Supporting northern Indigenous elders' right to self-determination in healthcare: Stanley Mission elders' experiences

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By

Adele Bibault

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OR

Dean
College of Graduate and Postdoctoral Studies
University of Saskatchewan
116 Thorvaldson Building, 110 Science Place
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Abstract

Through a wâhkôhtowin research paradigm that upholds relationality and responsibility, this research used a case study approach to explore the perspectives of First Nation and Métis elders from Stanley Mission on their experiences with their health and healthcare services on and off reserve. A literature review identified hospital barriers and gaps in access and services, and this information was used to guide conversational interviews. I discussed the findings from the elders' interviews in context with literature findings and information from the Saskatchewan Health Authority (SHA) website. Overall, this proposed research highlights the experiences of Stanley Mission elders and what does and does not work for them regarding their healthcare.

The major and minor themes of the research centred around the Cree worldview of wâhkôhtowin, a term emphasizing notions of being related. It largely reflected findings that suggested that most of the positive care and experiences in healthcare were attributed to good access to healthcare and support from family and community. Having healthcare available in the community and provided by community members is considered imperative for elders in the north. Community health workers and health professionals see through a community-based care lens that contributes to the wrap-around wholistic healthcare service provided by the Elders Haven, a reserve-based elder care facility in Stanley Mission, SK. Although the healthcare workers and health professionals at the Haven provide outstanding healthcare to elders, this research suggests the Haven will also benefit from having more sustainable, long-term financial, and infrastructural resources.

Facilities like the Elders Haven are vital for First Nation and Métis elders because of the various barriers they face when accessing hospitals. The elders' lived experiences and barriers to hospital services suggests that the health policies and jurisdictions of the federal and provincial governments, and hospitals themselves, need to better integrate to support the needs of Indigenous Peoples. Elders want and need to be able to stay close to home to receive continuing care. If elders cannot stay close to home for the care they need, they need to be made to feel welcome and safe in hospitals and other health care facilities.

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List of Abbreviations

BNA: British North American (Act)
CHT: Canada Health Transfer
CRF: Cultural Responsiveness Framework
DNR: Do Not Resuscitate
EMR: Emergency Medical Records
FNIHB: First Nations and Inuit Health Branch
FNMR: First Nations and Métis relations (SHA)
FSIN: Federation of Sovereign Indigenous Nations
IHWGTT: Indigenous Health Working Group Transition Team
INAC: Indigenous and Northern Affairs Canada
IRS: Indian Residential School System
LLRIB: Lac La Ronge Indian Band
LPN: Licensed Practical Nurse
NIHB: Non-Insured Health Benefits
NITHA: Northern Intertribal Health Authority
NPSU: Northern Planning and Sustainability Unit
RCAP: Royal Commission of Aboriginal Peoples
REB: Research Ethics Board
RN: Registered Nurse
SCAAP: Senior Citizens' Ambulance Assistance Program
SCPOR: Saskatchewan Centre for Patient-oriented Research
SDH: Social Determinants of Health
SHA: Saskatchewan Health Authority
SK: Saskatchewan
SMFN: Stanley Mission First Nation
TRC: Truth and Reconciliation Committee

1: Introduction

1.1 Introduction

Through a wâhkôhtowin[1] research paradigm that highlights relationality and responsibility, this paper uses a case study approach to explore the perspectives of First Nation and Métis elders from Stanley Mission on their experiences with their health and healthcare services. This paper, for brevity sake, uses the term "elders" to refer to Indigenous people[2] over 65yrs of age (on limited pension income), since they will likely get increasingly dependent on the healthcare system[3]. These elders highly value family and community support on their health journeys, this research uses wâhkôhtowin to highlight the value of these connections. There are many interconnected meanings in the nehiyawewin (Cree language, in the Woodland Cree, it is nehithowewin) term wâhkôhtowin, which refers to relatedness (Cardinal and Hildebrandt 2000; MacDougall 2006), but I will be broadly applying the relational and responsibility aspects of this paradigm in my research to better understand the healthcare experiences of elders in northern Saskatchewan.

