of the Canadian Mental Health Association's website.

Mental health: "Of or relating to the total emotional and intellectual response of an individual to external reality", "occurring or experience in the mind".

Physical: "Having material existence: perceptible especially through the senses and subject to the laws of nature". "Of or relating to the body: concerned or preoccupied with the body and its needs".

Emotional: "Of or relating to emotion: markedly aroused or agitated in feeling or sensibilities"

Spiritual well-being: “Things of a spiritual, ecclesiastical, or religious nature”, “Relating to, consisting of, or affecting the spirit”, “Of or relating to sacred matters”, “Concerned with religious values”, “Of or relating to supernatural beings or phenomena”.

Mussel (2005) describes the Medicine Wheel as a symbol used to represent the dynamic system of the mind, body, emotions, and spirit, and the needs related to each of these aspects that must be met for the development of human potential. There are four categories of needs in this wheel: physical, emotional, intellectual (mental), and spiritual.

Physical: Mussel states physical needs are defined as requirements for survival and personal growth. Mussel describes the “physical needs to include: oxygen, food, water, clothing, shelter, rest, exercise, sensory stimulation, sex, safety and security” (p. 116).

Emotional: Mussel describes the emotional needs to include: “recognition, acceptance, understanding, love, privacy, limits and discipline” (p. 117). Despite sex being categorized under the physical needs in the Medicine Wheel, the researcher categorized sex under emotional needs, after careful consideration of the manner and context in which the participant talked about sex.

Mental (Intellectual): Mussel describes intellectual (mental) development to include: “concepts, ideas, thoughts, habits and discipline” as the major cognitive needs of a person (p. 121). According to Mussel, perceptions, feelings, and thoughts shape our behavior. Further, “accumulated knowledge, concepts, ideas, beliefs and judgments; all the mental tools we use to make sense of, and to cope with, life” (p. 125). He proposed, “we may develop self-destructive behaviors because of negative words and actions others direct at us” (p. 125). For this reason the researcher categorized all negative behaviors described by the participants such as smoking, drinking, and drug use under mental wellness.

Spiritual: Mussel described spirituality as a process of caring and sharing, enriching one's sense of inner wholeness, togetherness and purpose on this earth. His examples included: "song, dance, and ceremony" (p. 122). With the Plains Cree people from Thunderchild First Nation, language and culture is related to spirituality (C. Clennel-Wapass, personal communication, July 15, 2006). To be culturally congruent the researcher categorized the participants' comments related to language and culture under spiritual wellness.

Description of Participants

Fourteen participants were involved in the study, all band members of the Thunderchild First Nation. Eleven of the participants resided in Thunderchild First Nation, one in Alberta, and the other two in Saskatoon. The participants involved in the study represented diverse backgrounds and varied in their age and level of education.

There were six females and eight males ranging from 19 to 71 years old. The researcher is unsure why there were more males than females who participated in this study. Perhaps the increased interest from the males was related to the topic being wellness based versus illness (deficit) based. However, the researcher is unsure. Four of the fourteen participants were Elders with equal representation from both genders (two females and two males).

The level of education varied from grade four to graduate studies. Eight of the fourteen participants had completed post-secondary education. Five of these eight participants had obtained degrees in various fields. Four of the six participants who had not received post-secondary education worked in the trades and domestic science. The remaining two: one had recently graduated from high school and was planning to pursue higher education, and the other participant (a male Elder) did not share with the researcher his employment or education history.

Interview Question One

The opening question asked: Tell me what health means to you? The responses will be separated and discussed individually under factors related to physical, mental (intellectual), emotional, and spiritual wellness; and lifestyle.

Physical

Participants talked about several aspects related to physical wellbeing. Comments were shared about exercise, nutrition, freedom from pain and illness, current state of wellness, and environment.

Exercise.

Three participants talked about exercise and activity as part of their definition of health. Participant 02 shared, “at least some exercise”, she continued to say “you see a lot of people now who don’t do anything and they get so overweight because all they do is just sit around and you know don’t do anything”. Participant 011 stated, “active, fitness wise”. Participant 014 stated, “exercise”.

Nutrition.

Three participants shared comments about nutrition. Participant 02 stated, “eating proper”. Participant 06 shared, “eating”. Participant 014 stated, “health is diet”.

Freedom from pain and illness.

Four participants shared comments about being free from pain and illness. Participant 02 stated, “when a person free from any ailments”, she continued, “you hear a lot of people complaining about aches and pains and this and that, so to be free of all that”. Participant 04 stated, “to be free of pain”. Participant 06 shared, “being able to live life to the fullest without having ailments holding you back”. Participant 013 stated, “body being healthy”.

Current state of wellness.

Four participants shared comments related to their current state of wellness. Participant 06 stated, “how you are”. She added, “being able to go up stairs without huffing or puffing”. Participant 07 stated, “healthy person”. Participant 011 shared, “how they feel”. Participant 013 stated, “condition you are and your family”.

Environment.

One participant talked about the environment as starting with the prenatal period including the home and the family. Participant 012 stated, “the environment they are brought up in”. He explained the environment includes, “upbringing, their house, their community, surrounding, extended family” He continued to say “right from the time you are developing in mother’s stomach and born, from that point forward”. He stated, “in mother’s stomach will determine much of the life outcome, either I’m disadvantaged from the get go or right in the pack to make my life what it can be”. He continued, “so it starts from the parent, parents”. He finished his comment by saying, “go from that point one month to one year olds what kind of influence, upbringing, education, or experiences put before you that shapes the kind of life you will have and starts directing you in a way you don’t know”.

Mental(Intellectual)

Participants talked about several aspects related to mental wellness. Comments were shared about knowledge, and value of health.

Knowledge.

Participant 02 shared “you also have to um continue to try to expand your knowledge”. She continued, “I keep thinking about Alzheimer’s and so forth and one of the things I’ve heard

is if you're reading a little bit every night you are continuously expanding your mind". She shared, "and I think what can I do to prevent that?".

Value.

Five of the participants shared their meaning of health related to value. Participant 01 stated, "health is something you can't buy, so if you have your health you are a millionaire". Participant 03 stated, "health is important to everything". Participant 08 stated, "means a lot to me, it is life". He also shared, "if healthy have a good life". He ended his comment with "being healthy is the natural way, not being healthy by popping pills into you" and "pills don't even heal you". Participant 09 shared, "getting sick people better". Participant 010 stated, "it is good to me, the only problem is I smoke too much". This response was difficult to analyze. The researcher took his response to mean he was satisfied with his health and had no current complaints or concerns. However, the researcher is unsure. There were some problems communicating during this interview. An interpreter of his choice had been offered and he had declined, "I'd rather not nobody help me". He eagerly and enthusiastically continued with the interview and answered the questions to the best of his ability given Cree is his first language.

Emotional

Participants talked about several aspects related to emotional wellness. Comments were shared about holistic wellness, stress, and support.

Holistic.

Two participants talked about their meaning of health from a holistic perspective. Participant 02 shared, "is of sound mind and body" and later she stated, "healthy mind and body". Participant 04 stated, "to be balanced emotionally, spiritually, physically, and mentally".

Stress.

Two participants talked about stress. Participant 02 stated, “stress free”. Participant 06 shared, “being stress free”.

Support.

Participant 05 shared her definition of what health meant to her “like a basic overall surrounding support of family and the community”.

Spiritual

Three participants shared comments related to spiritual wellness. Participant 011 described health as being internal and external. She stated, “external how you take care of yourself, active, fitness wise and internal is spiritual”. Participant 012 stated, “ going to Sweats, to learn about who I am”. He also shared:

> Indigenous belief is the Creator sets a path for us, for what he believes is our calling. It’s up to us to identify what it is. All starts with what we are doing to assist the creator with the blueprint. (Participant 012, personal communication, September 9, 2005)

Participant 014 stated, “health is diet, exercise, and spirituality”.

Lifestyle

Five participants shared comments about health being a lifestyle. Participant 06 shared, “your lifestyle, way of living”. She continued, “how you live your life every single day”. Participant 07 stated, “healthy lifestyle”. Participant 011 shared, “how you take care of yourself”. Participant 012 stated, “the way in which one lives their life”. He continued to share:

> Health doesn’t necessarily mean you have to abstain from drugs, many use marijuana to alleviate pain. Beer has other benefits, how responsible and how you use it. For me, do not allow to get into drugs, alcohol. Health is a very, not a narrow definable word. It is a

holistic word, lack of a better word that is all encompassing. (personal communication, September 9, 2005)

In summary, participants shared their meaning of health by talking about factors related to physical, mental (intellectual), emotional, and spiritual wellness; and lifestyle. Factors related to physical wellness included: exercise, nutrition, freedom from pain and illness, current state of wellness, and environment. Factors related to mental wellness included: knowledge, and value of health. The value of health was described in monetary terms, being important to everything and compared to being a millionaire. Emotional factors were discussed as having a sound mind and body, balanced emotionally, stress, and support. Factors related to spiritual wellness included attending Sweats, discovering yourself, and to identify the path the Creator has set for us. Being balanced physically, mentally, emotionally, and spiritually was described, as having a sound mind and body or a healthy mind and body. Lifestyle was identified as a way of living every day.

Interview Question Two

The second question asked: What does being healthy mean to you? This question is very closely related to the first question. The intent of this question was to explore perceptions of being healthy and what that meant to the participants. The responses shared by the participants were categorized into factors related to physical, mental (intellectual), emotional, and spiritual wellness.

Physical

Participants talked about several aspects related to physical well-being. Comments were shared regarding freedom from pain and illness, exercise, nutrition, cleanliness, and being independent.

Freedom from pain and illness.

Participant 01 shared, “being healthy means getting up in the morning, every morning, and not having no pain, just getting up with no hurt”. Participant 06 stated “being able to live life to the fullest without having ailments holding you back”. Participant 011 described being healthy as, “feeling good; not tired, lethargic; feeling active mobile; nothing blocking living and leading a normal life”. The researcher is not sure but interpreted this statement to be related to physical wellness even though parts of it could fall under mental wellness as well. During the follow up interview she added, “not having any illness or disease”. Participant 013 stated being healthy to him meant to be “free from sickness and disease”, he added “if your body feels good you feel good”.

Exercise.

Participant 02 talked about, “at least some exercise, get overweight have to stay active”. Participant 05 felt, “exercising” was an important part of being healthy. Later during the interview she shared, “now going for walks and clearing my mind is healthy”. She uses exercise as part of maintaining good mental health. Participant 06 offered one example of what health meant to her, “for one thing to go up the stairs without huffing or puffing”. During this description she started to laugh as she explained she had recently noticed she was starting to labour when she was climbing the stairs. Participant 07 answered this question by responding with “taking care of yourself, exercising” and as mentioned previously, “no smoking”. Several times during the interview he talked about the importance and necessity of being active as part of being healthy. Participant 09 talked about, “being active, healthy lifestyle” as being healthy. Later during the interview he gave examples of what he thought a healthy person looked like.

The examples he gave will be shared in the next question. Participant 010 stated, “exercise” as part of being healthy.

Nutrition.

Participant 02 talked about, “eating proper”, and participant 05 shared, “eating properly” as part of being healthy. Participant 010 stated, “eat good food” as part of being healthy. Participant 013 stated, “not being overweight” as part of being healthy.

Cleanliness.

Participant 010 mentioned several times during the interview the importance of trying to be and staying clean. To “stay clean” is an important part of being healthy for this participant. Participant 012 feels being healthy includes, “takes the time to keep a clean place”.

Independence.

Participant 04 described what being healthy meant to her in one sentence, “being healthy means to me you are able to do things on your own, to be independent”. She is in her sixties and currently working in a full time position. Participant 08 had very strong feelings about the importance of being independent, “being healthy means that you can do things, you can work, you can go out and work instead of being stuck on the damn reserve”. He continued to share, “being healthy is looking after your own self, you don’t have to depend on anybody including Indian Affairs, Indian Act, and everything”. This 66-year-old man shared with the researcher “right ear no hearing” and as a result of this impairment he could no longer work. During the interview he talked very loudly and at times the researcher felt he was shouting. It is the opinion of the researcher he has severe hearing impairment in his left ear as well. He was quite adamant about how his hearing impairment had impacted his life, “if I had my hearing I wouldn’t, I might be living here but I sure the hell would be working out some place”. He also shared, “they say

that you need education to work outside, they are full of bull cause I worked outside all of life" and "I didn't need education".

Mental (Intellectual)

Participants talked about factors related to their fears, decision-making, substance use, and value of health.

Fear.

Participant 02 was quite concerned about Alzheimer's, "biggest fear is Alzheimer's, what can I do to prevent that?". She shared one of her strategies, "continue to try and expand your knowledge" by "reading something new every night continuously working your brain", as part of preventing Alzheimer's.

Decision-making.

Participant 012 discussed at length issues surrounding mental wellness. According to this participant it is important to him to be "able to continue on the road of educating myself, learning, helping, and assisting". Having the ability to be "able to identify and think clear in regards to the choices I have to make that day, not tomorrow" was a priority. He talked about "for that day to make the right decisions or to be able" was a very important part of being healthy. He talked about being healthy as being able to practice what you preach. He stated, "if this is what you're preaching that is what you are doing". He talked about understanding "your kids that look at you" and the importance of "not being a hypocrite", for example, "saying you don't smoke when you smoke". He also talked about "being able to live with yourself" and being "able to say to self, I'm happy, comfortable with what I'm able to do (today), accepting". "Coming to an acceptance this is all I'm able to do and not getting stressed out". Participant 013 talked about "feeling good about yourself" as part of being healthy.

Substance use.

Participant 07 stated, “no smoking” after talking about “taking care of yourself” and “exercising”. Participant 010, a 71 year old man advised, “don’t smoke”. Participant 013, a middle-aged male, recommended, “no alcohol or tobacco use”. During the follow up interview he added, “ no drug use as well”.

Value of Health.

Participant 014 answered this question by sharing how he valued health. He stated, “it means everything to me, it really does”. He shared, “because as get older, forty especially can go downhill pretty fast”. He shared “if you’re not healthy can’t do anything because have something negative hanging over you”. “It’s like wanting to dance Pow Wow and having a broken leg” was his analogy.

Emotional

Participants talked about sex, being happy, balance, and stress as part of emotional wellness.

Sex.

Participant 03, a widow shared, “if you get a lot of sex you get healthy”. She smiled initially and began to laugh out loud as she made this comment; she has been a widow for several years.

Being happy.

Participant 05 talked about, “being happy”. She was very interested and concerned about mental health and wellness. She had shared with the researcher her personal experience with “anxieties”.

Balance.

Participant 012 talked about keeping “mental, physical, spiritual, emotional self balanced, not promoting one over the other”.

Stress.

Participant 05 talked about, “having, trying to maintain a stable mind; a stable mind would be my first choice”. Participant 06 shared, “being stress free”. She did not elaborate any further about this comment at this time or during the rest of the interview.

Spiritual

Participant 012 talked about the importance of not only being physically fit but making sure your mind, and spirit are also nurtured.

In summary, participants talked about factors related to physical, mental (intellectual), emotional, and spiritual wellness. Factors shared related to physical wellness included: freedom from pain and illness, exercise, nutrition, cleanliness, and being independent. Factors shared related to mental wellness included: their fears, decision-making, substance use, and value of health. The value of health was discussed as meaning everything. Factors shared related to emotional wellness included: sex, being happy, keeping a balance, and stress. Spiritual wellness was described as making sure your spirit was nurtured.

Interview Question Three

The third question had four parts in total for the participants to answer. The questions asked: What is a healthy person like to you or look like to you; A. Do you think you are a healthy person; B. What makes you a healthy or unhealthy person; C. What means you are healthy? Or when a person says you are healthy, what does that mean?

This first part of the question asked: What is a healthy person like to you or look like to you? The responses from the participants were categorized and separated into factors related to physical, mental (intellectual), and emotional wellness.

Physical

The participants described physical wellness as being related to level of activity and outward appearance.

Activity.

Participant 01 answered, “one who um can get up and move and do healthy things like go for a walk, go for a jog, play outside”. Participant 07 talked about being active as part of being healthy. Participant 08 described a healthy person as one “who walks around”. This 66-year-old man walks 2 to 3 kilometers every day. Participant 09, a 19-year-old male, described a healthy person as “fit”. Participant 010, a 71-year-old man, described a healthy person as one who can “work hard”.

Appearance.

Appearance was described in relation to weight, complexion (skin tone), attractiveness, facial expression, hair, and hygiene. Participant 02 described a healthy person as someone not being excessively overweight, and feels you can often tell if a person is healthy or not by their skin tone. She shared, “you know some people are extremely pale, and liver problems have yellowish skin”. She felt “being active I think that is the key is being active”. Participant 03 started her description with, “good color of skin”, and continued to share, “you know they help, they are not lazy, they are very active like that’s what I gather with these ones that are healthy”. Participant 06 shared she can tell by premature aging as an indication of their health. She also talked about a healthy person being “not sickly, skinny, or having a disease”. Participant 04

shared, “looks healthy” and continued to share personality traits she associated with health. They will be discussed under mental wellness. Participant 07 shared, “looking good”, he did not elaborate any further about this statement. Participant 05 stated, “someone who looks happy”. She continued to talk about “complexion wise, you can tell when someone is sick or not feeling well”. “Overall look of the person: complexion, skin tone, tells if healthy or not”. She talked about “expressions tell if something is wrong, thinking of the mental side of health”. Participant 010, a 71-year-old man, described a healthy person as one who “try and stay clean”.

Mental (Intellectual)

The participants described and gave examples of mental wellness and how they judged a person’s overall health by their attitude, use of drugs, and time spent with their family.

Attitude.

Participant 03 stated, “these who are not healthy they don’t want to do nothing”. She described healthy people as “they are not lazy”. Participant 04 described a healthy person as someone who is, “vibrant, happy, confident, secure, humorous (laughs a lot), can take criticism”. She also talked about the ability to “relate to any nationality, also not racist in terms of culture, very accepting of different culture, religion, belief systems and values”. Participant 05 described a healthy person as “someone who looks happy and is enthusiastic”. Participant 07 thought a healthy person “joked and stuff” and “they looked happy”. Participant 08 described a healthy person as one who “walks around and feel good”.

Substance use.

Participant 06 talked about a healthy person “not being wound up on pills or alcohol”. Participant 010 stated a healthy person “don’t drink”. Participant 09 described a healthy person

as one who is “not doing any drugs I guess”. He also described having a “straight forward mind, on track, leading his way, making the right decisions” as a healthy person.

Time spent with family.

Participant 01 talked about someone who “spend time with family” as a sign of a healthy person.

Emotional

Participant 06 described a healthy person as “very emotionally, they are how do you say, they are one level, not depressed”. Participant 011 stated if “healthy and go to work more apt to have circle of life, better connected” and “who you are connected to shows and reflects the individual”. The researcher interpreted this statement to mean individuals who are active and involved in their community are likely to be healthier individuals.

In summary, the responses from the participants were categorized and separated into factors related to physical, mental (intellectual), and emotional wellness. The participants described physical wellness as being related to level of activity and outward appearance. Appearance was described in relation to weight, complexion (skin tone), attractiveness, facial expression, hair, and hygiene. The participants described and gave examples of mental wellness and how they judged a person’s overall health by their attitude, abstinence of drugs, and level of activity with their family and community. Emotional wellness was described as being even mannered, and not depressed.

Interview Question 3A

This question asked: Do you think you are a healthy person? Three out of the fourteen participants answered yes.

Yes

Participant 01 responded with, “I do say so, yes I am a healthy person”. Participant 04 shared, “I think I am a very healthy person”. Participant 08 stated, “I think I am healthy though I got sugar diabetic, I’ve got high blood pressure and everything. If I didn’t take these damn pills I’d be healthier”.

Undecided

Nine out of the fourteen participants were unable to respond with a definite yes or no. They gave varying degrees or percentages of how healthy they thought they were based on their personal opinion. Participant 02 responded with, “to a certain point yes”. Participant 05 shared, “I can’t say 100% healthy, but average. Have ups and downs. Try not to get too overloaded. Have been through anxiety and that is not healthy”. Participant 07, “in some ways healthy, in some ways I’m not”. Participant 09 responded, “ya, sometimes”. Participant 010 shared, “not really, but I am trying to”. Participant 012 stated, “tough question. I think, believe that my goal is to become healthier. Every day I work towards being healthier…eventually I will be able to say I’m healthy. But I’m comfortable with who I am and what I am and know there are areas that need work. I know the Creator is not done with me yet…I think I am getting there, on my path to there”. Participant 013 shared, “I’d say I’m not as healthy as I should be because of my weight. If I were 30 pounds lighter I’d feel better and have more energy”. Participant 014 stated, “I would say for the most part. Diet and exercise wise”.