According to Shawn Wilson (2008), a paradigm is a broad principle that provides a framework for research, including methodology (Wilson 2008, 33). Wilson states that shared aspects of Indigenous research paradigms are relationality and relational accountability (7). Wâhkôhtowin, as defined by Cardinal and Hildebrandt (2000), is a "good relationship (of the First Nations, with the Creator and with one another)" (80). This good relationship extends to yourself, family, community, the earth, and all human and non-human relatives. Métis Scholar Brenda MacDougall (2006) furthers this definition by writing that wâhkôhtowin is an "expression of a world view that laid out a system of social obligation and mutual responsibility between related individuals – between members of a family – as the foundational relationship within communities" (433). Being related has responsibilities for oneself and others on how to treat each other. This research project helps highlight some cultural concepts of how this wholistic healthcare looks for elders in the North. The notion of wâhkôhtowin is that everything is related, and in this thesis, it is a wraparound concept that refers to the complete care of the individual by family and all levels of healthcare services.

[1] Spelling from Cardinal and Hildebrandt (2000).
[2] The term Indigenous in this thesis refers to First Nation, Métis, and Inuit people.
[3] Not necessarily referring to ceremonial Elders

Despite numerous health policies formulated by the federal and provincial governments and the SHA, there are still significant gaps in jurisdictions and barriers to access that Stanley Mission elders encounter when receiving or attempting to receive primary healthcare in Saskatchewan. A literature scan informed this research on hospital barriers and gaps to guide research interview questions. Using what I have learned from this literature, and interviews, I compared the barriers and experiences of elders involved in this research to academic literature and the guidelines and policies of the Saskatchewan Health Authority (SHA).

Elders experience a greater risk of developing chronic health conditions requiring additional Western medicine[4] and wholistic healthcare (Beatty and Berdahl 2011; Nelson and Wilson 2018; Rosenberg et al. 2009). Indigenous elders often must leave their communities and families to access medical healthcare services in the cities, thus resulting in more significant burdens and stresses upon them physically, mentally, economically, spiritually, and socially (Beatty and Berdahl 2011; Beatty and Weber-Beeds 2013). There are many barriers to why Indigenous elders do not or cannot access provincial healthcare services in the urban areas, including the confusing navigation between different health agency policies and jurisdictional issues on and off reserve and perceived racism while seeking healthcare in hospitals.

Despite the efforts of the SHA, there are persistent barriers to racism, language, and physical access to care in Saskatoon (Boyer 2017; Nelson and Wilson 2018; Saskatoon Health Region 2014; Stote 2015). To address some of these concerns, I explore the experiences that elders in the northern community of Stanley Mission have with their health and accessing healthcare. These research questions guide my thesis: What have been the experiences of First Nation and Métis elders from Stanley Mission regarding their health throughout their lives? Furthermore, how do these experiences relate to the care and policies provided by the Saskatchewan Health Authority?

This study reports on barriers to accessing health that First Nation and Métis elders experience in northern Saskatchewan and emphasizes the importance of respecting and upholding wâhkôhtowin in nehithawak (Woodland Cree) community healthcare contexts. The findings of this study can help inform Canadian healthcare by highlighting critical barriers to access to hospitals in hopes of reducing negative interactions and experiences northern elders

[4] By western medical system I am referring to the medical practices that the European settlers brought into Canada and is now considered to be mainstream medicine.

face upon entering hospitals. It is hoped that the findings of this study will also help increase cultural awareness of Northern First Nation and Métis elders' distinct needs. This research will also help broaden the understanding of what works and does not work in healthcare for northern elders.

1.2 Thesis layout

In Chapter One of this paper, I introduce First Nation and Métis elder health in Canada and a profile for Stanley Mission and the SHA. Chapter Two discusses wâhkôhtowin as a research paradigm and includes a literature review of Indigenous health in Canada, First Nations health policy and jurisdiction, and First Nations elder care in north Saskatchewan. Chapter Three outlines my methodology and methods to gather and analyze data and conduct research. In Chapter Four, I discussed the interview findings, and health access issues highlighted by the elders, emphasizing the importance of relationality and respect through wâhkôhtowin. At the end of each central theme, there is a comparative analysis between the SHA policies and the lived experiences of the elders interviewed. This discussion provides some context to the gaps in healthcare mentioned by the elders when accessing care in the hospitals. Following the discussion, I examine the limitations of this research. Chapter Five is the conclusion, including a short overview of the study, recommendations from the elders interviewed to minimize barriers to hospital access, and comments on future research.

1.3 Situating myself in the research

In following Margaret Kovach's suggestions in Indigenous Methodologies: *Characteristics, Conversations, and Contexts* (2009), I will situate myself in this research by discussing my cultural and familial background and my motivations for conducting this research. This section will anchor my knowledge in my experiences, showing how these experiences influence my research and worldviews. Kovach (2009) explains that self-location and transparency are central to an Indigenous and qualitative research paradigm (110-112). As Kovach explains, "Critically reflexive self-location is a strategy to keep us aware of the power dynamic flowing back and forth between researcher and participant. It prompts awareness of the extractive tendency of research" (112). In this section of my thesis, I identify and explain to the reader why I was interested in conducting this research.

I come from a European background with ancestral roots in Lithuania, Germany, and France/French Canadian. I am very close with my grandparents and feel solid connections to

them. My maternal grandparent's house was where we (me and my two sisters) would go after school most days. Grandma always had something homemade waiting for us to eat. During the initial stages of the COVID-19 pandemic, I saw my grandparent's health and happiness deteriorate because they could not visit with us. This isolation and lack of purpose affect the longevity of elders' lives. I have always looked at my grandparents as people with a wealth of knowledge and experiences, and I know that part of their purpose is to share what they know with us or the younger generations. My grandparents and many elders are irreplicable and hold unique generational knowledge. My grandparents are significant to me and are a driving force behind my passion for elder health research.

My maternal family is heavily involved with the westernized healthcare system, which has a turbulent past and present with the Indigenous peoples on Turtle Island (North America) and worldwide. I have wanted to be a doctor since I could remember and had learned about western medicine from my mother at a young age. I realized in my undergraduate degree that I had a very one-sided view of health and held some prejudiced views toward Indigenous peoples. I was ignorant of the discrimination and racism that I held in my heart toward Indigenous peoples. My worldview flipped upside down, when working with Indian Residential School Survivors[5] in my undergraduate honours thesis, and the realization of how colonized my mindset was forever altered my life path. Since then, I have felt a responsibility to learn more about other options for healthcare and racism against Indigenous peoples in Canada. I work toward decolonizing my thoughts and actions daily.

I was born in Calgary, Alberta, Treaty seven territory and oral practices of the Siksikaitapi (Blackfoot confederacy): Siksika, Kainai, Piikani, and the Îyâxe Nakoda and Tsuut'ina nations. Calgary is also the homeland of the Métis Nation of Alberta, Region 3. I moved to High River, Alberta, land of the Blackfoot confederacy and Stoney Nations, when I was four and grew up there until the Southern Alberta flood hit in 2013, and our family home was destroyed. I then moved with my family and completed my grade 12 on the traditional lands of the Kwakwaka'wakw peoples on Vancouver Island, BC. I completed my BSc (Hons) at the University of Victoria on the traditional territory of the Lekwungen, Esquimalt, Songhees and WSANAC Peoples. I was extremely fortunate to have my worldview shifted when I wrote my

[5] I use a majuscule S for Survivors as a sign of respect toward them and all who have survived the IRS system, both firsthand and intergenerationally.