No

Two out of the fourteen participants answered no. Participant 03 responded with, “no, I like to think I am but I know I’m not. If I don’t get my way when I get upset, when I can’t make my own money, I like working, when the house is dirty when things are dirty like you know I

like the house clean and the dishes done. I like to help whenever I can". Participant 06 answered, "nope, unhealthy".

In summary, three out of fourteen participants stated they thought they were a healthy person. Nine participants were undecided. Most of these participants responded initially with 'yes I'm fairly healthy but' and continued to give the researcher the reasons why they were unhealthy. Two of the fourteen participants answered no.

Interview Question Three B

This question asked: What makes you healthy or unhealthy? The responses will be discussed under two categories: healthy and unhealthy.

Healthy

The two themes identified as part of being healthy are related to physical, mental (intellectual), emotional, spiritual wellness; and employment.

Physical

Physical factors identified as being part of healthy included exercise, nutrition, hygiene, appearance, and sleep.

Exercise.

Thirteen out of fourteen participants identified exercise as a part of being healthy. Participant 01 shared, "I do a fair amount of exercise". Participant 02 stated, "I try to stay active, a lot of things I enjoy". Participant 03 talked about, "Very active person, don't let sickness get the best of me". Participant 05 stated "exercise" was part of what made her healthy. Participant 07 talked about being "active" as part of what made him healthy. Participant 08, a 66-year-old man, described himself as being healthy because he exercises every day, "now I can walk 2 or 3 kilometer every day". He also shared "because that's all I can see how you can look after your

ownself". Participant 09 talked about being healthy "by playing Junior B hockey and baseball in North Battleford district". Participant 010 stated part of what made him healthy was "exercising". Participant 011 stated being "active in and outside the home" as part of being healthy. Participant 012 talked about "the fact I try to exercise as much as I can" as being healthy. Participant 013 shared his healthy behavior included "always in sports, try to walk if you can't run, bowl, golf". Participant 014 talked about his healthy behavior "exercise regularly, stretch, kata". He laughed as he shared with the researcher he has weights "but only lift them when I move".

Nutrition.

Nutrition was mentioned by seven of the fourteen participants as part of their healthy behavior. Participant 01 shared he thought he was a healthy person "because I watch what I eat". Participant 02 responded, "I try to eat healthy". She added, "not being excessively overweight, if severely overweight in danger of diabetes, heart disease". Participant 04 shared "eat proper diet, have good nutrition" as part of what makes her healthy. Participant 05 talked about what makes her healthy and nutrition was part of her description "eat well". Participant 010 talked about "the way I eat" as part of his healthy behavior. Participant 011 talked about factors related to nutrition that contributed toward making her a healthy person. She shared she "drinks lots of water, snacks, water bottle". She explained the "schedule during the school year" contributed to being healthy by providing a structure and routine for their home. Participant 014 talked at length about nutrition. He explained "diet very important to me, wild game and natural Indigenous foods". He has "done a lot of reading about nutrition". He shared with the researcher he "did a study in my family". He explained the difference in health between his brothers and himself. The participant stated, "I eat a lot of wild meat and wild rice, my brother eats a Canadian diet of meat, potatoes,

fries". He states "they are quite overweight compared to myself, not overweight", also "I rarely get sick, my brothers are sick a lot".

Hygiene.

Two participants mentioned hygiene as a factor related to making them healthy. Participant 010 mentioned nutrition first and followed his comment by "stay clean". Participant 014 talked about "washing hands and self" as part of his healthy behavior.

Appearance.

Participant 06 laughed when asked this question, and answered, "oh I could go on and on, I'm just not healthy". As she was thinking about the question she answered, "my complexion is good you know ah hum" and continued to smile and laugh with the researcher. Later during the next part of the question this participant was very clear in her description of what made her unhealthy.

Sleep.

One participant (04), female elder, talked about "proper rest, adequate sleep" as contributing toward making her healthy.

Mental (Intellectual)

Factors related to mental wellness included substance use, and personal attitude.

Substance use.

Seven of the fourteen participants identified their choice of abstinence and regulation of substance use as part of what made them healthy. Participant 02 shared, "I abstain from drugs and alcohol". Participant 04, female elder, stated, "I don't take alcohol, I don't take drugs, I don't use over-the-counter drugs, I don't smoke" as part of what makes her healthy. Participant 010 talked about "not drinking" as being healthy and later shared "mostly drinking" as part of his

unhealthy behavior. The researcher interpreted this to mean he was aware that drinking was causing problems in his life and he recognized not drinking was healthier for him. Participant 011 responded by saying “don’t do drugs, limited casual drinker, probably non-drinking class”. Participant 012 answered “abstaining drugs and alcohol” as contributing to making him a healthy person. Participant 013 shared, “no smoking, two beer limit”. Participant 014 responded with “do not drink alcohol”.

Personal attitude.

Two participants talked about having a positive attitude, and shared how they approached life from this perspective. Participant 05 shared she would “try not to dwell on the downside of either my family or community”, and she tries to be “optimistic about life”. Participant 012 stated his positive attitude a couple of times, “I believe I’m on my road to becoming healthy” and “I believe I’m on my way, close to being healthy”.

Emotional

Being involved.

Three participants talked about being involved with their kids or in community events as factors that contributed to making them healthy. Participants 09 and 012 both mentioned being actively involved in parenting as part of what made them healthy. Participant 09, a nineteen-year-old male, shared “take care of daughter”. Participant 012, a thirty seven year old male, talked about “teaching my kids about getting along”. Participant 07 talked about “get involved in community events”, as part of being healthy.

Spiritual

Participant 012 described himself as being healthy because he exercises as much as he can and “go to as many ceremonies, dancing Pow Wow, learning about my language”. This

participant consistently expressed his holistic perspective toward health throughout the interview. He stressed the importance of the “four parts: mental, physical, spiritual, and emotional areas to be worked on” for overall health.

Employment

Six of the fourteen participants talked about being employed and being able to work as part of what made them healthy. Participant 03 shared “can’t work past 3 years it is getting to me because I like working”. Participant 04 ended her description of what made her healthy by saying “above all I am employed, I work, gives me something to look forward to”. She added it “keeps me happy physically, emotionally, and mentally”. This female elder also stated “makes me happy I can still work at my age”. Participant 07 shared he liked to be active, “like to work” and be involved in the community. Participant 08’s first response to the question was “working, physical labor” followed by walking two to three kilometers every day. Participant 09 answered, “work, member of the Health Board” as part of his description of what makes him healthy. Participant 012 shared “working, being able to provide and live up to my responsibilities as a man” as part of being healthy.

Unhealthy

The unhealthy behavior described by the participants were separated and categorized into four areas: physical, mental (intellectual), emotional, and spiritual imbalance.

Physical

Physical factors identified as being part of unhealthy included exercise, nutrition, and chronic condition.

Exercise.

Seven out of fourteen participants identified lack of exercise as contributing to them being unhealthy. Participant 02 felt she was healthy to a certain point but stated, “I need more exercise”. Participant 04 thought she was “a very healthy person” but shared “lack of exercise” did contribute to her being unhealthy. Participant 06 stated, “ I’m just not healthy” and shared examples of why. One example she shared was “I don’t exercise”. Participant 07 thought he was healthy in some ways and “in some ways not”. He shared “not exercising too much” as an example of being unhealthy. Participant 010 shared he did exercise and felt exercise contributed toward him being healthy and also acknowledged “not enough exercise” was contributing to him being unhealthy. Participant 011 shared she was “not committing the time to the gym, I have lost weight, need to get commitment back”. Participant 013 talked about “not enough exercise” as contributing toward him being unhealthy.

Nutrition.

Five of the fourteen participants talked about nutrition and how their current eating habits were contributing toward being unhealthy. Participant 06 freely stated, “my eating habits are terrible”. Participant 011 talked about “I love chocolate” and having “snacks after 7 p.m.”. She felt these habits contributed toward her being unhealthy. Participant 013 talked about “not eating properly, love hamburgers and fries”. He shared “I have to change my diet”. He expressed further concern about “preservatives and stuff added to food causing problems” and the “wildlife being exposed to pesticides”. He stated, “food may be cause of diabetes because of the preservatives and pesticides” exposure. Participant 014 thought he had healthy behavior related to diet and exercise. He did share he had one unhealthy dietary habit “occasionally have a coke or bottled pop”, otherwise he felt he had good eating habits.

Chronic condition.

One participant felt she was unhealthy "because I just had a stroke". She stated she feels "tired, sleepy all the time". The researcher is unsure if this condition had been diagnosed by a medical doctor or if this was the participant's opinion.

Mental (Intellectual)

Mental factors identified as being part of unhealthy included negative thoughts, smoking and drinking alcohol.

Negative thoughts.

Two out of fourteen participants identified negative thoughts as contributing to them being unhealthy. Participant 04 admitted she "feel jealous at times", and this contributed to her being unhealthy. Participant 012's first comment in response to this question was "I'm negative to a degree, when I hear what people say or think it gets to me". This participant shared that he has a "negative attitude that seeps in every now and then that gives me an attitude". He explained the attitude is from "part of my experiences growing, still have a chip on my shoulder".

Substance use.

Seven of the fourteen participants talked about their habits related to smoking and drinking alcohol as contributing toward them being unhealthy. Participant 04 talked about "being exposed to second hand smoke" as contributing toward her being unhealthy. Participant 06, a 30-year-old female, talked about being unhealthy because "I smoke, and have for twenty years". Participant 07 felt he was unhealthy because he was "smoking a little heavy, too heavy, and lungs not too good". Participant 09, a 19-year-old male, described his only bad habits, "I drink once or twice a month with my brother" and I "smoke when I drink". Participant 010 described what makes him unhealthy as "mostly drinking, doing all these smoking stuff". Participant 011

shared she was unhealthy because “I smoke, a smoker”. Participant 014 stated “cigarette smoking, approximately one pack a week” as contributing to him being unhealthy.

Emotional

Emotional factors identified as being part of unhealthy included jealousy and dealing with stress.

Jealousy.

Participant 04 talked about feeling “jealous at times” and she felt this was contributing to her being unhealthy. She did not give an example or elaborate about situations or conditions in which she felt jealous.

Stress.

Three out of fourteen participants talked about being stressed and this was contributing toward them being unhealthy. Participant 03 talked about being “upset, can’t work past 3 years it is getting to me because I like working”. She also shared when the “home is dirty feel unhealthy, upsets me”. Participant 04 talked about “stress related to job”, she did not offer any additional explanation at this time. She also mentioned, “stress in relationships”. Again she did not offer any additional explanation to her comment. Participant 012 talked about “not being able to partake or take the time to look after myself” as a factor contributing toward him being unhealthy. He also shared another concern with the researcher “I’m letting my job take priority, where I have become a workaholic”. He stated he used to go to ceremonies more often and lately his job has taken priority.

Spiritual

Participant 012 talked about there being times “it gets the best of you”. He shared “I should go to my ceremonies more often, I used to” but “I’m letting my job take priority, where I have become a workaholic”.

In summary, participants talked about healthy behavior related to physical, mental (intellectual), emotional, spiritual wellness; and employment. Physical factors identified as being part of healthy included exercise, nutrition, hygiene, appearance, and sleep. Factors related to mental wellness included substance use and personal attitude. Being involved with their children and community was part of emotional wellness. Factors related to spiritual wellness included attending ceremonies and learning Indigenous language. Employment, being able to work, was identified as part of being healthy.

The unhealthy behavior described by the participants were related to physical, mental (intellectual), emotional, and spiritual imbalance. Physical factors identified as being part of unhealthy included exercise, nutrition, and chronic condition. Mental factors identified as part of unhealthy behavior included, negative thoughts and substance use. Emotional factors identified as part of unhealthy behavior included feelings of jealousy and dealing with stress. Spiritual factors identified as part of unhealthy behavior included letting one’s job take priority over attending ceremonies.

Interview Question Three C

This question asked: What means you’re healthy? Or when a person says you are healthy, what does that mean?

Eight participants answered the first part of the question: What means you’re healthy? Six participants answered the second part of the question: Or when a person says you are

healthy, what does that mean? None of the participants answered both parts. The responses to the questions will be separated and analyzed according to whether the participant answered the first (Part A) or second part (Part B) of the question. The themes will be presented and followed by a summary.

Part A: What means you're healthy?

The responses shared by the participants for the first part of the question were categorized into factors related to physical and mental (intellectual) wellness.

Physical

When the participants talked about physical factors related to meaning they were healthy, they talked about: appearance, feeling good, being fit and active, and being pain free.

Appearance.

There were a variety of comments regarding appearance. Participant 04 shared, "not tired looking", "clean, good personal hygiene". She talked about their overall "appearance"; a healthy person looks "well nourished", as well has "good oral hygiene". She made a comment about "hair" being a part of meaning you are healthy but did not offer any additional explanation. Participant 06 shared, "I'm in good shape, I look good" and "my complexion is good". Participant 07 answered the question with one statement, " looking good and looking healthy". He did not offer any additional explanation at this time. Participant 010 shared his perspective, "it means you are looking good, and doing alright I guess".

Feeling good.

One participant talked about feeling good as part of her response. Participant 03 shared, "When I feel good I feel healthy". She shared "when I am sick I'm not happy". She told the researcher "when I dress good, have a bath feel good".

Physically fit and active.

Two of the participants talked about being fit and active as part of their response. Participant 02 shared, " you are active". Participant 09 responded by saying "you're fit".

Being pain free.

Three participants talked about being pain free and their body functioning properly. Participant 01 talked about "looking forward to getting up every day and it is a new day and I'm accepting the challenge because I have no pain". Participant 04 shared, "they don't see you in physical pain, see healthy and vibrant". Participant 06 talked about, "all my organs are functioning" and this to her meant she was healthy.

Mental (Intellectual)

When the participants were talking about mental factors related to meaning they were healthy, they talked about attitude, how a person thinks.

Attitude.

One participant alluded to a clear mind. Participant 01 talked about being able to "look forward to getting up every day and it is a new day and accepting the challenge because I have no pain". He further explained, "I feel good, I feel energetic" and "I can do whatever I wish I want to do, I am healthy enough to do". Participant 02 talked about having a "healthy mind and body". She talked about there being times at work when she was "really stressed out" and added "that is not really a healthy mind when you know when you are stressed out". She did not share the stressors at work or give any additional information about her statement. Participant 04 shared, "when I say I'm healthy I'm in good spirits, not tired looking". Participant 014 stated when you are healthy, "it's a good positive feeling and a confident feeling". Participant 09 talked about having a "straightforward mind". He did not elaborate at this time but in the previous

question he described a straightforward mind as “on track, leading his way, making the right decisions”.

Part B: Or when a person says you are healthy, what does that mean?

The second part of the question was answered by five of the fourteen participants. Their comments were categorized into two themes and the other comments that do not fit will be discussed individually. The two themes are: holistic perspective, and physical appearance.

Holistic

Participant 02 responded with “you are active, healthy mind and body”. Participant 013 shared, “if a person tells me I’m healthy” maybe they mean “physically, emotionally, maybe spirituality and overall wellness”. Both of these participants described health from a holistic perspective.

Physical

Other participants described health from physical appearance. Participant 02 talked about other people assessing her health status by her size only and not taking into account other aspects of health. She shared, “I think when a person looks at me they tell me that I’m healthy, they’re just looking at my size”. She shared when she says she has to get into shape to dance Pow wow they respond by “but you are in shape”. She added, “just because I’m slim doesn’t mean I am in shape”. She added “because I’m fairly slim they think I am really healthy, which I guess um is what they think”. Participant 05 talked about “probably, in their eyes I look healthy”. She added, “I look happy healthy”.

In summary, the responses shared by the participants for the first part of the question were categorized into factors related to physical and mental (intellectual) wellness. Physical factors related to meaning they were healthy included: appearance, feeling good, being fit and

active, and being pain free. Mental factors related to being healthy included: attitude, and how a person thinks. Attitude was described by a positive feeling, confidence, energy, and having a healthy mind.

The responses shared by the participants for the second part of the question were categorized into holistic perspective and physical appearance. Holistic perspective included physical, emotional and spiritual wellness. The physical factor mentioned was appearance.

Three participants had comments that did not fit into the identified themes. Participant 08, a 66 year-old-man, responded with "how would anybody know I am healthy ha? I'd have to ask how they know? Even the doctor he can't tell by looking at you"! After this comment he did not elaborate any further, so the researcher proceeded with the next question. Participant 011 talked about the credibility of the source, she shared "hear it from a professional like a doctor, be great". However, if from a stranger they would be making the assumption "from the physical appearance", and according to this participant they "wouldn't actually know if internally healthy". This participant had explained in a previous question when she talked about internal health she was talking about spiritual health. Participant 012 talked about how he could tell if others were healthy. He shared two examples. He stated, "you can tell how the parents are by the way the children behave in class". He added, "if disciplining problems, no order, that is how the family is". He also made the comment, "I've seen social workers who are advising and their life is a wreck" and he wonders "how can they be advising?"

Interview Question Four

This question had two parts. The first part of the question asked: How do you keep yourself healthy? The second part of the question asked the participants if they went for checkups. The two parts of the question will be analyzed and presented separately, followed by a

summary. Two participants shared comments that did not fit into the identified categories and these will be presented in the summary.

The responses shared by the participants were categorized under physical, mental (intellectual), emotional, and spiritual wellness.

Physical

Thirteen out of the fourteen participants talked about factors related to physical wellness. Factors related to physical wellness included exercise, nutrition, and hygiene.

Exercise.

Twelve of the fourteen participants talked about staying active or the type of exercise they did to keep themselves healthy. Only one participant specified how often he exercised and his daily routine. Participant 01 shared he keeps himself healthy by "keeping ah staying in shape". Participant 02 talked about "I try to stay active", later during the interview she shared she had started running with her 12 year-old-son. Participant 03 shared she keeps healthy by "staying active, do something". Participant 05 shared "try to get as much exercise as I can, even just little walks". Participant 06 shared earlier "I'm just not healthy, I don't exercise" but during this question she stated she did "exercise". The researcher interpreted this to mean she does try or thinks about exercise but doesn't do it often, however, the researcher is unsure. Participant 08 responded by saying "I just told you, by exercising". Participant 09 answered by "playing sports". He shared earlier he played hockey and baseball in the North Battleford District. Participant 010 initially responded by laughing and stated, "same as before, stay clean, exercise, and don't drink". Participant 011 responded, "being active, keeping up the pace I have to live with". Participant 012 shared "dance Pow Wow, because I believe that is where I deal with a lot of stress". He continued, "when I'm dancing no one can touch me" and "it would be interesting

to be a spirit and hear how much people talk". This was the same participant who shared earlier in a previous question that it bothered him "when I hear what people say or think it gets to me". This Participant also shared he likes to "run and exercise". Participant 013 talked about keeping himself healthy by "golfing, sports, bowling, hockey, walking, and Pow Wow dancing". Participant 014 shared he "recently started taking Tae Kwon Do twice a week in Lloydminster, Pow Wow dancing 2-3 times per day at home" and finished by saying "I'm very active". One participant talked about being employed and how that contributed to him being healthy. Participant 09 answered this question by using three words "playing, sports, and working".

Nutrition.

Seven of the participants talked about nutrition, their eating habits and how this contributed toward keeping themselves healthy. Participant 01 answered "things I eat", did not offer any additional explanation about his eating habits or patterns. Participant 02 shared, "I try to eat proper, not too much junk food". Participant 04 talked about how she likes to "eat fruits and vegetables" and she also takes "fish oil, calcium everyday". Participant 05 shared "I eat properly". Participant 06 stated she "watch what eat". Participant 011 gave more information about her eating habits, she shared "if I want something, take a smaller portion, still having what I want in smaller portions and less often". She also is "watching food labels, for example juice labels with no sugar, no trans fat in food and oils". She "always carry a water bottle". Participant 013 talked about how he is "trying to eat a healthy and balanced diet".

Hygiene.

One participant (010), talked about he liked to "stay clean" and that contributed to keeping him healthy.

Sleep.

Two participants talked about getting their rest. Participant 04 talked about how she "try to get adequate rest and sleep". Participant 06 talked about "a lot of sleep" as contributing to keeping herself healthy.