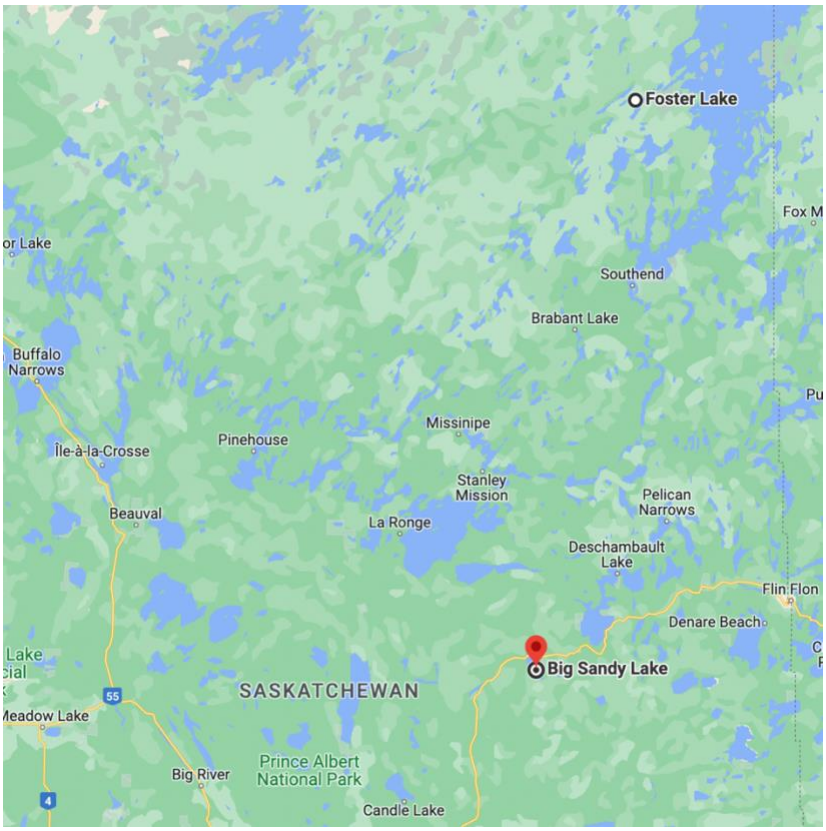
honours thesis with Indian Residential School Survivors about the repatriation of their childhood artwork from these "schools"[6].

I am a Master student in the Department of Indigenous Studies at the University of Saskatchewan, located on Treaty six Territory, the traditional land of the Cree; Blackfoot; Saulteaux; Dene; and Dakota Sioux Peoples and the homeland of the Métis. Saskatoon is on Treaty 6 land that was and continues to be stolen and dispossessed from the original keepers of the land through the Indian Act, breaking of the Treaties, discrimination, and ideas of white supremacy.

1.4 Stanley Mission profile

The Lac La Ronge Indian Band (LLRIB) is the largest First Nation band in Saskatchewan. It has identified their traditional use boundary stretching from more southern Big Sandy Lake to Foster Lake in the North, including most of central Saskatchewan in their traditional territory (see Figure 1).

Figure 1: Traditional Territory Map – Big Sandy Lake to Foster Lake (Google maps)



[6] Many Survivors of the IRS system do not believe they should be called schools, but institutions. The way these "schools" were run and what the children learnt there share little resemblance to the schools we know now.

The Stanley Mission First Nation (SMFN) and LLRIB were signatories of the Treaty 6 adhesion in 1889 (Figure 2) and amalgamated in 1950 (Northern Planning and sustainability Unit 2020). SMFN is a self-administered Woodland Cree (nehithawak) community on the Churchill River in northern Saskatchewan (Northern Planning and Sustainability Unit 2020). When the Treaty was signed in 1898, 150 people lived in Stanley Mission. Today there is an estimated population of 1951 (LLRIB n.d).

Figure 2: Treaty 6 territory and adhesion map (Geise, Paula 1997)

The Nehithawak (Woodland Cree people) lived in the Stanley Mission area before the settlement building, that was encouraged by the Church Missionary Society in the 1850s. According to the Northern Planning and Sustainability Unit (NPSU), the Stanley Mission area historically was a gathering place for the Woodland Cree people to hunt, fish and harvest (Northern Planning and Sustainability Unit 2020). The NPSU also states that the translation of Stanley Mission to Woodland Cree language (nehithawewin) is amaciwispimowinihk. However, the original name of this area is amachewespimawin which can be translated as "the place where hunters shot their arrows up the cliffs" (Northern Planning and Sustainability Unit 2020). In accounts of oral history from Stanley Mission's Community Plan, Stanley Mission was where hunters would "shoot arrows up the cliffs on Mountain Lake from their canoes. They would have

a good hunting season if the arrows went over the top. If the arrows failed to go over the top of the cliffs, they would have an unsuccessful year hunting" (Northern Planning and Sustainability Unit 2020).