Mental

Five of the fourteen participants talked about factors related to mental wellness when they shared how they keep themselves healthy. They talked about issues related to substance use and attitude.

Substance use.

Two participants talked about their personal habits related to substance use. Participant 07 stated he was "trying to quit smoking". He had shared earlier in the interview he thought he was unhealthy because he was "smoking a little heavy, too heavy, and lungs not too good". So he is trying to improve his health by not smoking. Participant 010 shared "don't drink". He also shared previously one of his unhealthy behaviors was "mostly drinking doing all these smoking stuff". He also feels the same way as participant 07 who is trying to change an unhealthy behavior and perceives this as keeping himself healthy.

Attitude.

Four participants talked about attitude and how this is related to keeping themselves healthy. Participant 02 shared "I know there is a lot of things I could change" so "I try to read and do some writing you know for myself, I try to do things I enjoy". Participant 05 shared she "try to look on the brighter side of things rather than what is". She continued, "I just try to take care of myself and my son" and "I know my son looks up to me". She also shared "I know if I feel good I know my son will feel good". Participant 06 talked about keeping herself healthy by

being “motivated”. Participant 012 talked about “loving my kids every day, showing them every morning, being thankful to see them at the end of the day” as part of keeping himself healthy.

Emotional

Stress.

One participant (06) talked about stress. She shared “try to limit the stress in your life”, she later added “be motivated”.

Spiritual

Two participants talked about their spiritual beliefs and how this contributed toward them being healthy.

Connection.

Participant 011shared, “mentally I have spiritual beliefs, feel connected to God and this gives me strength”.

Attending and participating at ceremonies.

Participant 012 shared several ways he keeps himself spiritually healthy. He talked about how he “goes to ceremonies”, is an “Elder’s helper”. He shared he thanks the “Creator for one more day” and is “thankful that nobody in the family has passed on”.

Check ups

The second part of the question asked the participants if they went for check ups. Participants shared they went for physicals, vision, and dental checkups. They also talked about specific tests they had done such as having their blood sugar tested, breast and pap screening.

Physicals

Participant 01 stated, “ seeing the doctor at least for a physical check up once at least once a year”. Participant 02 shared because of her age “I want to do that on a yearly basis just to

make sure". She shared "it is really important to me to try and stay as healthy as I can so I will be there for my kids". The researcher is unsure if she actually goes for an annual physical or if that is what she would like to do. Participant 04 stated "I have annual checkups every year". Participant 07 stated he has "regular annual checkups". Participant 09 answered "yep, every year". He has to get annual checkups as part of the requirement to play on his hockey team. Participant 011 shared she has "annual checkup every year". Participant 012 was very honest with his reply "odd checkup, being honest". He continued, "don't care for the doctor" but was concerned "with people being diagnosed with cancer and dying", so he tries "to go every six months, minimum once a year". He did add, "I need to do that more often". Participant 013 stated he has "a physical once a year". Participant 014 shared he goes "once a year for an annual checkup in Lloydminster".

Vision

Four of the participants mentioned having their vision checked or were concerned and needed their eyes to be examined. Participant 07 shared, "eye exam every two years". Participant 011 shared "need to have eye checked has been five years". After the interview the participant did go for an eye examination and was diagnosed with glaucoma. Participant 013 shared "eyesight is really good, no problems". He did not clarify if he had recently had his eyes examined or how regularly he had them checked. Participant 014 stated his "vision is stable, wears glasses, check every two years".

Dental

Three participants talked about dental checkups. Participant 07 stated his "last dental check about five years ago". He did not share if he had any plans of visiting a dentist in the near

future. Participant 011 stated she has “annual teeth checkup”. She is very happy with her teeth she shared my “teeth are awesome”. Participant 014 stated “dental once a year”.

Additional Screening

Three participants mentioned they had other checkups done on a regular basis. Participant 04 talked about having a “breast screen annually”. Participant 06 stated she hadn’t had a pap smear since her last child was born. Her youngest child is about ten years old. Participant 013 shared with the researcher he gets “blood checked every six months for diabetes”.

In summary, the responses shared by the participants were categorized under physical, mental (intellectual), and spiritual wellness. Factors related to physical wellness included exercise, nutrition, hygiene and sleep. Factors related to mental wellness included substance use and attitude. Stress was mentioned as a factor related to emotional wellness. Factors related to spiritual wellness included: connection to God, and attending ceremonies, and giving thanks on a daily basis. Two participants shared comments that did not fit into the identified categories. Participant 08 shared as part of keeping himself healthy “sometimes I don’t take the pills that they give me, I feel better that way”. Participant 012 shared, “when something happens in the family I’m there and probably take on too much”.

Participants shared they went for physicals, vision, dental, and additional screening tests. Additional screening tests included: blood sugar testing, breast and pap screening.

Interview Question Five

This question asked: What do you do differently from your ancestors to stay healthy? Participants’ responses were categorized under factors related to physical, emotional, spiritual wellness; and changes related to lifestyle.

Physical

Twelve out of the fourteen talked about factors related to physical wellness. Participants talked about activity and nutrition being different from their ancestors.

Activity.

Eight participants talked about the difference in activity levels when comparing themselves to their ancestors. Participant 01 talked about there being “way more choices for activity with and without family to stay healthy, to have a healthy lifestyle”. He stated, “exercise is easy you just don’t have to walk or run”. There are choices, “back then they probably used to just walk or go for a run”; today “we can ride out ten speed bikes or mountain bikes, go for a trail ride”. Participant 05 commented, “probably the exercise part of it, not sure if it would be different”. She added, “today now you have gyms”. Participant 06 stated, “I don’t do anything compared to them”. She shared, “my grandmother at age 80 tanning hides and smoking meat”. Participant 07 shared, “ancestors were very active, they didn’t have weights”. Participant 09 talked about, “we are getting lazier, they had to do hard labor”. He added things we do differently “playing sports, hockey”. Participant 012 stated, “probably lazier than my ancestors”. He also shared, “because back then they were always moving, active, doing something”. Participant 013 talked about sports, “not too much sports back then”. He shared, “my dad never played hockey or soccer, they didn’t have a facility or even a vehicle to travel in”. He also shared, “ancestors walk, nowadays we take a vehicle for everything”. He felt “because ancestors walked all the time they were probably more physically fit”. Participant 014 talked about “martial arts is different”.

Nutrition.

Nine participants talked about the difference in nutrition when they compared themselves to their ancestors. Participant 04 stated, “actually my ancestors would have been healthier than I am because they had a much healthier diet”. She commented that “venison” is healthier. She shared “my diet is different”. She stated she is “eating lots of fruits; stay away from fats, bacon, and pork; exercise; stay away from substance abuse”. The researcher interpreted this last comment to mean how her lifestyle is different in comparison, although she did not say this specifically. Participant 05 stated, “the eating would be different”. She did not elaborate or share any additional information about what would be different. Participant 07 talked about the “current diet is different from ancestors”. He added, “traditional food, wild meat is supposed to be good for you”. Participant 08, a 66-year-old-man, initially stated, “I don’t think I am any different” and later added, “the main problem is everybody is the diet has changed from a long time ago”. He continued, “you are what you eat”. Participant 010, a 71-year-old-man, started his comment with “well years back it was better”. He then laughed and stated, “looks like I said a little too much already, I feel faint”. He continued to say the “food, fishing, hunting” was better. He shared, “you could eat anything and not have any trouble, now with the spray you can’t eat anything”. Participant 011 made the comment, “I think they ate a lot of fried food, fried bannock”. She did not make any other comment related to nutrition. Participant 012 responded by saying “diets are different”. He added, “told not to be fussy and eat what is put on the table, I practically eat everything”. Participant 013 talked about “food” being different, “we have more choices” and have “vitamins”. Participant 014 stated, “Ancestors didn’t count calories”. He also stated, “I’m sure they didn’t have access to foods we do now such as corn, berries”.

Emotional

More time for ourselves.

One participant (02) made the comment, “I think today we tend to have more time to ourselves whereas long time ago everything they did was for their livelihood. She gave the example, “you know physical activity that or things that I want to do, not that I have to do them in order to survive”. The researcher interpreted this statement to mean there is less stress today to survive compared to when our ancestors were living.

Spiritual

Ceremonies.

One participant 07 talked about the similarities of spiritual wellness. He stated “similar in some ways to the Cultural Center”. He shared they have, “Pipe ceremony, Sweet Grass ceremony”. He added he goes “to feasts and helps out”. The researcher interpreted this to mean he is involved in similar ceremonies as his ancestors were.

Lifestyle

Participants talked about factors related to lifestyle. They talked about issues related to the environment and animals; the impact of technology; family and a few comments were made that did not fit into the identified categories. These comments will be discussed in the summary.

Environment and animals.

Participants shared comments related to the environment and animals. Participant 08 shared, “they used to live off the land”. Later in the interview he shared his concerns about “everything is getting so damn polluted”. He commented he has to “buy water to feel safe”. Participant 012 talked about the “animals were a lot healthier, the plants, pesticides, diseases”. This participant did not give any examples or add clarification to his statement, so the researcher

is unsure of the complete meaning behind his comment. Participant 014 talked about "moderation", he stated, "have to be conscious of the pollutants in the air or what the animals may have eaten". He continued to share "I won't eat river fish, will eat Jackfish from the lake because of concern about pollutants".

Impact of technology.

Five participants shared comments about how the lifestyle has changed from their ancestors. After analyzing their comments it became apparent the changes they were commenting on were a result of technology. Participant 02 talked about having access to things the ancestors didn't. She talked about "vitamins, immunization, chiropractors, all kinds of things". She talked about "long time ago everything was for their livelihood" and now "physical activity is a choice". Participant 09 shared "I guess life is easy now a days, we have vehicles, we are getting lazier, they had to do hard labor". Participant 011 shared, "they didn't have the resources we have". She also stated, "when they died they probably didn't even know what they died from". She also talked about "they weren't exposed, now we are exposed to everything". During the follow up interview the researcher asked for clarification of this statement. She responded with ability to access information, "we have more information, news, radio, TV, everyone talks about it quickly". She added, "we are informed, so many diseases, aware of different things" like "we can catch sexually transmitted infections", it is "controllable". Participant 012 talked about "education as well is different". He explained, "they had holistic education, their education was the land". Participant 013 talked about having "more choices to make our bodies healthy". He also talked about there being "cures for things they didn't have such as TB" and "controlling diabetes".

Family.

One participant talked about family and how today's family was different. He stated, "Family was a big thing, a community, living together and getting well together". He continued, "agreeing together and nobody went against them". He did not offer any additional explanation at this time or when he spoke with the interviewer the second time about this comment.

In summary, participants' responses were categorized under factors related to physical, emotional, spiritual wellness; and changes related to lifestyle. Factors related to physical health included activity and nutrition. Having more time for self care was identified as a factor related to emotional wellness. The similarity in practices related to spiritual wellness was mentioned; the Cultural Center in Thunderchild First Nation has Pipe and Sweet Grass ceremonies on a regular basis and is open to the community. Participants talked about factors related to lifestyle: environment and animals; the impact of technology; and family.

There were a couple of comments that did not fit into the identified categories. Participant 03 answered the question by saying, "it's work, and keep myself active like exercise and keep motivated". The researcher repeated the question and she did change her response. The researcher is unsure if she didn't understand the question or if that was her perceived difference when comparing herself to her ancestors. Participant 08 initially responded with "I don't think I am any different". He may have responded this way because of his age, 66 years-old, and having lived a similar lifestyle to his ancestors.

Interview Question Six

This question asked: What do you do when you are sick? The responses were categorized into preventative and secondary practice. Preventative practice referring to the health practices

the participants did to prevent getting sick. Secondary practice refers to what the participants did once they were sick.

Preventative Practice

Three of the participants talked about health practices they did to keep themselves healthy. Preventative practice included: taking vitamins, getting a flu shot, and an annual physical.

Vitamins.

Participant 011 stated, “take daily vitamins: calcium, magnesium, vitamins B and C, and Echinacea for the winter”. She shared “I haven’t been sick for years”. She told the researcher she knows when she is getting sick by signs. She shared her signs, “tired and nose starts to run, I can physically see the change” and from that she knows “I’m getting exhausted”. Participant 014 shared he does “take some vitamins and minerals”. He did not share with the researcher what type of vitamins regime he follows. Participant 013 stated he takes “a multivitamin” and “vitamin C” and drinks “orange juice and milk for calcium”.

Flu shot.

Participant 013 shared he gets “a flu shot every year”.

Annual physical check up.

Participant 013 shared he goes for a “yearly physical check up”. He shared with the researcher, “if I get sick usually just a cold or flu”.

Secondary Practice

Secondary practice included waiting, waiting and trying a herbal remedy, going to see a doctor, and going to the hospital.

Waiting.

Seven participants talked about waiting for a while before going to see the doctor. Participant 01 responded, “depends on really quite how sick I am”. He added, “if I am sick enough, give it a couple of days then I will go see the doctor”. This participant did not talk about resting or trying alternative remedies before going to the doctor. Participant 03 responded by saying “just lay there upset” and “I fight and I get out of it”. She did not give any explanation or share any other remedies she may use or when she would go to see a doctor. Participant 011 shared, “when I am sick I will rest”. She continued, “normally I’m not a sick person” and she knows when she is getting sick by being “tired and nose starts to run”. She stated, “if sick, runned down from spreading self too thin”. She did not talk about other remedies or when she would go to see a doctor. Participant 012 stated, “I’m an individual when I get sick I really get sick, I hardly get sick”. He explained, “if I have a cold I know it is coming on and try to go to a gym or run, sweat it out”. He continued to say, “rarely see a doctor unless forced to or taken”. He added, “sometimes there is nothing I can do and I end up sleeping”. He shared he will get up “as long as he can”. He did acknowledge that he doesn’t “take time to nurture myself or my body”.

Waiting and trying a herbal remedy.

Four of these seven participants talked about waiting and trying herbal medicine or natural herbs before going to see a doctor. Participant 02 shared when she is sick she will “stay in bed, my kids and husband look after me”. “If I can’t handle at home go to the doctor”. She added, “generally we use Indian Medicine, neocitran, home remedies first”. She finished by saying, “try to stay away from doctor as much as possible”. Participant 05 shared, “when I am sick I don’t see the doctor or anything, I try to overcome it myself”. She added, “I don’t see the doctor for medication”. She told the researcher “there are times I’ll ask my gramma or mom for healing medicines they drink, maybe Rat Root to chew on”. Participant 08 stated, “really don’t

do much, stay home and try help myself". He added, "don't take pills". He explained, "when I am sick I try to find out what is making me sick and I don't really go to the doctor because all he will do is give me pills". He finished his comment by saying "so I try to figure out what will do me good, maybe herbal medicine". Participant 014 shared he will, "drink a lot of cranberry juice, rat root, various remedies and natural herbs". He added, "I don't do pills of any kind, I can't handle Tylenol". He states he "never really liked taking pills of any sort, don't trust pills". He has seen "many people taking pills and become dependent".

Doctor.

Four participants talked about going to see a doctor when they are sick. Participant 04 shared, "I go see a doctor right away, something urgent I will go to the hospital right away if it needs to". Participant 07 stated, "I go to a doctor and find out what is wrong". Participant 09 shared, "I see a doctor, find out what is wrong, get a prescription". He added, "that is about it, stay home if it is that bad". Participant 013 stated, "if I feel like getting sick next day go to doctor and get checked". He added, "if I get sick usually just a cold or flu". He shared he knows his "body well enough to know when something is wrong, like if I'm going to be sick".

Hospital.

Two participants talked about going to the hospital when they are sick. Participant 010 stated, "really sick I go to the hospital". Participant 06 shared, "I go to the hospital". She added, "when I am not at death's door, depends how sick I am, continue with daily task if possible". She added if she couldn't continue with her daily tasks she will "go to sleep".

In summary, participants talked about preventative and secondary practices when sharing what they did when they were sick. Preventative practice included taking vitamins, getting a flu

shot, and yearly physical. Secondary practices included: waiting, waiting and trying a herbal remedy, going to the doctor, and going to the hospital.

Interview Question Seven

This question asked: Who do you talk to first when you are sick? Participants responded in three ways: to their spouse/partner, and or a family member, or nobody.

Spouse/Partner

Six participants indicated they talked to their spouse first. Participant 01 answered, “the first person I talk to is my wife”. Participant 04 shared, “my husband”. Participant 06 shared, “usually my husband first”. Participant 07 stated, “common-law wife”. Participant 09 shared, “my common-law wife first”. Participant 013 stated, “common-law wife”.

Family Member

Participant 02 shared, “my mom”. Nine of the participants talked to a family member when they were sick. Participant 05 stated, “my mom”. Participant 010 responded “ one of my daughters, she is a nurse”. Participant 011 shared “my husband and my kids”. She continued to share “you know I’m tired and need to relax”. The researcher interpreted this to mean she told her husband and her kids she was sick so they could help her get some rest. During the last question she shared she felt she was getting sick as a result of being exhausted. She told the researcher she also talked to her “sister, if something wrong to get advice”. She shared her sister is a registered nurse. The participant talked about her sister being a “good role model, practices what she preaches”. She shared with the researcher “I wouldn’t see a doctor who is 200 pounds; it is not just a piece of paper that makes a person a professional”. Participant 014 responded with “don’t laugh, my mom”. He shared “she knows all these recipes and natural remedies”.

Nobody

Three participants shared they tried to keep it to themselves when they were sick. Participant 03 answered, nobody, if I talk to my kids they'll take me to the hospital. In her opinion, hospitals can't do anything about her condition, "my sugar goes up and down". Participant 08, a male elder, responded, "me, I talk to myself". He continued to share, 'I don't even tell my wife, she wouldn't know what the hell is wrong anyway". He explained why he didn't tell a doctor, "when try to tell the doctor what is wrong with you he doesn't believe you, he tries to make his own diagnosis instead of listening to you". One married participant, 012, answered "myself". He stated "I try to keep it to myself and not get anybody worried". "If something serious, let my wife know and my mom or whoever". He repeated "I try to keep it to myself".

In summary, six participants talked to their spouse or partner first, five participants talked to a family member first, and three of the participants didn't talk to anyone when they were sick.

Interview Question Eight

This question asked: Where do you get your health information? The researcher separated and categorized the frequency of each response to determine the most commonly identified sources of information. Participants identified six sources to obtain information: media, health professionals, family and friends, job or university setting, Health Food store, and the health center in the community.

Media

Eight out of the fourteen participants talked about getting health information from the media. The type of media varied from reading books, pamphlets, posters, and billboards; and listening to the radio, and watching TV.

Reading.

Participants shared they are getting their health information from reading books, pamphlets, posters, and billboards; internet; radio; and TV. Participant 014 stated, “books”. Participant 013 shared he reads the National Inquirer and will “ask the doctor about it” whether it is “true”. Participant 03 shared, “I remember what I read, I don’t forget”. She also shared, “I read a lot about health in the clinics, anywhere if there is pamphlets”. She continued, “I read a lot of them”. She told the researcher “I take a handful and I take them home” and “when I am laying down, and I want to find out something I pick them up and read them”. She laughed while she explained, “that’s how I have an idea of what to do”. Participant 04 stated, “reading pamphlets”. Participant 011 stated, “read pamphlets”. Participant 012 shared, “from what I read”, “mostly posters, billboards, some place waiting you read the magazines”. Participant 013 shared, “posters”. Participant 014 talked about using the “internet”. He shared with the researcher he “always knew something unhealthy with current Native diet because Indigenous bodies have not adjusted”. He continued to share, the “trade goods: sugar, salt, flour are exactly what are killing our people”. He commented when you “add lard and milk to this Canadian diet and very unhealthy”. He wanted to make sure the researcher knew “bannock is not traditional food of Indigenous peoples”. This participant shared with the researcher he has done extensive reading about nutrition and is very concerned about the current nutritional status of his family and community.

Health Professionals

Seven of the fourteen participants talked about getting health information from health professionals. Participants talked about health professionals that included: nurses, chiropractor, doctors, and the Health Hotline.

Nurses.

Two participants talked about getting health information from nurses. They were specific about where these nurses worked. Participant 06 stated, “nurses in the community”. Participant 02 stated, “nurses not from Thunderchild”. This participant shared when she needs health information or advice after hours she will “call the hospital and talk to the nurses”. She did not share or elaborate why she preferred to consult nurses outside the community.

Chiropractor.