The Church Missionary Society aimed to bring Christianity to the North and assimilate Indigenous peoples to European ways of life. According to Karmen Renae VanderZwan's (2010) Master Thesis, *Archaeology and oral history at the Stanley Mission Old Village*, the establishment of missions based on farming and agriculture was central to meeting these goals, as being self-sustaining meant that the parishioners could live with the community and have constant contact with community members. Further, VanderZwan stated that farming was also seen as a way by the mission to teach Woodland Cree people the value of planning and labour (9).

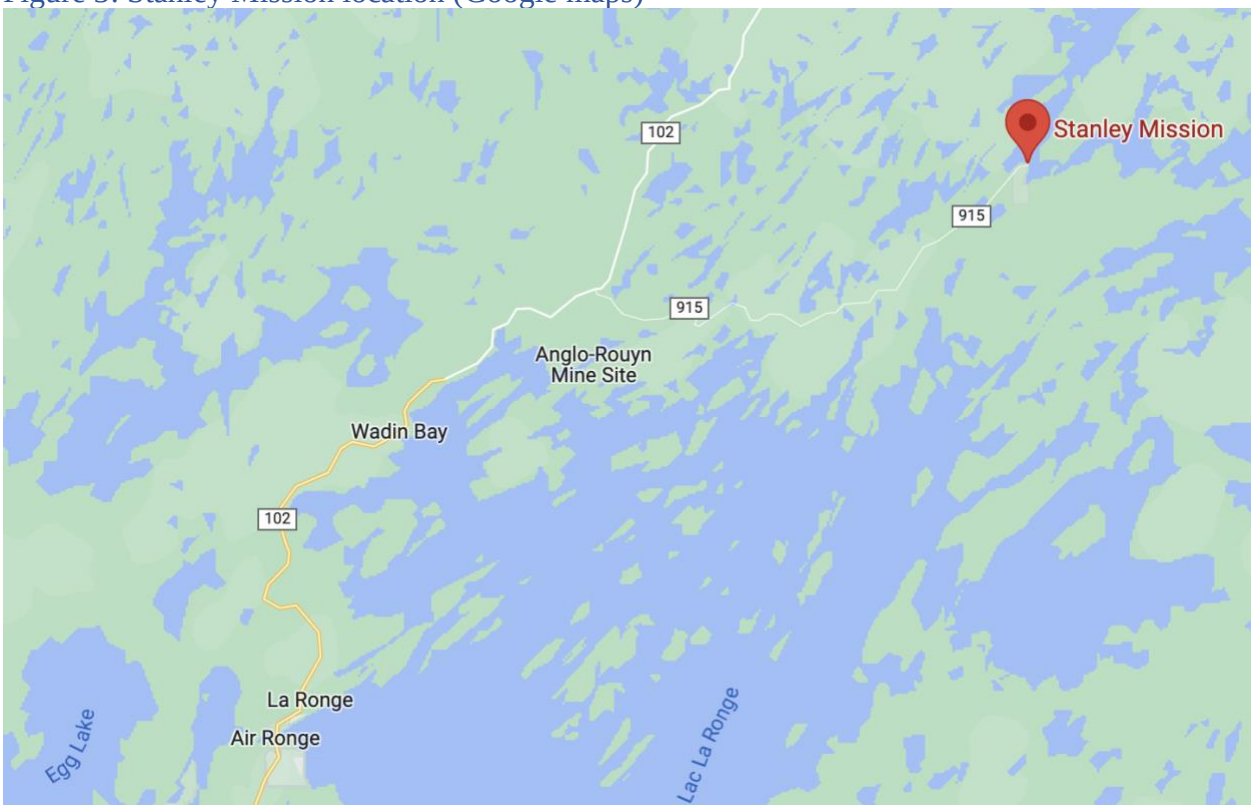
The Stanley Mission Old Village site was located directly across the water from the contemporary community of Stanley Mission. This land was chosen for a mission because of its agricultural promise and inability to flood, and it provided direct access to trade routes on the Churchill river (VanderZwan 2010). According to VanderZwan (2010), the Hudson's Bay Company (HBC) permitted missionaries to establish missions in Rupert's Land for trade routes. VanderZwan reports that in 1852, Reverend Robert Hunt moved to the Old Village site and established a mission with houses, a school, a church, and a trading post. Some of the people built houses at the Old Village site but would only live there in the summer. Stanley Mission was busy in the summer with missionaries who were there year-round, traders, and Woodland Cree people who came back from their traplines in the spring. VanderZwan (2010) states that families would plant gardens, fish, hunt, hold dances and go to church in the summers, then in the fall, they would return to their traplines until the following spring.