Participant 04 shared she gets some of her health information from a “chiropractor”. This participant started seeing a chiropractor when her son-in-law became a chiropractor.

Doctors.

Participant 02 shared, “primarily from the doctor and the nursing staff”. Participant 07 stated, “doctor”. Participant 08 shared, “you experience the medical, you experience doctors, you go to some doctor you know he’ll tell you one thing”, and “you go to another doctor he’ll tell you a different thing”. Participant 010 stated, “doctor”. Participant 011 shared she gets some of her information while “sitting in a doctors’ office”.

Health hotline.

Participant 02 shared, “when we lived in North Battleford they had the Health Hotline if it’s after hours”. Participant 03 laughed as she shared, “ from a 1 800 number”, and continued to say “Health Hotline”.

Hospital.

Participant 02 shared, “I will phone the hospital and talk to one of the nurses and they usually are pretty good you know in Turtleford”, she added, “they kind of answer all your questions”.

Family and Friends

Seven of the fourteen participants shared they obtain health information from family with and without medical backgrounds, friends and acquaintances.

Family with medical training.

Participant 01 shared “from my sister, what to eat and what, she is a nurse”. He did not mention any other sources at this time. Participant 04 shared, “a lot of information from my daughter, she is a registered nurse”. Participant 010 stated, “my daughter”, earlier he had shared “she is a nurse”. Participant 011 shared, “a lot from my sister”, earlier she had shared her sister “is a nurse”.

Family without medical training.

Participant 09 laughed as he shared his response, “my parents, they tell me what they think, if they are not sure they make me go see a trained professional”. He shared a trained professional included a “doctor, maybe a nurse (registered nurse)”

Friends and acquaintances.

Participant 05 shared, “talking with family and friends”. Participant 012 stated, “from talking to people”.

Job/University

Job.

Participant 04 stated she gets some of her health information by “professional development”. She is a social worker and worked previously as a certified nursing assistant (CNA) for 22 years prior to changing careers. Participant 06 shared it “really helps I sit on the Health Board”.

University.

Participant 011 shared, “going to university” has become a new source of health information. She is currently enrolled in a social work program.

Health Food Store

Participant 04 shared she gets some of her health information from “Moms Nutrition” a health food store in Saskatoon.

Health Center in the Community

Community health center.

Participant 013 talked about the Health Center as a source of where he obtains his health information. He shared, “sometimes get information in the mail from the Health Center, which included Turtleford, recommends how to avoid and what to do”. He shared, “read information on the wall, posters, and pamphlets “at the Health Center”.

Member of the health board.

Participant 05 stated, “well usually brought to attention at the Health Band level”. Participant 05 is a member of the health board and as a result is kept updated and current with health and health issues. Participant 06 stated, “really helps I sit on the Health Board”.

In summary, participants get their health information from the media, health professionals, family, friends, acquaintances, job, while attending university, Health Food Store, and the Health Center in their community. The media included: books, pamphlets, posters, billboards, internet, radio, and TV. Health professionals included community and hospital nurses, chiropractor, doctors, and the Health Hotline. Family included members with and without medical training. The family members mentioned with medical training are currently practicing as registered nurses. The community included the Piyesiw Awasis Health Centre, and being a

member of the Health Board. One participant (08) shared he "looks around" and by "experience" he obtains his health information. This participant did not elaborate or share any additional information about the meaning of his comments with the researcher.

Interview Question Nine

This question asked: Have your feelings about health changed in the last 5 years? Four participants answered no, nine participants answered yes, and one participant was not sure. The participants who indicated no change about health the past five years will be presented first.

No

Participants 06 and 07 simply stated, "nope" and did not share any additional information. Participant 09 responded, "no, it hasn't changed". He continued to share, "still learning, trying to catch up with what is new". Participant 012 shared, "no". He continued, "I've always had the same attitude about health from the get go". He added, "feelings still the same about drugs and alcohol". Earlier during the interview he shared he has always abstained from all drugs and alcohol. He stated, "my attitude hasn't changed because if it did I would be different, still have the same view". This participant throughout the interview talked about health from a holistic perspective and shared his journey trying to address his personal health from a balanced perspective.

Yes

Ten of the fourteen participants' feelings had changed about health in the last five years. Their feelings and concerns are related to three themes: aging, change in health care services, and knowledge. One participant talked about having a chronic condition and how that has impacted his life. His comments will be presented in the summary.

Aging.

Participant 02 shared, “my thinking about health has changed”. She shared, “ at my age now I’m really concerned about my health and my husbands’ health”. She laughed as she shared we all try to “convince him to quit smoking”. She shared with the researcher there was a lot of things “we need to work on” but “at least we are all thinking about it, we’re all talking about it at home” so “we’re all kinda striving for the same thing now”. Participant 04 shared, “actually I can say I’m very fortunate, I have had excellent care, not like my sisters”. She continued, “definitely have changed, one foot in the grave, definitely think about health”. She stated she was “thankful for each day you wake up”. “When young don’t think about it, take it for granted”. She also felt “when older you are more helpful to others when they are sick”. Participant 013 stated, “Because I’m getting older wish I had done more self care when I was younger, for what you do and don’t do affects you later”. She did not elaborate or give any examples of activities she wished she had done when she was younger. Participant 013 stated, “as grow older my body needs more supplements, vitamins, better diet, as get older need to lose weight to decrease heart attack, try to be active”.

Change in health care services.

Several participants talked about the change in health care services. One participant talked about the positive changes and others talked about their concerns related to the changes in health services. Participant 013 talked about “health care has become better the last five years, even for our Elders”. He talked about the increase in services available in Thunderchild. He talked about there being Home Care workers available to do “cooking, cleaning, bathing” in the community. He continued to share, “we have a good health system”. He gave examples of the improvement in health care. He shared, “we now have a dentist every day, and dental therapist

from Thunderchild", there are "flu shots available", and "once a month give Elders a vegetable box".

Several participants talked about their concerns about some of the services in the health care services. Participant 011 responded to the question by saying "not necessarily health, but health care has changed". She stated, "health seems to be declining". She shared, "people with money seem to be able to access better health care". She shared, "we all deserve equal rights, access, and opportunity to health". She stated, "if talking with lower class, poverty difficult to be healthy" because "it cost money to eat healthy". She continued, "you buy what you can afford or have a budget". She shared her concern some people may not be able "to see a specialist if referred because related to money". She did not elaborate any further about this comment. Participant 03 responded to the question by saying "ya lots" and proceeded to talk about her recent knee surgery and how the experience had been negative. She stated, "people don't look after you as much they used to before". She stated, "they don't pay no attention to you, like a dog I'll say because I know". She continued to tell the researcher "when I went for my surgery years ago, they used to on wheels like you know on a bed" now "you walk over there and you sit there and you walk into the surgery room, before it was nice to ride in a stretcher". She commented, "before it was nice, put you to sleep before you see these things". Participant stated she "heard hammer and chisel" and this was upsetting. She was also surprised; they "expected me to walk the next day". She felt there was, "no respect, if you can't make it tough luck".

Knowledge.

Participants talked about knowledge changing their feelings about health. Knowledge about the following conditions had changed their feelings about health: nutrition, smoking, anxiety disorders, diabetes, and fetal alcohol syndrome (FAS). Participant 01 shared, "cause

today there is a lot more greasy foods out there so you really got to watch what you eat and what your kids eat to try and stay healthy". His wife, participant 02 shared, "my thinking about health has changed and then like I said you know at my age now I'm really concerned about my health and my husband's health". The family is trying to "convince him to quit smoking". She shared her concerns, "even the way used to eat and how I cook now, cholesterol, fatty foods, junk food". "I cook trying to make a little bit more healthier, I'm more concerned with diabetes". She also expressed "I'm really concerned about FAS, it might be primarily due to what I see at the school". She also shared, I "don't want to be a burden to my kids". On the positive side she shared they are "all talking about health at home, all striving toward the same goal". Participant 05 responded by saying "ya, yes it has". She shared, "I never knew what anxieties were or anything". She had learned "it has taken a high toll, the disease of the 90's". She shared from personal experience she "had to learn from there to have a healthy body". She shared with the researcher in retrospect "when I was going through that I didn't really look after myself". She shared she "now going for walks and clearing my mind, is healthy". Participant 014 answered by saying, "yes, because it has started including the mind". Before it was "physical concerns and diet". He shared he is "starting to meditate, and self-healing journey". He has "noticed injuries heal faster". He talked about people in his age group and their "unhealthy living and attitude, they are overweight and have lost teeth". The participant stated, "I have all my teeth" and "I have maintained 165 lbs for 25 years". He told the researcher "two years ago brother died and I cut two feet of hair and hair is almost back to the same length". The researcher observed the participant's hair to be long, thick, shiny, and very healthy looking. He continued his story, "you can will hair to grow". He shared he reads "a lot from other cultures and absorb what I find helpful, Japanese and Chinese". He also uses "meditation to deal with stress".

In summary, four of the participants had not changed their feelings about health in the last five years. Nine of the participants had changed their feelings about health as a result of aging, change in health care services, and knowledge. The changes in health care services were positive and negative. The positive changes included increased services available in the community such as: home care, access to a dentist and dental therapist, flu shots being available, and once a month Elders receive a vegetable box. Participants expressed concerns about health care changing related to surgical procedures, and access. Knowledge about the following conditions had changed their feelings about health: nutrition, smoking, anxiety disorders, diabetes, and fetal alcohol syndrome (FAS).

Participant 09 answered this question by saying, “I don’t think it did”. He explained, “always had this, I’ve always seen these problems, even being off the reserve”. “Being Native or Aboriginal they just give you a pill or a band-aid”. He shared, “the white society they get the main things that help them like a MRI”. He shared with the researcher, “ I have tried to get one 5 or 6 years and couldn’t get one”, and “I can’t even get one, why I don’t know”. He stated, “when I go to City Hospital, only white people sitting there”. He turned to the researcher and said, “how come is that?” He then answered, “because you’re Indian!” He finished his comment by saying “Health Canada doesn’t help with nothing, I think want to do away with their benefits, and that is a treaty right”.

Interview Question Ten

This question asked: When you thought about this interview is there anything you hoped I would ask but didn’t? Eight of the fourteen participants did not have anything else to add at this time and they shared some general comments. Six of the participants raised areas of concern or issues that had not been discussed previously. Their concerns were related to: nutrition, decrease

in services, perceived difference in treatment of Aboriginal and non-aboriginal peoples in the health care system, and politics at the federal and local band level impacting the delivery of health care.

Even though eight participants didn't have a particular area of concern, some of them did share a personal thought or statement about the research process with the researcher. Participant 01 responded by saying, "I guess if I am healthy my wife and my kids um would be probably healthy to because it is a family together, that is it I would say". He also shared with the researcher, "I think it is good that someone like you takes the time to interview people from back home to see our different opinions of what healthy being healthy means and stuff". He ended his comment by sharing, "always try and stay active, as soon as no longer active lose ability to keep up with life". Participant 02 answered, "no, probably later on as I think about it there might be something". Participant 05 wanted clarification from the researcher that she had answered the questions correctly, "just wondering if I'm on the right track with you, like I said I'm more on the mental health side, perhaps from my personal experience". Participant 06 stated, "no, because I wasn't sure what to expect or what kind of questions you'd be asking". Participant 07 was brief, "nope". Participant 09 responded with, "no, actually nothing, not really sure what to expect". Participant 010 stated, "no" and did not add anything else to his comment. Participant 012 shared, "no, I really didn't know what to expect, now that I've gone through it I guess there is different perspectives to health". He also made the comment, "questions were open enough to touch on, both pretty well covered and if it didn't I threw it in". Participant 011 commented that is was "really good to see a university student and the interest, interesting to see the data". She felt this project would have a "huge impact on how people feel". She also added it was a

"personable interview, should be commended". She thought "all the questions are good, looking for individual opinions".

Six of the fourteen participants talked about issues related to health from their perspective. They discussed: nutrition, their community, change in services, perceived difference in treatment of Aboriginal and non-Aboriginal peoples in the health care system, and politics at the local band and federal government impacting the delivery of health care.

Nutrition

Nutrition was mentioned by one of the participants (014). He told the researcher he had been "hoping you would ask about my feelings about the 'cave man diet' and 'prehistoric diet' is important for healing". He continued to share, "it is the only way our people will heal is by returning and practicing a prehistoric diet, before white men came".

Community (Thunderchild First Nation)

Participant 013 thought there might be questions "about our community, are they healthy?" In his opinion "too many people are overweight, popping pills, too much drinking". He wanted to talk about "and what could we do to help each other as a community". He felt "we do have good community health programs in place, great improvement in the last ten years". Areas of improvement included: the Health Center, Home Care, and having a taxi service since the 80's. He felt the community "need to access the brand new school, Health Center has weights". In his opinion to reduce the need for duplication of exercise equipment, the community should have access to the exercise equipment in the new school and at the Health Clinic. He expressed concern about "Old Timer Hockey, tough to get the group out".

Services

Physiotherapy.

Participant 03 talked about the decrease in available services and how this had impacted her health. She recently had knee surgery and required physiotherapy as part of the rehabilitation. She shared, “I had a surgery, they won’t even pay for my physio”. She expressed concern about the delay in receiving physiotherapy, “it was delayed, delayed, delayed, yep”. She continued to share, “I had to really fight to get it but I’m getting it”.

Home care.

This participant (03) also stated she needed home care after her surgery and was refused because her son lives with her. She shared “son is disability can’t even help me with anything but he tries, he helps me”. She shared with the researcher she told her doctors and they told her “nope, he’s on disability they’ve got to come and help you”. She stated “and they never did like you know”.

Prescription.

Participant 03 expressed frustration with having a prescription for orthotics related to her ‘diabetic stable foot’ and not being able to replace the previous pair, “I wear them out and I told them I need a set”. She explained the “orthotics still haven’t been paid for” and as a result she will go without the orthotics until the fee is covered.

Hearing aid.

Participant 03 continued to share the problems she has had with services related to obtaining her hearing aids. During the initial interview she shared with the researcher “they say they were gonna pay for I would say 5-8 years ago and they haven’t even paid them yet”. “They still owe for my hearing aids”. This participant was clear about her frustration with how the secondary services were followed up and submission for payment for those services. She felt it wasn’t a priority and that it should be attended to in a prompt manner. She stressed the

importance of providing aids “for us to feel better about ourselves”. She shared, “sure I’ve got the hearing aids but I don’t feel good because I owe them”. She was concerned the hearing aids could be repossessed “they can come and say well we need those hearing aids, then what do I do?” She stated, “if I don’t have nothing, then I can’t hear nothing, you know what I mean?” This participant is currently on disability and no longer able to work as she had done in the past. When the researcher met with the participant the second time she shared the bill for her hearing aids had been paid; so now she had both hearing aids. She shared with the researcher, “have been without left hearing aid 9-12 months”.

Decrease in coverage.

Participant 04 shared her concern about the cuts in coverage, “prescriptions, and chiropractic care”. This female Elder expressed her overall concern about losing coverage, and is especially concerned about the poor people and the impact it will have on their health and ability to access health services. Participant 011 thought she would be asked if she had seen a difference in services for natives. She expressed concern, “I have seen it is declining and limited yearly”. She shared her personal experience with the cutback in the dental services in Alberta. She explained, “used to get teeth cleaned twice a year, now half a mouth and go back for the bottom”.

Perceived Difference in Treatment of Aboriginal and Non-Aboriginal Peoples in Health Care

Ambulance service.

Participant 04 thought she would be asked about the difference “I see the care given to non-native people because that is something I really noticed the care the difference”. She was concerned about dealing with this issue “in a nice way without hurting the non-native people”. She continued, “they’re not treated the same as the white person, that is what I was thinking”.

She gave an example using the local ambulance attendants, and drivers. She stated, “they take a while and also when they arrive at the scene like you know our people are not treated ah accordingly the way it should be”. She shared, “one of our elders died like that”. This elder “told them she couldn’t move and they made her stand up, apparently she had a broken hip”. According to the participant this elder was 85 years old and they made her climb up on to the stretcher. This participant felt this Elder would have lived had she been treated properly.

Medical appointments.

Participant 04 also talked about her experiences of accompanying her sisters when they had appointments with their doctor. She described their appointments with their doctors as being very different from her medical appointments. She explained, “ with my sisters the doctors will be writing a prescription before they have finished telling their problem”. She stated, “with me I will ask what causes this, I always make the doctor explain to me”. She concluded her comment with “ physical appearance makes a difference how you will be treated, if clean and polite will get good care”. Participant 011 thought she may be asked a question regarding the difference between natives and non-natives in health care system. She did not elaborate or give example of what she meant by this statement.

Politics at the Local Band and Federal Level Impacting the Delivery of Health Care

Local taxi service.

Participant 03 expressed frustration about the current taxi service being provided in the community. She stated, “don’t talk to anybody because nothing ever gets done”. She had an appointment “to get my heart checked”, she missed her appointment because she didn’t want to take the taxi to Saskatoon that day. “Don’t want to take taxi, a guy has dialysis, have to wait for five hours, I need to be able to rest”. She shared she wasn’t feeling well and during this time she

would have no place to rest so she missed her appointment. She felt if she had taken her own car "at least I can lay down in my car and have a rest and just go there and come right back". This request for mileage had gone back and forth between Chief and Council of Thunderchild First Nation and the Health Director because Health had denied her request. Her finishing comment regarding this incident was "should be more helpful in the community".

Communication within the community.

This participant (08) felt there should be more communication between Chief and Council and the community regarding community events such as Elders Dinners and in general regarding health planning. They "should have more communication because they are always leaving us out for the Elders for dinners for dinners like ah on Wednesdays they have Elders lunch". She made the comment "we're all meals on wheels, they never bring us our meals". She continued "some people get meals on wheels, it seems only certain people get it". She (participant 08) added,

> In the community because it is lack of communication like you know it's only what they want to do they do not what we want, like you know, what we want they don't want to do. It's what they want what they can do is what they do and that's not right.

Local social services.

This participant shared she was frustrated and wanted to "move out of the reserve and move to the city". She stated "at least city welfare is good to you when you are sick, when you give them letters they honor it and that is the way I like it". During the interview she had talked about "doctors' letters like you know they shouldn't put them on the side they should work with them", it appears to the researcher she felt the doctors' letters did not have the same impact in the

community as they had in the city. She stated social services are poor on the reserve compared to the city welfare services.

Local band reform.

Participant 04 talked about the health services being provided by the Thunderchild First Nation and offered suggestions for improvement. She felt there should be a reform at the band level of administration due to the lack of services being provided in the community and local health facility. She expressed concern about "feeling the nurses don't seem to care about the bumpy road to Turtleford" and how this impacts the comfort of the local residents. She felt if they had more training they could do the dressing changes for the community members in their homes and save the trips to the local hospital. She also shared participants had to travel at least one hour to receive physiotherapy and the mileage was not guaranteed, compromising the ability to attend recommended treatment.

Federal politics.

Participant 08 shared several comments regarding health and the federal government. When the researcher initially asked the participant this question he initially answered no, and then added "I just wanted to know what it was all about, but to have an interview like this I don't know, I don't know if it makes a difference". The researcher responded with:

> It does help to do this interview um what it does is it helps you the Plains Cree Aboriginal person tell other people, the white people, the health professionals how you think about health. And that helps them understand Aboriginal Native people.

As the researcher was speaking this male elder interrupted and stated:

> I think I think is the main problem is they don't even listen to these things. If they were listening to them to Aboriginal people, who you'd think would be like this? No way. You

> can't tell me that Canada or whatever being for us is as doing all their power to try to put away these go with their aspirin and bandage treatment they give animals. You can't tell me that this helps if they did it would of done something long time ago (Participant 08).

This male elder expressed very strong feelings toward government, Aboriginal and the federal government. He expressed:

> This is the problem right here, the reserves and all the Indian leaders right from the Assembly First Nations (AFN). They can't talk for nobody. Federated Saskatchewan Indian Nation (FSIN) they can't talk, for even Chief and Council right here they can't talk for you. Too chicken or what! (Participant 08).

This participant freely shared his feelings and offered some suggestions toward improving the current Aboriginal situation. He was clear and felt strongly about his statement:

> Who is going to help the Indian? They've been saying that for how long, 150 moons ago? They have to help themselves and do away with Assembly First Nations (AFN), Federated Saskatchewan Indian Nation (FSIN), and all the Indian Associations or whatever, the hell with them. They can't do nothing for Indians, all they're do is up there for themselves (Participant 08).

This participant stated, "I'd rather stand alone myself". He continued, "White people stole from everyone and they tell me they are going to help us? He feels, "medical establishments don't give a damn, establishment doesn't give a damn, face reality". He shared, "I faced reality a long time ago". Participant 08 shared his early experience of being removed from his home, "ever since took me to residential school at age [early childhood] I have been fighting the white society". He continued to say, "steal all our resources and our land, I don't like what I see, being dominated by someone who stole our land".

In summary, eight of the participants stated they did not have anything else to add at this time. Six of the participants expressed concern about: nutrition, their community, health services, perceived difference in treatment of Aboriginal and non-Aboriginal peoples in the health care system, and politics at the local band and federal level impacting the delivery of health care. Concerns about health services included: delayed physiotherapy, home care, living aid prescription, hearing aids, chiropractic coverage, and decrease in coverage for health services such as dental care. Perceived difference in treatment of Aboriginal and non-Aboriginal peoples in the health care system included ambulance care and medical appointments. Politics at the local band included: taxi service, communication within the community, social services, and recommended reform. Federal politics included comments regarding Aboriginal and Federal government organizations that included: Assembly of First Nations (AFN), Federated Saskatchewan Indian Nation (FSIN), Health Canada, and the Federal government.

Interview Question Eleven

This question asked: Picture yourself being the healthiest possible you can imagine. What would have to happen for you to achieve that? The participants answered this question by discussing factors related to physical, mental (intellectual), emotional, and spiritual wellness; economics; environment; and politics.

Physical

Ten of the fourteen participants talked about the following factors related to physical wellness: exercise, nutrition, appearance, and pain.

Exercise.

Eight participants talked about beginning or maintaining an exercise regime as part of reaching optimum health. Participant stated she needed, “things to exercise with” such as a

"walking machine (treadmill)". Participant 013 stated the "Band should spend more money on sports" the community needs an "all-purpose facility like a sports complex with a pool". He stated they have to commute to Lloydminster or North Battleford to go swimming. Participant 07 shared he needed to, "start exercising, I bought weights and they are sitting downstairs". Participant 014 shared he has started training again in the "martial arts". Participant 02 shared she needed to "stay on my exercise program to keep mind, body, and soul healthy". She shared she was having "difficulty sticking to an exercise routine/program because family responsibilities interfere". She shared with the researcher she has "started running with son". Apparently he is enjoying the running as well. Participant 06 responded by saying "exercise lots". She did not clarify what "lots" entailed. Participant 011 shared she would like to "have ideal body". She shared the measurements "38, 28, 28". She talked about how she would have to incorporate exercise into her life by going to the "gym" and by walking, "walk the extra block instead of driving". Participant 012 talked about keeping "myself fit". He did clarify this comment by saying health was "not just fitness" but a balance between physical, mental, emotional, and spiritual well-being. Participant 013 shared he would need an "exercise, weight program" or "ride a bike" to assist in achieving in optimal health.

Nutrition.

Four of the fourteen participants talked about nutrition, their eating habits and the changes they would need to make to achieve optimum health. Participant 06 stated she would have to "change my diet" to move towards an optimum level of health. She did not explain or gives examples of how she would change her diet. Participant 07 talked about eating "better food, healthier foods". Participant 08 shared "go back to the old peoples diet, they didn't have diabetes". He stated, "a lot of these diseases brought by the white people, the natives were killed

by these diseases". He was firm about the need to "go back to the old way of eating". He also shared his concern about "eating all this stuff injected with who knows what". Participant 013 stated to reach optimum health he would have to "first of all change eating habits". He suggested to help improve the nutritional status of people in the community the "Health Center would give out multivitamins for adults once they reach a certain age".

Appearance.

Two participants talked about factors related to appearance. Appearance was discussed in relation to having an ideal body, being able to experiment with skin care products and colored contacts, and being clean. Participant 011 shared she "would like to have ideal body" with the corresponding measurements of 38, 28, 38. She also shared she would like to do "self care" such as using "skin creams". She expressed she would like to "be able to afford to experiment with colored contacts". Participant 010 stated to be as healthy as possible he needed to "stay clean".

Pain.

Two participants talked about pain as a barrier to obtaining optimal health. Participant 02's first comment was, "not to have arthritis (back, left knee, right wrist)". She shared with the researcher she has "tried magnetic bracelets with some success". Participant 03 stated, "my knee to get better".

Mental (Intellectual)

Eleven of the fourteen participants talked about factors related to mental wellness that would need to be addressed for them to reach optimal health. Participants talked about the following factors: abstinence and substance use; attitude; counseling and attending workshops.

Abstinence and substance use.

Six of the eleven participants talked about issues related to abstinence and substance use. Five participants talked about how they would have to quit smoking. Two of the six participants talked about not drinking alcohol as part of reaching optimal health. Participant 01 stated he would have to "quit smoking". He added, "I'd have to have cancer first before I'd quit". Participant 05 shared, "quit smoking for sure". Participant 07 shared, "I have to quit smoking, my number one problem". Participant 09 answered, "a lot of things I guess". He stated, "I'd have to stop my bad habits" like "drinking, I think I could stop drinking, maybe drink once a month while watching a game or something" and "cigarettes". Participant 010 stated he would have to "stay sober and stay healthy that way". Participant 014 stated he would have to "quit smoking cigarettes".

Attitude.

Nine of the fourteen participants talked about factors related to attitude. Participant 01's first comment was, "you have to want to live, have goals, hope". Participant 012 shared he needs to make "sure I stay focused". He stated earlier "need a strong will" and this is accomplished if there is a balance between "physical, mental, emotional, and spiritual wellness". He talked about "making sure what I've done is all that I can do, and feel content with decisions I've made". He shared, "to me every day is a new day". He talked about mental conditioning "puts power behind your physical strength to help create motivation". He gave the following example, "if felt like fighting and told to fight there would be a different outcome".

Knowledge.

Participant 09 shared, "I'm not that crazy, I think; maybe go to school, graduated 2 years ago". Participant 012 stated, "sickness is related to mental health issues, we need to understand

that". He continued," the question is how many people understand or care to understand this?" Participant 012 talked about, "continually looking after mind and spirit, doing things every day to condition". He gave examples, "like reading; listening to elders, people; exercising; conditioning the mind to get into problem-solving" and being "involved in mental health".

Counseling and attending workshops (healing).

Two participants talked about healing and understanding the origin of sickness. Participant 011 stated, "I would need to deal with trauma I have experienced". Participant 012 stated he has attended "Journey conferences; Inner Child workshops; learn how cellular process works within your system" to "understanding where sickness comes from". He shared an example, "cancer can develop from abandonment, get the mind to think in different ways".

Emotional

Motivation.

Participant 05 stated, "have to be motivated but I don't know how". She later shared "probably support from my partner" and "to discuss health with my family and friends" would "motivate me" and "help me to stay motivated". She shared "a lot of changes, try to have a healthy mind".

Attitude.

Participant 06 talked about changing "outlook on life itself", that included "the way you see yourself and other people, widen your perspective towards things, to be more open-minded". Participant 010 talked about being, "a good person". He did not elaborate or share any examples of what he meant by a good person. Participant 013 stated, "the final decision is up to the person; need to get motivated to utilize services in the community". He stated there is a

"detoxification/cultural center" in the community. He also stated there is a "high problem with gambling" in the community.

Being happy and having healthy relationships.

Participant 011 shared, "being healthy is being happy in present situation and having healthy relationships". She explained, "relationships that enhance who you are, instead of draining you".

Stress and setting limits.

Four participants talked about factors related to stress and self-care. Participant 05 shared "try to have a healthy mind, less worry and less stress". She shared, "stress and anxiety is what causes me the most problems". Participant 06 stated, "get rid of extra baggage that stresses you out". She did not share how she would accomplish getting rid of the extra baggage. Participant 011 stated, "I would need to address mental health, need to feel good about myself" and "I need to set clear boundaries with family and friends so I'm not running all the time". She shared she is "currently running and something still gets missed". Two participants mentioned self-care. Participant 011 stated, "I would have more of myself to give if I was healthier".

Issues related to family.

Four participants talked about issues related to family as impacting their ability to reach optimal health. Participant 01 shared, "I'd have to have my entire family together, gives me a reason to want to be healthy". Participant 04 stated, "my children to be healthy, grandchildren to be healthy". She also wanted "to be at home and not working away (Meadow Lake)" so she "would be able to spend more time with children and grandchildren". She shared she "would be able to help my children when they need me (provide support)" and "I would feel good about myself being able to help my children". This participant was also concerned and wanted her

"sisters to be happy". She did not elaborate or share information about why she was concerned about her sisters. Participant 05 stated, "probably support from my partner, help me to stay motivated". She talked about "family support" and stated "to discuss health with my family and friends, this would motivate me and maybe get their support". She shared she was expecting a baby in January 2006. Participant 06 stated, "give your family and children lots and lots of love".

Love.

Participant 01 stated, "I need tender loving care (TLC) 24 hours, seven days a week (24/7). Participant 03 initially laughed out loud and replied, "win 649". Then she became tearful as she continued to share "love, caring, sharing, feel important, feel valued".

Spiritual

Growth.

Five participants talked about factors related to spiritual wellness impacting their ability to reach optimal health. They discussed wanting to grow spiritually, being grateful, and the value of learning the language and culture. Participant 014 stated he wanted to, "immerse and grow" that "something is missing in my life, maybe the spiritual realm". He stated, "the totally healthy person has mind, body, spirit in tune" and "my spirituality is lagging". He shared he wants "to become more aware of spirituality and how fits in personal life". He told the researcher he has "been exposed to different religious concepts and now beginning to find my mine (own) in the natural world". He shared his "father was a Shaman, he was a healer, he knew the animal and plant spirits". He continued, the "elements water and fire are more important than we ever realized". This participant did not share any additional information about the elements of water and fire with the researcher at this time. Participant 011 stated, "I would need to address spirituality". Participant 01 stated he needed to "give thanks, be grateful for each day".

Language and culture.

Two participants talked about language and culture being intact for optimal health. Participant 012 answered this question from a general perspective and then from a personal perspective. As a general statement that does not apply to him personally he made the comment that “language and culture” need to be “intact” because language and culture “defines who you are”. Participant 08, a male elder, shared his concerns, “our young people don’t have a clue who they are, they don’t know their culture” and “this is what they should know, they should know who they are”. He shared a comment made by another elder from Cold Lake. This elder from Cold Lake “talks about this” an “apple”. An apple is “white on the inside and red outside”. Participant 08 continued, “they need to know who they are and be proud, they will go a long ways”.

Economics

Participants talked about factors related to economics: financial stresses, employment, and changes in health services as impacting their ability to reach optimal health.

Financial stresses.

Two participants mentioned financial concerns. Participant 03 shared with the researcher she needed “to have basic needs met”. She gave examples, “clothing, stuff for house, house, furniture”. She made the comment “one good thing the car is paid off” when she was sharing what she needed to achieve her healthiest state. Participant 04 shared, “less financial worries/stress, would be nice not to have to make payments”. She stated, “once house paid off in July 2006” she “will be happier”.

Employment.

Four of the participants mentioned employment as a factor impacting their ability to reach optimal health. Participant 01 stated he needed, “steady employment”. Participant 03 stated she needed a “job, to pay for own needs”. Participant 04 wanted “to be at home and not working away”. Participant 013 stated, “need a job”. “Feel depressed if at home and can’t buy things you need, get depressed, get into drugs”. He stated that “more jobs are needed in the community”.

Change in health services.

Participant 013 stated, “Medicare does not cover what is used to” for example “Tylenol, Dimetapp, Tylenol #3”. Participant 08 shared, “get rid of all the white people (laugh), they say they find stuff to cure people with but it is for their own people, they make money out of it”. He continued, “I think it is the way to go back to the way of the old people”. He added, “need to get this damn health care equal to white people, we are only getting the bandaid thing”. He stated, “even go to a clinic, the white people go first, because they have soonias (money), money isn’t everything anyway”. He continued, “they (the white people) getting all their money from stealing resources”. He explained, “the natives never surrendered anything, not the birds or animals” and “all the resources is theirs”. He finished this comment by saying, “legally it is all theirs because of the treaties”. This participant shared another concern, “they have a director who is a white woman, it shouldn’t be”. “Health care is a Treaty Right”, and “I don’t think she knows or cares about Treaty Rights”. He continued, “we are seeing a lot of things being cut off like culture”. He shared an example, “Sundance needs assistance to be sponsored, getting to be a hassle, it is my culture”. He stated, “this health director doesn’t know the culture of what the treaties, maybe she is good at managing but we need better services”.

Environment

Water and pollution.

Participant 08 shared, “even water, I used to drink slough water and no problem”. “Now everything is getting so damn polluted, have to buy water to feel safe”. He continued, “don’t know why they don’t try to clean up these damn rivers and lakes, need to check where all the bad stuff is coming from (pollution)”.

Politics

Factors related to politics included concerns about communication within the community, independence, and resolving the long standing issue around the Treaties.

Communication within the community.

Participant 08 stated, “the Chief and Council don’t know their own people”. He continued, “they do not inform their own people”. He shared, “this is election year, get some people who understand the Treaty”. He finished this comment by saying, “it is nice to talk about this stuff, maybe I’ll run for Chief”.

Independence.

Participant 08 shared, “my dad used to live here, farm here, but there was always that Indian Agent that told him what to sell, what to do all the time”. He continued, “he (my dad) sold everything and moved to St. Walburg”. “The reason was he didn’t like the Indian Agent and Indian Act, didn’t like the white man telling him what to do”. He stated, “needed a permit to do something”. He shared, “If the white people would quit telling and ordering the Indian people what to do, quit bossing”. He continued, “they should look at themselves and what they did to this beautiful land, all the polluting they’ve done”. “They have no respect for mother earth, but legally this is all their land and all the resources”. He mentioned another concern, “get this damn

Indian Act out of the way, just leave". He continued, "let us live on Treaty 6 the way the older elders made the Treaty". "We can work, we don't need them". He stated, "they've been telling us what to do since they landed here". He continued, "Christopher did not discover this world, the Indian people were living here and already knew about it". He stated, "that is their (the white man's) first lie". He shared, "the only thing is leave us alone, let us live our own way". He explained, "that would overcome a lot of stress". He shared, "my dad and I we made our own way, sure we paid a little taxes but at least we had our own freedom to do what we wanted to". His final comment was "Let us be free, be free of the Indian Act, and stop telling us what to do".

Resolve the long-standing issues around treaties.

Participant 08 stated, "Assembly First Nation (AFN) is nothing just an arm of the government, puppets". He continued, "the white man started changing the Treaty". He stated, "the Indian should write the Treaty in Indian symbols/language so the white man cannot change the Treaty". He shared, "the English language is a two-faced language, so many meanings for one word". "If you say one thing, they say I meant the other way". "This is the way they interpret the Treaties". He continued, "that is why their justice system doesn't work, it is going crazy". He finished this statement by saying, "have to hang on to the Treaties or everything will be lost, the white man will steal everything".

In summary, the participants answered this question by discussing factors related to physical, mental (intellectual), emotional, spiritual health; economics; environment; and politics.

Physical factors identified as being part of optimum health included exercise, nutrition, appearance, and pain. Mental (intellectual) factors identified as being part of optimum health included: abstinence and substance use, attitude, knowledge, counseling and attending workshops (healing). Emotional factors identified as being part of optimum health included:

motivation, attitude, being happy and having healthy relationships, stress and setting limits, and love. Spiritual factors identified as being part of optimum health included: spiritual growth, learning language and the culture. The participants shared economic concerns related to personal financial stress, being able to meet their basic needs for food and shelter, employment, and changes in health services. There is concern about the environment, specifically the water and pollution. Concerns about politics at a local and federal level were mentioned. At the local Band level there is concern about lack of communication, the necessity for Indigenous people to be independent, and the importance of resolving the issue surrounding the Treaty Rights of Indigenous peoples.

CHAPTER FOUR

DISCUSSION AND RECOMMENDATIONS

This chapter will present the discussion and recommendations from the study. The discussion will be presented according to the initial research questions asked by the researcher before initiating the project: How do the Plains Cree people define health? How do they understand health? How do they address their health concerns? Where do they get their health information? How do they maintain their health? What do they need to obtain optimal health? What are their perceived barriers in obtaining health? Do they view health from a holistic perspective? Do they practice holistic health? The research questions will be discussed utilizing the data gathered from the eleven interview questions answered by the participants. A summary of the key findings will follow. Following that summary a definition of health from this study will be presented, and contrasted with the World Health Organization's definition of health. The implications for nursing education, practice, and research will follow. Finally, methodological strengths and limitations will be presented.

After completing the data analysis, and evaluating the themes from the questions, it was apparent to the researcher that the participants' descriptions of obtaining health were closely related to the Health Canada's Determinants of Health. The researcher refers to the Public Health Agency of Canada (PHAC), and Visions as sources of information about the Determinants of Health. Health Canada was the original source for the Determinants of Health, and now PHAC and Visions are considered credible sources for discussion regarding the Determinants of Health. Visions is a "Centre of Innovation committed to developing and communicating a deeper understanding of Aboriginal population health"(Visions, 2002/03). Visions is funded by First Nations & Inuit Health Programs Directorate M. S. B. Health Canada. PHAC (2004) credits the

Lalonde Report in 1974 for establishing this framework for the “key factors that seem to determine health status: lifestyle, environment, human biology and health services”. Since then, this basic framework has been expanded and refined.

How do the Plains Cree People Define Health?

There were four predominant themes derived from the data using thematic analysis: factors related to physical, mental (intellectual), emotional, and spiritual wellness; value of health; factors related to the environment; and factors related to economics. The first theme, factors related to physical, mental (intellectual), emotional, and spiritual wellness, presents the perceptions of health described by the participants. The second theme, value of health, explores the perceived significance of health described by the participants. The third theme, factors related to the environment, presents concerns related to the prenatal period, parenting, family, and the community. The fourth theme, factors related to economics, looks at the issues around employment and independence. Each of these themes will be discussed in this chapter.

Factors Related to Physical, Mental (Intellectual), Emotional, and Spiritual Wellness

The majority of participants were concerned about factors related to physical, mental (intellectual), emotional, and spiritual wellness, in that order.

Physical.

The participants in this study described health as “when a person is free from any ailments”; “free from sickness and disease”; “to be free of pain”; “being healthy means getting up in the morning, every morning, and not having no pain, just getting up with no hurt”; ‘being able to live life to the fullest without having ailments holding you back”; “body being healthy”; “if your body feels good, you feel good”; “exercise”; “active”; “eating proper”; “health is diet”. Physical comfort was noted to be a priority, and pain appears to be one of the most readily

visible and acknowledged barriers to enjoying life. Freedom from pain and illness was reiterated as part of being healthy. This descriptor, being free from pain and illness, may be a common perception of health for the Plains Cree. It is interesting to note the definition of health in the Merriam-Webster online dictionary (2006) is similar: “freedom from physical disease or pain”. Roberts (2005) interviewed the Woodland Cree of Northern Saskatchewan about their experiences with cancer. As part of her research she asked the participants “what does being healthy mean for you?” According to Roberts, the most common responses were “not being sick” and “being free of pain” (p. 94). Further, Roberts noted, “for the majority of respondents, being healthy meant absence of illness and pain” (p. 94). Hakim and Wegmann (2002) reported similar findings from their study. They interviewed 94 Elders of different multicultural backgrounds about their perceptions of health. Their study included Native American, Hispanic (Latinos), African American, and Vietnamese Elders. According to Hakim and Wegmann when the Native Americans were asked what being healthy meant to them the following responses were obtained: “ ultimate good feeling”; “doing what he wants to”; “having his dog, woman, care, and house”; “not being sick”; “Good Spirit”. Hakim and Wegmann summarized their concept of a healthy person “seemed to embody someone who could get around and do what they have to do without much difficulty” (p.169). Bartlett (2005) explored conceptions of health and wellbeing for Métis women from three large Aboriginal organizations in Manitoba. The participants in her study described health as “good nutrition, and physical activity”; “feeling good in your own body”; having the energy to undertake basic daily activities”; “optimum functioning of the body”; and “having access to a clean and safe environment”.