The church, now the oldest standing building in Saskatchewan and a national historic site, was built by George Fox/Cook, who started construction in 1854. Construction lasted six years and was finished in 1860 (University of Saskatchewan 2022). This church soon became the cornerstone of the community, where many social gatherings were held.

The settlement migrated to the south side of the river, where the contemporary village is with the establishment of the reserve and the HBC Trading Post. According to VanderZwan (2010), reserve land was designated on the south side of the river for Woodland Cree families in 1920. The reserve was next to the HBC store and buildings, which encouraged people to relocate

to the south side of the river, away from the Old Village mission. In the early 1970s, everyone had moved to the south side of the river where the contemporary village still thrives, leaving the church standing just on the other side of the water (University of Saskatchewan 2022; VanderZwan 2010).

Figure 3: Stanley Mission location (Google maps)



The population of the Stanley Mission Reserve increased after the passing of the amendment to the Indian Act in 1985, called Bill C-31 and continues to increase exponentially (University of Saskatchewan 2022). Bill C-31 was an amendment to the Indian Act to reinstate women and children who had lost status due to discriminatory membership provisions. According to the Stanley Mission website, when Bill C-31 passed, the population of Stanley Mission increased as more women and families regained their status in the eyes of the Canadian government and were able to move back on reserve into the late 1980s (Northern Planning and Sustainability Unit 2020). According to Statistics Canada, the population of Stanley Mission has increased by 9.5% from 2016-2021, and elders aged 65-84 represent 4.8% of the population (Statistics Canada 2021).

As the population grew, the need for accessible transportation did as well. Transportation to and from Stanley Mission until 1977 was mainly by water and air. This increasing population has implications for healthcare due to the difficulty of travelling to and from the community, thus decreasing utilization and access significantly (Northern Planning and Sustainability Unit 2020). There was a float plane that would provide the community with transportation and seasonal in the early 1920s. An airstrip was built in 1969 to provide mail, goods, and medical transit services to the reserve and settlement. A highway was built in 1978 that connected La Ronge to Stanley Mission, increasing the accessibility to hospitals (Northern Planning and Sustainability Unit 2020).

Currently, there are two health clinics in the Stanley Mission area, the Stanley Mission Health Clinic and the Wellness center. The nearest hospital access is in La Ronge (eighty kilometers away). The LLRIB provides transportation to and from this hospital, and minor emergency and medical transportation are provided for residents on reserve by the Amachewespimawin Health Services (Northern Planning and Sustainability Unit 2020).

With the increase of people and their growing healthcare needs in Stanley Mission came the need for greater self-determination over local healthcare capacity and first-level services. According to the LLRIB website, the LLRIB signed the Health Transfer Agreement with Medical Services Branch, or First Nation's and Inuit Health Branch (FNIHB), in 1993. This transfer was initially for three years, then it was extended to five, then to the year 2005 (Lac La Ronge Indian Band Health Services n.d.). A health transfer agreement is essentially the Federal government transferring their health authority to the First Nation and providing the Nation with funds to control its healthcare, programs, and services (Waldram, Herring and Young 2012). The LLRIB Health Transfer Agreement includes Public Health Nursing, Water Quality testing, the Prenatal nutrition program, and others (Lac La Ronge Indian Band Health Services n.d). The people of Stanley Mission took control over their local community health services in 1998, including program funding and services through a health agreement with the Health Services Branch (federal government) (Stanley Mission health services n.d.)

As a result of being self-administered, Stanley Mission built and operates an elder care home, Elders Haven, in the community that is unique for its wholistic, culturally responsive elder care services. The 10-bed care home opened in June 2003 and was funded by the local Band Council and community fundraising efforts (Stanley Mission Health Services n.d.). This Elders

Haven is vital for Stanley Mission elders and other communities near Stanley Mission (Pauls 2003). The Elders Haven allows elders can receive care in their community, minimizing many barriers they face when accessing healthcare elsewhere.