Participants from the present study consistently talked about good nutrition and regular exercise as part of being healthy. These findings are consistent with Roberts (2005) and Bartlett

(2005) but not with Hakim and Wegmann (2002). Roberts (2005) states, "participants mentioned that good physical health entails eating right, exercising …"(p. 94). Bartlett (2005) states, "physically well individuals eat a proper diet; are physically active and fit; ensure their children have adequate diets and nutrients; and work hard" (p. S25). Hakim and Wegmann (2002) found that persons from all ethnic groups in their study except the Native Americans indicated they maintained health by exercising, eating right, and going to the doctor regularly. The Native Americans in their study maintained health by "going to a key person" (p. 166).

Mental (Intellectual).

The participants in this study described mental health as "being balanced mentally"; "is of sound mind"; "able to identify and think clear in regards to the choices I have to make that day"; "being able to live with yourself"; "feeling good about yourself"; "no alcohol or tobacco use"; "able to continue on the road of educating myself, learning, helping, and assisting". Roberts (2005) and Reynolds (1993) found similar responses with their participants. Roberts' (2005) participants described mental health as "being at peace"; "being happy and thinking properly" (p. 94). Reynolds (1993) studied the nature of health promotion within an Ojibwe culture. Participants in her study perceived that if there was an unbalance in the mental aspect of being, this could "cause physical illness" (p. 111). Further, the Anishnabe participants in Reynolds' study perceive health is promoted by "Living the Good Life". Living the Good Life meant "not drinking or using drugs" (p. 118). The Anishnabe believe the "use of alcohol and drugs creates unbalance" (p. 111). Bartlett (2005) described mental/intellectual as "involving the mind, learning, and remaining curious about life" (p. S25). Some of the participants in Bartlett's study stated, "that elders who can teach and learn both old and new information are intellectually

well" (p. S25). In Bartlett's study, some of the Métis women described emotionally well individuals as "…free of drugs and alcohol…" (p. S25).

This data is linked to Health Canada's fourth health determinant, education. The Public Health Agency of Canada (PHAC) (2004) states "education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances". "It improves people's ability to access and understand information to help keep them healthy" (PHAC, 2004**)**.

Education has been an area of concern for many members of Thunderchild First Nation. With the transfer of education from Indian Affairs to the Bands, there was a capped budget. Prior to this transfer, all qualified treaty students were sponsored to pursue higher education. This limited budget has resulted in many potential students being turned away and requested to reapply for funding the following semester or year. However, according to the RHS (2002/03) almost "half of …First Nations adults surveyed …have graduated from high school. Just about one-quarter of these high school graduates (22.9%) have received a diploma from trade, technical, or vocational school, or had received a diploma from a community college or CEGEP, while a minority (5.1%) had obtained a bachelor's or master's degree or doctorate" (p. 51).

Overall, the participants from Thunderchild First Nation have higher levels of education when compared to the results from the RHS (2002/03). Nine of the fourteen participants in this study had graduated from high school (62%). Two had completed their grade eleven and two had completed grade ten. One participant had grade four. Five participants had obtained degrees in various fields (36%). Four of the six participants who had not received post-secondary education worked in the trades and domestic science (29%).

Emotional.

Emotional wellness was described by the participants as " being stress free"; "having, trying to maintain a stable mind"; "mental, physical, spiritual, emotional self balanced"; "being happy"; "teaching my kids about getting along"; "like a basic overall surrounding support of family and the community"; "get involved in community events". Roberts (2005) found "emotional health was often combined with mental health, there did not appear to be a definite distinction" (p. 94). According to Roberts (2005) being emotionally healthy meant being able to talk to someone regarding issues, "talking would allow one to get it out of your system" (p. 94). Reynolds (1993) stated the Anishnabe perceive an unbalance in the emotional aspect of being "could cause physical illness, especially cancer" (p.111). Bartlett (2005) found "no one is perfectly emotionally balanced, and quickly releasing negative emotions is essential" (p. S25). The participants in her study describe emotionally well-balanced individuals as "those who can identify feelings and keep others' feelings confidential; manage and control emotions in daily life; and understand that emotional well-being can only truly arise within one's self" (p. S25). These participants thought emotionally well individuals are thought to be "…acting as positive emotional role models" (p. S25).

Health Canada's second health determinant, social support networks, address the significance of being connected to someone else. PHAC (2004) states, "support from families, friends and communities is associated with better health". Further, "the caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems". The common thread of emotional wellness between the studies was the correlation of emotional wellness and being or feeling connected to someone else. This sense of connection appears to contribute to emotional well-being. Unfortunately,

there is overwhelming evidence of health and social disparities that would strain the existing social support networks accessible in First Nation communities.

Spiritual.

The participants described spiritual wellness as “going to Sweats, to learn about who [I] am”; “making sure your mind, and spirit is also nurtured”; “go to as many ceremonies, dancing Pow Wow, learning about my language”. Roberts (2005) found spiritual health “was more of an afterthought” (p. 94). One of the participants in her study shared the following “I wonder if someone’s soul, what is called spirituality, is part of one’s mithoyawin as well, if one is to pray, to have faith, to have someone to turn to, this is part of what I’ve read but it’s probably true” (p. 94). Reynolds (1993) found “spiritual health was identified as a very important aspect of being” (p.111). One participant in Reynolds’ study shared:

> We have a holistic approach to health-meaning body, spirit, emotions. This means you have to feed healthy foods to your body, healthy teachings for your spirit in order to achieve balance, and then emotions will follow. People need to be balanced in all these areas (p. 109).

The participants mentioned spirituality, however, it was not discussed in depth with the researcher. Perhaps this is a result or combination of the limited contact with the researcher, the comfort level of the participants, or unwillingness to share information regarding spiritual practices with the researcher.

Value of Health

The second theme, value of health, explores the perceived significance of health described by the participants. Good health was clearly valued by six of the fourteen participants and perceived as necessary and fundamental to enjoy life. They equated having good health with

being able to have a good life, equivalent to being a millionaire, and integral to everything in life. One of the participants answered “getting sick people better”; the researcher assumes he answered from the perspective of being a health board member. It is apparent to the researcher that the participants clearly valued health and perceived their current status of health as impacting their ability to enjoy the daily activities of living and life. The researcher was unable to find any literature or study that explored how Indigenous peoples valued health as found in this study.

Factors Related to the Environment

The third theme, factors related to the environment, presents concerns related to the prenatal period, parenting, housing, family, and the community. One of the participants was quite specific in describing the environment. He clearly stated the prenatal period was a factor in determining “much of the life outcome”. He did not offer any additional information about the factors the fetus may be exposed to that concerned him.

There is an abundance of literature to support the evidence of the prenatal period influencing the initial growth and development of the unborn child, potentially impacting their life forever. These concerns are consistent with the tenth determinant of health, healthy child development. Evidence from the Second Report on the Health of Canadians (as cited in the PHAC, 2004) states “experiences from conception to age six have the most important influence of any time in the life cycle on the connecting and sculpting of the brain’s neurons. Positive stimulation early in life improves learning, behavior, and health into adulthood”. Further, the Report states, “a loving, secure attachment between parents/caregivers and babies in the first 18 months of life helps children to develop trust, self-esteem, emotional control and the ability to have positive relationships with others later in life” (PHAC, 2004). In addition, “infants and

children who are neglected or abused are at higher risk for injuries, a number of behavioral, social and cognitive problems later in life, and death" (Second Report on the Health of Canadians as cited in the PHAC, 2004). Further, this report discusses "tobacco and alcohol use during pregnancy can lead to poor birth outcomes". Visions (2002/03) states, "the effect of prenatal and early childhood experiences on subsequent coping skills, competence and future well-being is very powerful. Children born in low income families are more likely to have low birth weight, to eat less nutritious food and to have difficulties with health and social problems throughout their lives". Clearly, parenting and the home environment greatly influence the healthy growth and development of children. There is an abundance of literature regarding the impact of colonization and residential schools that clearly supports the negative impact these events and the ongoing impact of continued colonizing practices has on the home environment of our Indigenous youth. The Indigenous home environment has undoubtedly been compromised as a result of colonization and more recently, residential schools (Mussell, 2005; Wesley-Equimaus & Smolewski, 2004). Wesley-Equimaus & Smolewski (2004) assert the importance to:

> Remind people that Indigenous social and cultural devastation in the present is the result of unremitting personal and collective trauma due to demographic collapse, resulting from early influenza and smallpox epidemics and other infectious diseases, conquest, warfare, slavery, colonization, proselytization, famine and starvation, the 1892 to the late 1960s residential school period and forced assimilation (p. 1).

Factors Related to Economics

The fourth theme, factors related to economics, discusses employment and independence. Six of the fourteen participants talked about being employed and being able to work as part of what made them healthy. The following descriptors were shared with the researcher "can't work

past three years it is getting to me because I like working"; "above all I am employed, I work, gives me something to look forward to"; "makes me happy I can still work at my age"; "like to work"; "working, being able to provide and live up to my responsibilities as a man".

The First Nations Regional Longitudinal Health Survey (RHS) (2002/03) found "there was a relationship between paid employment and perception of health" (p. 51). "First Nations people who have paid employment report better health than those who do not have paid employment" (p. 51). According to the RHS employment, "or the lack of it, is a major concern to many of our First Nations adults surveyed"(p. 51).

This data is linked to Health Canada's fifth health determinant, employment and working conditions. PHAC (2004) states, "employment has a significant effect on a person's physical, mental, and social health. Paid work provides not only money, but also a sense of identity and purpose, social contacts and opportunities for personal growth" (PHAC, 2004). A major review done for the World Health Organization (WHO) found "that high levels of unemployment and economic instability in a society cause significant mental health problems and adverse effects on the physical health of unemployed individuals, their families, and their communities" (Second Report on the Health of Canadians cited in PAHC, 2004). The participants in the study shared they felt good about themselves if they were able to provide for themselves and for their families. The current high rates of unemployment for Indigenous peoples needs to be further examined, and addressed promptly in order to facilitate decreasing the health disparity between the Aboriginal and non-Aboriginal peoples in Canada.

Mental (Intellectual)

Negative thoughts were described as contributing toward individuals being unhealthy, "I'm negative to a degree, when I hear what people say or think it gets to me"; have a "negative attitude that seeps in every now and then that gives me an attitude".

Emotional

Participants described having feelings of "jealousy at times'; and being stressed was contributing to them being unhealthy "stress in relationships"; "upset, can't work past three years it is getting to me because I like working"; "stress related to job"; "I'm letting my job take priority, where I have become a workaholic".

Bartlett (2005) described the dimensions of emotional well-being for adult and elder Métis women to include feelings such as "anger, sadness and joy, hurting, grieving, feeling sorry for one's self, and physical symptoms of nervousness, stress and anxiety" (p. S25). Participants in Reynolds' (1993) study described health from a holistic perspective and reiterated the importance of having balance between the physical, mental (intellectual), emotional, and spiritual self. They did not describe their feelings or specific stressors related to health promotion.

This researcher was surprised that only one participant talked about feeling jealous, one talked about her experience with anxiety, and the remaining participants mentioned stress but shared very little information as to how the stress was impacting their health and how they felt. It is reasonable to assume the participants in this study experience most if not all the emotions described in Bartlett's study, however, they did not share this with the researcher. The researcher is unsure if this was related to limited contact time, and or the participants' level of comfort with researcher.

How do the Plains Cree People Address their Health Concerns?

Practices when Sick

The participants' health practices varied when they were sick. Their responses fell into two categories: preventative and secondary practice. Preventative practice included taking vitamins, getting a flu shot, and yearly physical. Secondary practices included: waiting, waiting and trying a herbal remedy, going to the doctor, going to the hospital.

In general, the participants all had a routine they followed when they were sick, and there was quite a contrast between the participants. Two participants (011,014) talked about resting when they were sick and did not share any additional information about their next step or indicate when they would consult someone. Eight participants (01,02,03,05,08,011,012, 014) shared they usually wait for a while when they are sick, and four (02,05,08,014) of them will try a herbal remedy or Indian medicine. Of these eight participants only two (01,02) indicated after waiting they would go see a doctor. Of the four participants (02,05,08,014) who tried herbal remedies or Indian medicine only one (02) indicated she would go to see a doctor after trying alternate remedies.

Interestingly, the National Aboriginal Health Organization (NAHO) (2004) has done a public opinion poll on What First Nations Think About Their Health and Health Care, and found "fifty-one per cent of respondents reported having used a traditional Aboriginal healer or medicines, of which, 37 per cent had done so in the previous six months, and 52 per cent in the previous 12 months" (p. 28). Further, NAHO (2004) states, "respondents in Saskatchewan reported the highest use of traditional healers and medicines at 62 per cent while respondents in Ontario had the lowest at 43 per cent" (p. 28). According to the data collected in this project, 29

per cent of the participants shared they use Indian medicine when sick; this is substantially lower than NAHO's findings. The researcher is unable to explain the difference.

Four participants (04, 07, 09, 013) shared they went to see a doctor as soon as they were sick, to find out what was wrong. If it was urgent one participant (04) went directly to the hospital. Two of the participants (06,010) talked about going to the hospital as soon as they were sick. After participant (06) responded, she clarified her response would depend on the severity of the sickness.

Two participants (05,08) stated they didn't see a doctor when they were sick. Some of the participants had very strong ideas and reservations about taking pills or medication from the doctor. One participant (014) made the comment he didn't trust pills of any type. He shared his experience of seeing many people taking pills and becoming dependent on them.

In general, the participants appeared comfortable with their personal routine when they were sick.

First Person to Contact when Sick

When participants in this study were sick they typically responded by talking to their spouse/partner, and or a family member, or kept it to themselves.

Eight participants indicated they talked to their spouse first, six of these participants also talked to a family member. If the participant had a partner, they talked to their partner first, and then a family member. The nine participants who talked to family members about being sick talked to their dad (013); their mother (02, 05, 09, 014); daughter (04, 010); children (011); and participant 06 simply answered "my family members". The two participants who talked to their daughters indicated their daughters were nurses. The researcher assumed these participants

talked to their daughters first because they were registered nurses and trusted their opinion and advice over other family members.

Participants who were single or separated (05, 010, 014) talked to a family member first. Two participants (01, 07) indicated they talked only to their spouse and no one else. It is interesting that two of the three participants who did not talk to anyone when they were sick are related, they are mother and son. Perhaps this is a value in their family not to talk about sickness, not to worry others, however, the researcher is unsure. Of the three participants who did not talk to anyone when they were sick, two are married and the other is a widow.

In this study, six participants talked to their spouse or partner first, five talked to a family member first, and three of the participants didn't talk to anyone when they were sick. In Hakim and Wegmann's (2002) study, the participants "looked to family first and to the doctor or traditional western medicine second for their health information" (p. 170). Further, "Native Americans specifically noted they have to seek the traditional healer first" (p. 170). The researcher is unsure why the participants did not share a second source (other than a family member) as a source of health information.

Where do the Plains Cree People Obtain Health Information?

It is important to note that most participants obtain their health information from a variety of sources. The commonly utilized resources in descending order were: the media (eight of the participants), health professionals (seven participants), family and friends (seven participants), job or university (three participants), community health center (two participants), and a Health Food store (one participant).

There did seem to be a common pattern. The majority of the participants shared they either read information or consulted with a health professional if they had a concern. The next

step was to discuss the information with a family member or a friend. The only time this order was different was if the family member was a health professional. If the family member was a health professional they were consulted first or right after reading literature. It is interesting that an equal number of participants obtained information from health professionals and family or friends. Contrasting, Hakim and Wegmann (2002) found the Native Americans "talked about listening to that particular nurse (the nurse is from the same tribe) and her recommendations. She seemed to be a major source to them for their health information" (p. 166). Hakim and Wegmann did not discuss any other sources for health information, so the researcher assumed the community nurse was the major source for their health information.

How do the Plains Cree People Maintain their Health?

Plains Cree people maintain health in relation to how they define and understand health. The themes derived from the data using thematic analysis are very similar to the themes generated when the participants were defining health. Participants talked about practices related to: physical (exercise, nutrition, hygiene, adequate sleep), mental/intellectual (abstinence, positive attitude), emotional (limit stress), and spiritual (connection, attending and participating at ceremonies-Sweats, learning traditional language) wellness; and employment (having the ability to work and be employed) as part of keeping themselves healthy (contributing to them being healthy).

Interestingly, the activities described as contributing to their health were the same activities, which if not practiced, contributed to them being unhealthy. Participants are aware of their unhealthy behaviors, they freely shared with the researcher the behaviour they were trying to change to become healthier. Further, participants perceive trying to change behavior, for example to quit smoking or to quit drinking, as working toward keeping themselves healthy.

Hakim & Wegmann (2002) had similar findings, “most talked about exercise, eating right, and going to the doctor on a regular basis”, “spiritual or religious beliefs seemed to be a universal pattern for all of the groups” (p. 169). According to Hakim and Wegmann (2002) when they asked what participants did to keep themselves healthy, “the common response reflected themes of western medicine”. Most of their participants talked about “exercise, eating right, and going to the doctor on a regular basis” and “spiritual or religious beliefs seemed to be universal patterns for all of the groups” (p. 169). Further, “both Native Americans and African Americans discussed going to their spiritual advisor with health problems”, “all the groups talked about prayer, whether to God or to their ancestors”, and “participation in religious activities such as going to church seemed to signify good health to many of the respondents” (p. 170). It appears the participants in Hakim and Wegmann’s study focused on physical and spiritual practices to maintain health.

Participants in this study collectively described their health maintenance related to a holistic perspective. They discussed practicing factors related to physical, mental (intellectual), emotional, and spiritual wellness. In addition, employment was reiterated as a factor that contributed toward them being healthy. It is apparent to the researcher that the participants’ in this study are combining practices from the Western world and from their traditional (Cree) world to be healthy and to maintain their health. This is consistent with Roberts’ (2005) research, “ living in and taking from both the traditional Woodland Cree knowledge system and the Western knowledge system has been a recurrent theme” (p. 120).

In addition to their health practices participants shared they went for physicals, vision, and dental checkups. They also talked about specific tests they had done such as having their

blood sugar tested, breast and pap screening. Only two participants stated they did not go for check ups.

Only one participant expressed uncertainty regarding the value of checkups “like being diabetic you have to, they want you to go every so often”. “I don’t know why to tell you the truth, sometimes I think it is just every time you go see a doctor, money for them”.

What do Plains Cree People Need to Obtain Optimal Health?

What do the Plains Cree People Perceive as Barriers in Obtaining Optimal Health?

Participants were asked to picture themselves being the healthiest possible they could imagine, and asked what would have to happen for them to achieve that optimal health. The participants answered this question by discussing factors related to physical, mental, emotional, and spiritual wellness; economics; environment; and politics.

Physical factors identified as necessary to obtain optimal health included regular exercise, improved nutrition, appearance (good hygiene and access to skin care products), and being pain free. Mental factors identified as necessary to obtain optimal health included: abstinence (quit smoking, and drinking); attitude (necessary to have goals, and to want to live); knowledge regarding “sickness is related to mental health”; counseling and attending workshops (to start the healing). Emotional factors identified as necessary to obtain optimal health included: positive attitude, accepting personal responsibility; “being happy in present situation and having healthy relationships”; effectively dealing with stress and setting limits with family and friends; being connected and able to spend time with family; feeling loved and valued. Spiritual factors identified as necessary to obtain optimal health included: spiritual growth, and being grateful; learning language and the culture. Economic factors identified as necessary to obtain optimal health included: decreasing personal financial stress (being able to meet their basic needs for

food and shelter); being employed; and finding an equitable solution to deal with the decreases in health coverage. The environment, specifically water pollution was identified as a concern that needs to be addressed immediately. Politics at the local (increased communication within the Thunderchild First Nation Band administration) and federal level (Indigenous people to be independent, and the importance of resolving the issue surrounding the Treaty Rights of Indigenous peoples) need to be addressed to improve the health status of Indigenous people.

Do the Plains Cree People View Health from a Holistic Perspective?

There is a common perception that Aboriginal peoples view health from a holistic perspective (Bartlett, 2005; Spector, 2002; Walker & Irvine, 1997; Yi-Onn Leong et al., 2004). The majority of responses from the participants suggest there is a believed or perceived combination of factors necessary to define their meaning of health and to be healthy. Almost all of the participants identify that health is interdependent on several factors. From the data collected, the majority of participants defined health from a physical and mental perspective with less discussion about emotional and spiritual wellness. Further, the issues and concerns were directly related to their personal experiences with health.

The researcher noticed that when the responses from the participants are compiled there is definitely a holistic approach or view of health that is comprehensive and fits with the Medicine Wheel concept. Individually, when the responses are considered it appears that approximately half of the participants view health from a holistic perspective. However, when the participants were asked what they needed to obtain optimal health the vast majority of them shared a holistic approach that did involve physical, mental (intellectual), emotional, and spiritual wellness. Most of the participants identified and recognized they would need to address their emotional and

spiritual needs to attain optimal health. However, they did not share this with the researcher when sharing their initial perspective of health.

Do the Plains Cree People Practice Holistic Health?

Approximately half of the participants talked about health from a holistic perspective during the interview. Essentially all of the participants acknowledged that in order to obtain optimal health they would have to address their health from a holistic perspective that included physical, mental (intellectual), emotional, and spiritual wellness. From the data collected it appears that awareness and practice of holistic health have not been integrated for all the participants in this study. However, the participants have the knowledge, and are aware of holistic health.

Key Findings

There were four predominant themes derived from the data. Participants consistently discussed factors related to physical, mental (Intellectual), emotional, and spiritual wellness; value of health; factors related to the environment; and factors related to economics. The key findings from the study are summarized below and will have been discussed in this chapter. These key findings were derived from the participants' comments and should be acknowledged as contributing to the Plains Cree description/definition of health:

- Almost all of the participants identify that health is interdependent on several factors. Further, the issues and concerns were directly related to their personal experiences with health.
- Participants clearly valued health and perceived their current status of health as impacting their ability to enjoy the daily activities of living and life.

- Dealing with racism continues to be a concern for some of the participants in the study. There were perceived differences in the treatment of Aboriginal and non-Aboriginal peoples in the health care system. Specific comments were made related to the ambulance service, referral for special tests such as a MRI, and medical appointments.
- The activities described as contributing to their health were the same activities, which if not practiced, contributed to them being unhealthy. Participants are aware of their unhealthy behaviors, they freely shared with the researcher the behavior they were trying to change to become healthier. Further, participants perceive trying to change behavior, for example to quit smoking or to quit drinking, as working toward keeping themselves healthy.
- Concerns about health have changed related to aging, change in health care services (benefits decreasing), and knowledge.
- It is necessary for the Cree language and culture to be intact for optimal health.
- Participants in this study are combining practices from their traditional (Cree) world and the Western world to be healthy and to maintain their health.
- Most of the participants obtain their health information from a variety of sources. Listening to the radio and reading pamphlets was identified as the most common source, followed by consulting with health professionals.
- Concerns about the environment include the prenatal period, home environment, parenting, the community, and pollution (water, animals).
- Politics at both the local Band and Federal level are perceived as impacting the delivery of care.

- Improving communication between the Band administration and Band members is viewed as a priority by several of the participants.
- Participants talked about factors related to economics: financial stresses, employment, and changes in health services impacting their ability to reach optimal health.
- Difficulty accessing health services (i.e. physiotherapy) and the decreased health coverage (i.e. prescriptions, hearing aids) is a concern.
- When the responses from the participants were compiled there was definitely a holistic approach or perception of health that was comprehensive and fits with the Medicine Wheel concept. Individually, it appears that approximately half of the participants view health from a holistic perspective. However, when the participants were asked what they needed to obtain optimal health the vast majority of them shared a holistic approach that did involve all the four areas of the Medicine Wheel/holistic health.
- Participants' descriptions of obtaining health were closely related to Health Canada's Determinants of Health.
- This data supports that Health Canada's Determinants of Health may be an appropriate frame for federal, provincial, and local policy makers to implement structural changes necessary to decrease the health disparities between the Indigenous peoples and the rest of Canada.

Definition of Health from this Study

Determining a definition of health from this study was an arduous task. The researcher reviewed the data collected countless times, evaluated all the comments shared by the

participants, the major themes, and finally after deep reflection arrived at a definition of health from this study. To define health from the study was challenging, since the researcher strived to synthesize the most accurate reflection of health from the perception of the participants involved in this study. From the data collected, the researcher defines health as "a state of physical, mental (intellectual), emotional, and spiritual wellness; that includes economic and political independence".

World Health Organization's (WHO) Definition of Health

WHO (2006) states its mission "is the attainment by all peoples of the highest possible level of health". Its major task is to combat disease, especially key infectious diseases, and to promote the general health of the peoples of the world. The constitution of WHO defines health as " a state of complete physical, mental and social well-being, and not as consisting only of the absence of disease or infirmity or mental retardation" (WHO, 2006).

Relationship Between the Plains Cree and the WHO's Definition of Health

There are similarities between the two definitions of health. Both definitions include physical and mental wellbeing, however, WHO does not mention spiritual, economic, or political independence as part of being healthy. Clearly, there is a discrepancy between the definitions of health. Moodie (1973) states this definition was written in 1946 "in the preamble to the Constitution of the World Health Organization" (p. 129). Hains (1993) states:

> Forty years later WHO (1986) identified the basic needs of all human beings as: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. These were said to be pre-requisites for health, and it is here that a mention is made of the relationship between the environment and people's health (p. 129).

As Hains (1993) states, “the common goal is to see Aboriginal people healthy again, and a mutual understanding of the meaning of health, is the beginning step towards a healthier future” (p. 130). It seems logical to the researcher that a definition of health that is accepted, valued, and endorsed first and foremost by Indigenous peoples, health care providers, and policy makers, would facilitate positive relations and ensure equal collaboration and partnership while working together to improve the health of Indigenous communities.

Originally, the researcher believed the WHO’s definition of health would be most relevant to the Plains Cree definition of health. However, in doing the analysis, the definition of health and the data collected from this study are more closely related to Health Canada’s determinants of health. In retrospect, it would have been a better fit to have compared the findings with the determinants of health versus the WHO’s definition of health. As a result, the researcher will discuss the findings in relation to Health Canada’s determinants of health.

Health Canada’s Determinants of Health

The Public Health Agency of Canada (PHAC) (2003) states, “at every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behavior”. Further, “they do not exist in isolation from each other…the combined influence of the determinants of health that determines health status”. (PHAC, 2003). Therefore, strategies to improve population health must address the entire range of factors that determine health.

Visions (2002/03) lists Health Canada’s Determinants of Health as: “ income and social status; social support networks; social environments; education; employment and working conditions; physical environment; gender; culture; personal health practices and coping skills;

healthy child development (HCD); biology and genetic endowment". Further, Visions acknowledges:

> Culture and ethnicity are important in shaping the way people interact with health care system, their participation in programs of prevention and health promotion, access to health information, health related lifestyle choices, their understanding of health and illness and their priorities.

Interestingly, in this current study, perceptions of health, and descriptors of what participants would need to obtain optimal health are the same as the factors identified in Health Canada's determinants of health, with the exception of gender not being mentioned. This data supports that the Health Determinants may be an appropriate framework to address the health needs of Indigenous peoples, and an appropriate frame for federal, provincial, and local policy makers to implement structural changes necessary to decrease the health disparities between the Indigenous peoples and the rest of Canada.

Implications and Recommendations

The recommendations and implications for health professionals are derived from the data collected in this study. Each question provided valuable insight to assist health professionals toward effectively directing and focusing current health promotion strategies within the Plains Cree population of Thunderchild First Nation. During data collection, the researcher noticed quite a variety in the responses regarding perceptions of health and health maintenance and upon deep reflection offers the following suggestions.

Nursing Education

Nursing theory and practice are closely related. Theory affects practice and practice affects theory. It is logical to assume if we recognize the need for change, awareness, and

increased sensitivity to Indigenous peoples issues, there will have to be a process that ensures or at the very least initiates or reinforces a common thread in the attitude of all health professionals. To ensure nurses are adequately prepared to meet the increasing demands of providing culturally appropriate health care to diverse populations, it is necessary to mandate cross cultural training within professional education. This cross cultural training would be inclusive of the different ethnic and minority groups, with an emphasis on Indigenous culture. It is reasonable, given the trend of inter-professional education to extend this recommendation to include all health care professionals.

In terms of knowledge of Indigenous cultures, the cross cultural training would ideally include and explore the initial and continued impact of colonization and residential schools on Indigenous peoples' current health and social status. As part of the cross cultural training alternative models of health such as the Medicine Wheel would be examined and presented as a culturally appropriate model for all levels of care: primary, secondary, tertiary, and health promotion with Indigenous peoples. In addition, special attention should be given to Health Canada's Health Determinants to provide a larger context to understand the complex factors that are interrelated and impact an individual's health.

To enhance the effectiveness of cross cultural training, nursing students should be encouraged to take electives that provide a foundation to understand the origins of racism, sexism, and classism within the Canadian context. Understanding the history of how Canada developed as a country provides a context to effectively understand the current complexity of the existing health and social problems experienced by many individuals, particularly the Indigenous peoples in Canada.

Cross cultural awareness could be initiated as part of the basic nursing curriculum, in communication class, generally taught in the first year. Knowing ourselves is the first step towards developing cross cultural awareness and sensitivity. Rew (2000) states:

> Once we know who we are, we can appreciate how our attitudes, beliefs, and behaviors may be in conflict with others who are not a part of our unique culture. We can begin to acknowledge our own biases and then begin to understand how others might be biased in an entirely different direction (p. 204).

Nursing Practice

Promote Holistic Health

Ideally nursing practice would use the concepts gathered through cross cultural training to provide and promote holistic health using the Medicine Wheel for health promotion. All health care professionals should aspire to routinely promote and practice holistic health. In addition, nurses should aspire to practice holistic nursing. Holistic nursing "addresses the whole person within the context of the care environment" (Rew, 2000, p.204).

Health professionals should consciously promote holistic health by expanding their vocabulary to consistently include all factors related to health: physical, mental/intellectual, emotional, and spiritual wellness, when in contact with (all) clients. This diligent practice would model a holistic approach toward health and would help decrease the current stigma attached to mental and emotional health. In addition, this practice of holistic health promotion would reinforce to their clients that physical, mental/intellectual, emotional, and spiritual wellness are interrelated and ultimately affect their health status. This practice could be implemented during general conversations with clients that may include but are certainly not limited to the following: scheduled visits (prenatal, post natal, immunization, well baby clinics); emergency care; routine

physical examinations; admission forms to day hospital and hospital (all wards should address or at least initiate discussion about mental, emotional, spiritual health); and home visits.

Implement Holistic Health Promotion

In nursing practice students and graduates could be encouraged and expected to utilize the Medicine Wheel (holistic health) for all health promotion, including primary, secondary, and tertiary care. Traditionally, health promotion has focused on changing behavior (physical aspect) and typically ignored the mental/intellectual, emotional, and spiritual factors that may be contributing to the behavior (physical aspect). Bartlett (2005) shares an example, "the mainstay for addressing diabetes mellitus has been counseling on physical aspects-diet and exercise, and screening and treatment for physical complications" (p. S25). Bartlett's (2005) study found "that the physical area presents most stress for Métis adult women. Spiritual, emotional, and intellectual impacts of diabetes on individuals and their families have generally not been considered" (p. S25). Further, Bartlett states, "neither have resources that might be drawn from these areas of strength often been integrated or applied to addressing such entities" (p. S25). Bartlett suggests there are untapped strengths from a person's spiritual, emotional, and mental self that could be incorporated into health promotion. It is reasonable, given the growing trend of providing holistic care; the Medicine Wheel could be used for health promotion in all populations.

Incorporate Socioeconomic and Cultural Factors

In nursing practice professionals need to be cognizant of the socioeconomic and cultural factors that may impact or impede communication with Indigenous peoples. Using the concepts gathered through cross cultural training, and having a comprehensive understanding of the historical and social context of Canadian Indigenous history, and a complete understanding of

the Determinants of Health would enable the nurse to provide care and information within the appropriate context of the client's environment in a competent and sensitive manner. It is important to recognize there are a multitude of Indigenous cultures and variation within the cultures.

Throughout health promotion it is imperative to consider the client's real or perceived barriers when health teaching, or giving information regarding lifestyle changes. The client's socioeconomic environment needs to be considered for all health promotion activities and information regarding lifestyle changes. Nurses need to understand and respect that every client is an unique individual with a different baseline of knowledge regarding health and wellness that has been influenced by their cultural practices and language. This baseline of knowledge needs to be examined on an individual basis, especially when interacting with people from different cultures and ethnicity, to facilitate effective health promotion.

Specific Campaign Recommendations

Screening.

Even though the majority of participants in this study shared they went for checkups on a regular basis, it was apparent to the researcher some of the participants did not understand the implications or importance of specific screening such as blood sugar, breast exams, and pap tests. Health promotion should target and reinforce the value of screening services by reinforcing verbally and by providing brochures. In some instances it may be more helpful if these brochures were translated into Cree. In addition, when English is the second language, an interpreter should be consulted with all health promotion activities.

Guidelines to seek medical attention/alternatives.

It seems reasonable to the researcher that there should be a targeted campaign geared toward providing guidelines of when it is recommended to see a doctor and for using emergency services for children and adults.

Discussion around drugs, natural herbs and remedies.

It is imperative to have open communication and discussion about the use of natural herbs and remedies between the user and health professionals responsible for their care. Community Health Nurses (CHNs) in First Nation communities can initiate this discussion and encourage the clients to share information with their doctor(s). All health professionals should be asking this question as part of routine assessment when asking about current medication regimes. By the health professional approaching the topic, it will give clients an opportunity and permission to talk about their use of herbal and natural remedies.

To address the apparent mistrust of taking pills or medication prescribed by the physician, the CHN in the community should provide ample opportunity for clients to discuss their concerns and provide the appropriate health teaching regarding the medication. It is the communication sender's responsibility to ensure the client understands the health teaching and to place the information within the context of their understanding. When working with diverse cultures, especially Indigenous peoples, this will likely increase the amount of time required to ensure effective communication.

Healthy Lifestyles

Health promotion activities should be geared toward living a healthy lifestyle. This health promotion of a healthy lifestyle should use the Medicine Wheel. Using the Medicine Wheel would be culturally appropriate and promote holistic health. Nursing practice using the concepts from cross cultural training, awareness and understanding of the historical and social context of

Canadian Indigenous history, and comprehensive understanding of the Health Determinants would promote healthy lifestyles considering the context of the Indigenous person. The health promotion campaign should take into account the geography, location of the community, and the available socioeconomic resources.

Participants from this study shared that aging and growing older has certainly impacted their feelings about health. These feelings and concerns seem to have led to healthier lifestyles practices or at least a greater awareness and desire to change current lifestyle patterns. Perhaps this age group should be targeted with a healthy lifestyle campaign. This age group (approximately 40 to 47 years old) is still raising children and their change in lifestyle would directly impact the upcoming generation.

Dissemination of Health Information

The participants shared the media continues to have a great impact on their knowledge base. It may not change behavior, however, it provides the initial awareness of new information. This awareness can be the first step toward creating the opportunity for further health promotion or education. Interestingly, the participants in this study rated the radio and pamphlets as the media most commonly used for new health information. The results of this data clearly support the need for pamphlets to be developed and distributed in First Nation communities.

Nursing Research

Pursuing and maintaining health included a combination of information and practices from both the Western and Traditional Indigenous world. Further collaboration and research is necessary to determine if the findings are similar among other Indigenous peoples' in Saskatchewan.

Collectively, the participants in this study defined health from a holistic perspective. Individually, about half of the participants described health from a holistic perspective. Further collaboration and research is necessary to determine if the findings are similar among other Indigenous peoples in Saskatchewan.

The effectiveness of using the Medicine Wheel or other holistic model for health promotion needs further research among Indigenous peoples and other cultures with in the Canadian population.

The participants in this study primarily reside in Thunderchild First Nation. There is a need for future research to look at participants from this culture who live in urban areas.

Different segments of the Indigenous population need to be studied to see if there are some similarities, related to the Determinants of Health, to effectively address health promotion.

Methodological Strengths & Limitations

One of the underlying strengths of this study was the participants' willingness to participate, and to sincerely share their feelings and concerns related to health with the researcher.

Another strength was the Chief and Council of Thunderchild First Nation and the Health Board who were extremely supportive, excited about the research, and actively recruited participants by talking about the research and encouraging involvement. The researcher assumes this support and enthusiasm was related to her being a health professional (RN), and a band member of the Thunderchild First Nation. In addition, she has family members currently residing in the community, and has maintained contact with the community by regularly attending traditional celebrations such as Pow wows, Round dances, and Sundances for the past thirty-five years.

Another strength was using the Kaupapa Maori Methodology. Using this Indigenous Methodology ensured cultural congruence, and presented an alternative paradigm/methodology to conduct research within Indigenous communities in Canada.

Further, a descriptive research design, being descriptive, this allowed all the voices of the participants to be heard and presented with the findings.

This study does not address the generational difference in perceptions of health. Hakim and Wegmann (2002) recommended the researcher collect demographics to see if there was congruency with their data. They stated "we seemed to find in our study that the perspective on health was more generational as opposed to cultural" (personal communication, April 13, 2005).The researcher was surprised by the lack of intergenerational differences given the span in age and life experience (education) of the participants' involved in the study. This study was not consistent with the Hakim and Wegmann findings.

Upon reflection, after evaluating the participants' responses during the interviews, the researcher would revise the questions used during the interview. Even though the questions had been developed and used by other authors successfully, this researcher found them to be redundant and wondered if it constrained the response. The researcher would remove question two and reframe question three.

Research findings are relevant and applicable to the Plains Cree people in Thunderchild First Nation and perhaps to other Plains Cree people living within the province. The findings of this study are non-transferable to other groups of Indigenous peoples.

Final Comment

This research acknowledges that Aboriginal peoples have their own body of knowledge and ways of knowing. This research initiated dialogue with Saskatchewan's Plains Cree people

to provide the foundation to close the gap and assist in understanding how Plains Cree people define health and how their unique perspective contributes to their overall health status. Having this knowledge is an important first step in program planning for all areas of health and delivering effective health care for Aboriginal Peoples.

Appendix A:

Poster for Recruitment

Looking for Participants from Thunderchild First Nation to Participate in a Research Study on Aboriginal Health

1. Are you a Band Member of Thunderchild First Nation?
2. An Elder (50 years and older) or an adult greater than 18 years of age?
3. Interested in participating by sharing your definition of health?

*Participation in the study means you will be interviewed two times, in English or Cree, taking approximately one hour each time. In addition, you will be asked questions such as your age, gender, and marital status.

*If you meet the requirements above and are interested in participating in the study, please call the number below. Leave a message, and I will return your call. I look forward to hearing from you!

*For more information contact:

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Phone: (306) 966-6466

Email: Aboriginal_Health_Researach@yahoo.com

Appendix B:

Initial Presentation to Chief and Council & Health Board of Thunderchild First Nation (2005)

Research Proposal

Defining Health from an Aboriginal (Plains Cree) Perspective

Holly C Graham RN, BA, BScN
Graduate Studies & Research
Supervisor:Lynnette Leeseberg Stamler, RN, PhD
May 3, 2005

Aboriginal Health is a National Concern

- Aboriginal people as a population do not have the same health as other Canadians
- Limited research toward understanding how Aboriginal people understand, define, and identify their health concerns

Aboriginal Peoples have:

- Their own body of knowledge
- Their own ways of knowing
- Sharing this knowledge is an important step toward developing and planning appropriate programming and delivering effective health care

This research can provide an opportunity for Thunderchild Band members

to share their knowledge and definition of health

Consent:

- Approval from Thunderchild Band (Chief & Council)
- Approval from College of Nursing Thesis Committee
- Approval from University of Saskatchewan Behavioural Research Ethics Board
- Verbal & written consent from participants

Research Question:

What if any, is the relationship of the definition of health perceived/described by Contemporary Plains Cree People and the World Health Organization's (WHO) definition of health?

Procedure:

- Consent
- Assigned a code number
- Letter describing the research study
- Contact information for the researcher & supervisor

Procedure (cont.):

- Demographic questions: i.e. age, gender
- First interview - approximately 1 hour
- Second interview - 2 to 3 weeks later to respond to my interpretation of the first interview
- Receive a blanket and tobacco as a token of appreciation for sharing knowledge

Semi-Structured Interview (11 Questions):

- Tell me what health means to you?
- What does being healthy mean to you?
- What is a healthy person like to you or look like to you?
- How do you keep yourself healthy?
- What do you do differently from your ancestors to stay healthy?
- What do you do when you are sick?

Semi-Structured Interview cont.

- Who do you talk to first when you are sick?
- Where do you get your health information?
- Have your feelings about health changed in the last 5 years?
- When you thought about this interview is there anything you hoped I would ask?
- Picture yourself being the healthiest possibly you can imagine. What would have to happen for you to achieve that?

Participants:

- Thunderchild Band Members (on & off reserve)
- Elders Greater than 50 years of age
- Males & females greater than 18 years of age
- Interested in participating

Participants will receive:

- Consent form
- Data/transcript release form
- Letter describing the study
- Contact information for both the researcher & supervisor

Confidentiality:

- Identifying information such as names will be removed from the data
- Participants will be assigned a code number
- Master list with the real names will be kept under lock & key accessible to researcher and supervisor

Analysis of Data Collected:

- Qualitative software
- Demographic data – descriptive statistics
- Themes
- Compared to WHO's definition of health

Dissemination of Information:

- Findings will be presented at a public forum (i.e. Band Meeting)
- Opportunity for Band Members & Chief and Council to ask questions, discuss any concerns about the information gathered and how it will be disseminated
- Findings from the study will be shared with other health professionals within the health care system

Why Participate?

- To share knowledge of how Plains Cree people define health
- To help health professionals have a better understanding of Aboriginal perception of health
- Understanding Aboriginal perception of health is a key step toward developing & providing culturally appropriate health care

Questions?

Contact Information:

- Holly C Graham, RN, BA, BScN
  Phone: (306) 966-6466
  Email: Aboriginal_Health_Research@yahoo.com
- Lynnette Leeseberg Stamler, RN, PhD
  Phone: (306) 966-1477
  Email: lynnette.stamler@usask.ca

Appendix C:

Letter to Participants

Recruitment Letter

Dear Participant:

This letter is to introduce you to a nursing research study and to ask you to participate in the study. I am a Master student at the University of Saskatchewan, College of Nursing. The purpose of the study is to define health from an Aboriginal (Plains Cree) perspective. The information you share will assist in providing insight and awareness of how Aboriginal people define and perceive health. I am interested in talking with men and women who are 18 + years old and are interested in participating in this study.

Participation in the study means that I will interview you two times in a mutually agreed upon location and time. The first interview will be as soon as possible, and the second interview will be approximately two to three weeks later to discuss the findings from the first interview. The second interview is an opportunity for you to clarify my interpretation of the previous interview. All interviews will be audiotaped but will be coded to ensure confidentiality. Each interview is expected to last one hour but can be longer if you wish. In addition, I will ask you some information such as your age, gender, marital status, number of children, living arrangements, and level of education. At the end of the second interview, you will receive tobacco and a blanket as a token of appreciation for sharing your knowledge.

If you meet the criteria listed above and are interested in participating in the study, please call me at (306) 966-6466. If I am not in, please leave a message on the machine, and I will return your call. I look forward to hearing from you!

Sincerely,

Holly C. Graham
Enclosures

Appendix D:

Approval from Thunderchild Band, Band Council Resolution (BCR)

Chronological Number:
2005-2006#29

File Reference No.:

BAND COUNCIL RESOLUTION

The Council of the	**THUNDERCHILD FIRST NATION**		
Date of duly convened meeting:	**May 3, 2005**	Province: **SASK**	

Whereas the Chief and Council of the Thunderchild First Nation met at a duly convened Chief and Council meeting on May 3, 2005 at the Thunderchild First Nation and;

Whereas Holly Graham, a citizen of the Thunderchild First Nation, made a presentation to the Chief and Council regarding a health thesis study to complete her Masters Degree and;

Whereas Holly Graham requested permission from the Chief and Council of the Thunderchild First Nation with respect to capturing quantitative and qualitative data on health statistics of Thunderchild citizens at no cost to Thunderchild and;

Whereas Chief and Council of Thunderchild recognize the opportunity in capturing data that will assist Thunderchild citizens in living a healthy lifestyle;

Now Therefore Be It Resolved that the Thunderchild First Nation hereby give permission to Holly Graham to complete a health study of Thunderchild citizens.

(Councillor)
Ira Horse

(Chief)
Walter Jimmy

(Councillor)
Darryle Weekusk

(Councillor)
Bernadine Walkingbear

(Councillor)
Violet Weekusk

(Councillor)
Arnold J. Wapass

(Councillor)
Norman Moyah

(Councillor)
Charlie Paddy Sr.

Appendix E:

Approval from the University of Saskatchewan Behavioural Research Ethics Board

UNIVERSITY OF SASKATCHEWAN
BEHAVIOURAL RESEARCH ETHICS BOARD

http://www.usask.ca/research/ethics.shtml

NAME: Lynette Stamler (Holly Graham) **Beh #05-144**
Nursing

DATE: July 14, 2005

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the Application for Ethics Approval for your research study "Defining Health from an Aboriginal (Plains Cree) Perspective" (05-144). Thank you for making the requested revisions.

1. Your study has been APPROVED.

2. Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

3. The term of this approval is for 5 years.

4. This approval is valid for one year. A status report form must be submitted annually to the Chair of the Research Ethics Board in order to extend approval. This certificate will automatically be invalidated if a status report form is not received within one month of the anniversary date. Please refer to the website for further instructions http://www.usask.ca/research/behavrsc.shtml

I wish you a successful and informative study.

Dr. Valerie Thompson, Chair
University of Saskatchewan
Behavioural Research Ethics Board

VT/cc

Appendix F:

Re-approval (Annual) from the University of Saskatchewan Behavioural Research Ethics Board

UNIVERSITY OF SASKATCHEWAN

Biomedical Research Ethics Board (Bio-REB)
Ethics Office (VP Research), University of Saskatchewan
Room 305 Kirk Hall, 117 Science Place
Saskatoon, SK S7N 5C8

STATUS REPORT FORM

JUL 0 3 2006

This form is submitted for the following purpose

✓ Annual status report and re-approval request. When was the ethics approval for this study due to expire? Date: _____

___ Notice of study closure.

Report Prepared by: Holly C Graham Date: June 26/06

ONGOING REVIEW REQUIREMENTS: This approval is valid for up to one year. The REB will require the submission of an annual status report at least one month prior to the expiration date indicated below. Please note if the Status Report Form is not submitted by the one-year expiry date, the ethics certificate will automatically expire.

1. **PRINCIPAL INVESTIGATOR** Holly Graham / L L Steinhauer Supervisor

   NOTE: An investigator who does not maintain a physical presence at the trial site in proportion to the inherent level of risk that subjects will be exposed to cannot continue to be identified as the principal investigator. The responsibility must be transferred to a new principal investigator.

2. **DEPARTMENT/DIVISION**

3. **REB FILE #** Beh 05 - 144

4. **STUDY SITE(S)** Thunderchild First Nation (data collected)

5. **TITLE OF PROTOCOL AND PROTOCOL # (where applicable)** Defining Health from an Aboriginal (Plains Cree) Perspective

6. **SPONSOR (where applicable)**

   Scholarship from Indigenous Peoples Health Research Center

7. **BRIEF SUMMARY OF PROGRESS OF STUDY** (projected completion date for recruitment and data collection, number of subjects admitted to date, target enrollment, anticipated end-date). Are subjects currently receiving study treatment or interventions, or is the study only active for follow-up to endpoints? Data collection ~~completed~~ corrected, currently writing the last chapter of the thesis. Anticipating the oral defense in early Aug / Sept 2006. There were 14 participants involved in the study

8. **ARE THERE ANY ASPECTS OF THIS STUDY WHICH SHOULD BE BROUGHT TO THE ATTENTION OF THE REB** (i.e., any new information or knowledge bearing on the anticipated risks or anticipated benefits, and therefore possibly affecting subjects' ongoing decision to participate in this study. Clinical trialists should reflect upon adverse events associated with their protocol).

   N/A

9. **WHAT ARE YOUR CURRENT SAFETY REVIEW PROCEDURES FOR THIS RESEARCH PROJECT** (i.e., drug safety monitoring board (DSMB), clinical end-point committee (CEC), hotline, periodic reporting to the ethics board)?

   N/A

10. **PRINCIPAL INVESTIGATOR**

    Holly Graham / L L Steinhauer Co-Supervisor June 26/06

    Signature Date:

For Administrative Use Only:

Approved On: July 25, 2006 Expiry Date: July 1, 2007

Signature of Chair or designate: CTEC

Please note that this form, once signed by the chair or designate, serves as your official re-approval certificate.

Appendix G:

Consent for Research Participants

University of Saskatchewan

Consent Form

You are invited to participate in a study entitled Defining Health from an Aboriginal Perspective. Please read this form carefully, and feel free to ask questions you might have.

1. RESEARCHER

Holly C. Graham

College of Graduate Studies & Research

University of Saskatchewan

Phone: (306) 966-6466

E-mail: Aboriginal_Health_Research@yahoo.com

2. PURPOSE OF THE STUDY

I, _____, agree to participate in this research study; the purpose is to define health from an Aboriginal perspective.

3. PROCEDURE

I agree to be interviewed by the researcher, Holly Graham, a graduate nurse, regarding my definition of health. The interview will be audio taped, and the researcher will also take notes. I understand that the benefits of this study are to expand the knowledge available to nurses about health defined from an Aboriginal perspective. The first interview is estimated to take one hour and the second interview is estimated to take 45 minutes. I understand that I will receive tobacco and a blanket after the second interview is completed as a token of appreciation for sharing my knowledge.

4. POTENTIAL RISKS

I understand that the anticipated personal risks to me are minimal and not greater than those generally encountered in daily life. I understand that participation in the study may also involve risks that are currently unforeseeable.

4. CONFIDENTIALITY OF RECORDS

I understand that as a participant in this study, my confidentiality will be maintained. I will be given an identification number, and all information obtained will be coded to maintain my anonymity. Quotes from the data may be used in written results, but will only be identified by participant identification number. The original audiotapes, transcripts, and notes will be kept but will be kept in a locked cabinet and will be coded to maintain anonymity qand available only to the researcher and her thesis supervisor.

5. RIGHT TO WITHDRAW
I may withdraw from the study for any reason, at any time, without penalty of any sort. If I withdraw from the study at any time, any data that I have contributed will be destroyed.

6. QUESTIONS
Any questions concerning any aspect of this study will be answered by Holly Graham, R.N., (306) 966-6466 or by her supervisor Lynnette Stamler, RN, PhD, (306) 966-1477. This study has been approved on ethical grounds by the University of Saskatchewan Behavioral Sciences Research Ethics Board on (pending). Any questions regarding your rights as a participant may be addressed to the committee through the Office of Research Services (306) 966-2084. Out of town participants may call collect. Results of the study will first be presented at a public forum at the Thunderchild First Nation to provide an opportunity for Chief and Council and band members to ask questions. Any concerns mentioned by the community will be resolved in a manner acceptable by both the Thunderchild First Nation and the researcher before submitting for publication or in thesis format.

7. CONSENT TO PARTICIPATE
I have read and understood the description provided here. I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above, understanding that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

_____ _____

Signature of Participant Date

_____

Signature of Researcher

Appendix H:

Transcript Release

Data/Transcript Release Form

I, _____, have reviewed the complete transcript of my personal interview in this study of defining health from an Aboriginal perspective and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Holly C. Graham. I hereby authorize the release of this transcript to Holly C. Graham to be used in the manner described in the consent form. I have received a copy of this Data/Transcript Release Form for my own records.

_____ _____

Participant Signature Date

_____ _____

Researcher Signature Date

Appendix I:

Original Seven Interview Questions from Hakim & Wegmann's Study

Original Seven Interview Questions from Hakims & Wegmann's Study, 2002

1. What does being healthy mean to you?
2. What is a healthy person like to you or look like to you?

    -Do you think you are a healthy person?

    -What makes you a healthy or unhealthy person?

    -What means you're healthy? Or when a person says you are healthy, what does that mean?
3. How do you keep yourself healthy?

    -Checkups?
4. What do you do differently from your ancestors to stay healthy?
5. What do you do when you are sick?
6. Who do you talk to first when you are sick?
7. Where do you get your health information?

Appendix J:

Request to use Questionnaire & Permission Received

March 28, 2005

Helen Hakim
University of Texas at Tyler Longview University Center
3201 North Eastman Road
Longview, TX 75605
USA

Dear Ms. Hakim:

I am writing to request permission to use the questionnaire developed in the study of A Comparative Evaluation of the Perspective of Health of Elders of Different Multicultural Backgrounds, published in the Journal of Community Health Nursing 2002. I have attached a copy of the questions developed for that study.

I am a nurse currently enrolled in graduate studies at the University of Saskatchewan. The questionnaire would be used as the instrument to collect the data for my thesis. The thesis will be focused on defining health from an Aboriginal (Plains Cree) perspective. For further discussion or questions you can contact me by e-mail at H_Graham_@msn.com or by telephone at (306) 665-1821.

Sincerely,

Holly C. Graham

Enclosure

msn Hotmail

h_graham_@msn.com Printed: April 13, 2005 1:36:53 PM

From : <Helene_Hakim@mail.uttyl.edu>
Sent : April 13, 2005 1:21:19 PM
To : H_Graham_@msn.com
CC : Debbie@wegmann.org
Subject : use of our questionnaire

Holly,

Ms. Wegmann and I are honored that you would like to use our tool. I would recommend that you collect demographics so you can see what correlations you find in your data. We seemed to find in our study that the perspective on health was more generational as opposed to cultural.
We would also like to hear about your findings. So please keep in touch. Good luck with your thesis.

Appendix K:

Interview Questions

Interview Questions

Location: _____ Interviewer: _____

Name/ Code Number: _____

Age: _____ Gender: _____

Marital Status: _____ Number of children: _____

Living arrangements: _____

Highest Level of Education completed: _____

1. Tell me what health means to you?
2. What does being healthy mean to you?
3. What is a healthy person like to you or look like to you?
    A. Do you think you are a healthy person?
    B. What makes you a healthy or unhealthy person?
    C. What means you're healthy? Or when a person says you are healthy, what does that mean?
4. How do you keep yourself healthy?
    A. Checkups?
5. What do you do differently from your ancestors to stay healthy?
6. What do you do when you are sick?
7. Who do you talk to first when you are sick?
8. Where do you get your health information?
9. Have your feelings about health changed in the last 5 years?
10. When you thought about this interview is there anything you hoped I would ask but didn't?
11. Picture yourself being the healthiest possibly you can imagine. What would have to happen for you to achieve that?

Appendix L:

Medicine Wheel

Medicine Wheel

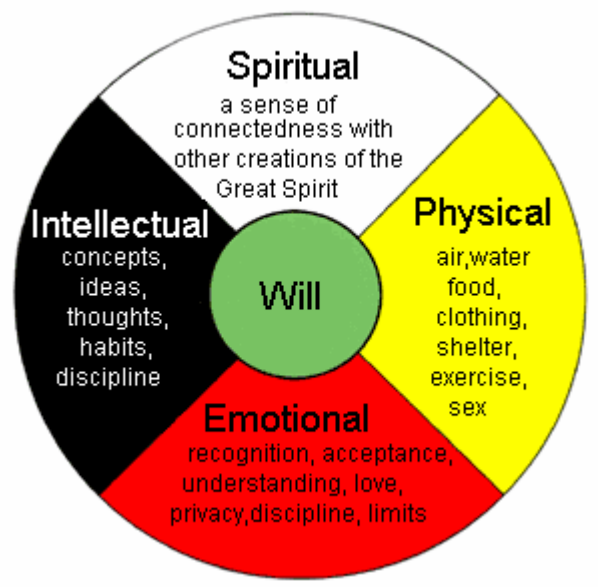

Diagram recreated by Teagan Orchard from Mussell, 2005.

The Medicine Wheel is a symbol used to represent the dynamic system of mind, body, emotions and spirit, and the needs related to each of these aspects that must be met for the development of human potential. When the model is used in this way and applied to oneself, it becomes a powerful tool for increased self-knowledge and self-care. The circle represents wholeness and movement or action. Like other concepts that represent simultaneous activity, this one is depicted in a static state, in order to highlight the four charts and each of their respective elements.

There are four categories of needs in this wheel: physical, emotional, intellectual and spiritual. Needs are defined as requirements for survival and personal growth.

Mussell (2005) The Aboriginal Healing Foundation

Appendix: M

Final Presentation to Thunderchild Administration (2006)

Defining Health from an Aboriginal (Plains Cree) Perspective

Graduate Studies & Research
Holly Graham RN, BA, BScN

November 10, 2006

Aboriginal Health is a National Concern

- Aboriginal people as a population do not have the same health as other Canadians
- Limited research toward understanding how Aboriginal people understand, define, and identify their health concerns
- Abundance from illness perspective: diabetes, FASD, TB…

Provide a Current Overview

- Defining health and health practices from a contemporary Plains Cree Perspective

Research Questions

- How do Plains Cree people define health?
- How do they address health?
- Where do they get their health information?
- How do they maintain health?

Research questions cont.

- What do they need to obtain optimal health? Perceived barriers?
- Do they view health from a holistic perspective?
- Do they practice holistic health?

Aboriginal Peoples have

- Their own body of knowledge
- Their own ways of knowing
- Sharing this knowledge is an important step toward developing and planning appropriate programming and delivering effective health care

Framework

- Kaupapa Maori Theoretical Framework
  - is related to being Maori
  - is connected to Maori philosophy & principles
  - assumes validity & legitimacy of Maori, language & culture, concerned with autonomy over own cultural well-being

Process

- Approval from College of Nursing Thesis Committee
- Approval from Thunderchild Band (Chief & Council, Health Board)
- Approval from University of Saskatchewan Behavioural Research Ethics Board
- Verbal & written consent from participants

Consent/Procedure

- Consent
- Assigned a code number
- Letter describing the research study
- Contact information for the researcher & supervisor

Procedure cont.

- Demographic questions: i.e. age, gender
- First interview - approximately 1 hour
- Second interview - 2 to 3 weeks later to respond to my interpretation of the first interview
- Receive a blanket and tobacco as a token of appreciation for sharing knowledge

Semi-structured Interview (11 Questions):

- Tell me what health means to you?
- What does being healthy mean to you?
- What is a healthy person like to you or look like to you?
  - Do you think you are a healthy person?
  - What makes you a healthy or unhealthy person?
  - What means you're healthy? Or when a person says you are healthy, what does that mean?
- How do you keep yourself healthy? Checkups?
- What do you do differently from your ancestors to stay healthy?

Semi-structured Interview cont.

- What do you do when you are sick?
- Who do you talk to first when you are sick?
- Where do you get your health information?
- Have your feelings about health changed in the last 5 years?
- When you thought about this interview is there anything you hoped I would ask?
- Picture yourself being the healthiest possibly you can imagine. What would have to happen for you to achieve that?

14 Participants

- Thunderchild Band Members (on & off reserve)
- 6 female, and 8 males
- Elders: 2 females (57, 65) and 2 males (66, 71)
- Ages 19 to 71
- Education: grade 4 to 1 years of Graduate Studies

Participants received

- Consent form
- Data/transcript release form
- Letter describing the study
- Contact information for both the researcher & supervisor

Confidentiality

- Identifying information such as names were removed from the data
- Participants were assigned a code number
- Master list with the real names have been kept under lock & key accessible to researcher and supervisor

Data Analysis

- Manual
- Thematic Analysis: "focuses on identifiable themes and patterns of living and/or behaviour" (Aronson, 1994)
- Traditional Medicine Wheel
- Compared to WHO's definition of health
- Determinants of Health

Plains Cree Definition of Health

"A state of physical, mental (intellectual), emotional, and spiritual wellness; that includes economic and political independence"

Findings/Discussion

- Theme: factors related to physical, mental/intellectual, emotional, and spiritual wellness
- Other factors: value of health; environment; economic and political independence
- Health Canada's Determinants of Health

Recommendations

- Nursing Education
  - Mandate cross cultural training (holistic models of health)
- Nursing Practice
  - Promote holistic health
  - Implement holistic health promotion
  - Incorporate socioeconomic & cultural factors
  - Specific campaign recommendations

Recommendations cont.

- Nursing Research
  - Further collaboration & research necessary to determine if findings similar among other Indigenous peoples in Saskatchewan

Dissemination of Information

- Findings will be presented to Chief and Council (November 10) and the Health Board (November 30)
- Opportunity to ask questions, discuss any concerns about the information gathered and how it will be disseminated
- Findings from the study will be shared with other health professionals within the health care system

Acknowledgements

- The Indigenous Peoples Health Research Centre (IPHRC)
- Thunderchild First Nation (my community)
- Supervisor:Dr. Lynnette Leeseberg Stamler, and thesis committee: Peggy MacLeod, Dr. Rose Roberts, and Judge Mary Ellen Turpel-Lafond
- Children: Teagan & Aiyana

Questions?

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