When staff are connected with the community, the barriers of healthcare are lower. According to the Elders Haven Coordinator, there are 20 elder care aides and one licensed practical nurse on staff at the Elder Haven. Doctors come from La Ronge twice a week to check up on the elders in the Haven. Almost all the staff who work at the Elders Haven are people who grew up in Stanley Mission, and all are band members. Band members have a better sense of culturally appropriate and self-determining healthcare models, and many elders feel more at ease with people they know providing care to them. June Pauls, a writer for the Saskatchewan Sage, noted that familiarity with the community can significantly reduce barriers to accessing care and also create a more friendly environment for the elders (Pauls 2003).

1.5 Saskatchewan Health Authority profile (SHA)

The SHA has jurisdiction over providing health services in Saskatchewan and operates hospitals outside reserves. It is the largest organization in Saskatchewan and employs over 40,000 employees including physicians (Saskatchewan Health Authority 2023a). According to the SHA website, the SHA is "responsible for delivery of safe, high-quality healthcare for the entire province" (Saskatchewan Health Authority 2023a). The SHA website states that it is committed to improving healthcare for people in Saskatchewan and that they are striving to "work together to better coordinate health services across the province to ensure you [patients] receive the right care, in the right place, at the right time, and by the right provider, *wherever you live in Saskatchewan* [emphasis added]" (Saskatchewan Health Authority 2023a.). The SHA has also committed to Truth and Reconciliation and reiterated healthcare Calls To Action from the TRC (2015a). The Calls to Action the SHA is committed to are listed below:

> 18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the healthcare rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.
> 19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities and publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and

child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20. To address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. We call upon those who can effect change within the Canadian healthcare system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:

- Increase the number of Aboriginal professionals working in the healthcare field.
- Ensure the retention of Aboriginal healthcare providers in Aboriginal communities.
- Provide cultural competency training for all healthcare professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

55. We call upon all levels of government to provide annual reports or any current data requested by the National Council for Reconciliation so that it can report on the progress towards reconciliation. The reports or data would include, but not be limited to, progress on closing the gaps between Aboriginal and non-Aboriginal communities in a number of health indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services...

These calls to action are important to include here because the SHA states they are committed to addressing them (Saskatchewan Health Authority 2023c) and the TRC guidelines can provide an ongoing direction for improving relations and working with Indigenous peoples in healthcare. As the experiences of the people interviewed in the Stanley Mission study here suggests, much work still needs to be done. For example, the jurisdictional problems, as mentioned in calls 18 (government policies), 20 (jurisdiction and health coverage) and 21(sustainable health funding), are discussed in the literature review, and the research findings and discussion areas address sections 19 (closing health gaps), 22 (cultural inclusion in healthcare), 23 (more Indigenous health care providers and training), 24 (cultural training) and 55th (reporting) call to action.

To address some of these calls to action, the SHA created an Indigenous working group and has been involved in responding to the Cultural Responsiveness Framework that was developed by the Federation of Sovereign Indigenous Nations (FSIN) (FSIN 2013). The FSIN created this document with a project advisory team and other partners (FSIN 2013). This framework outlines both First Nations and the "mainstream" worldviews and the potential benefits of these two systems working together. It included three strategic directions,

> Restoring First Nations community-based health and wellness systems . . . establishing a 'middle ground' for engagement between mainstream and First Nations systems and worldviews . . . [and] transforming mainstream health service delivery to be culturally responsive. (2)

This framework suggests that the healthcare system would be significantly improved for First Nations and Métis Peoples by working together and ensuring better equity in healthcare.

According to their website, the SHA recognizes the importance of working with First Nations and Métis people. The First Nations and Métis Health Services (FNMHS) branch focuses on hospital patients' mental, physical, spiritual, and emotional health. FNMHS creates space for Elders/Cultural support workers in hospitals who guide and support patients' health journeys. FNMHS advocates for proper communication between patients and healthcare teams, coordinates insured and non-insured benefits, increases cultural safety through sharing knowledge and promotes access to traditional health practices in hospitals (Saskatchewan Health Authority 2023b). The SHA website states the FMNHS provides support “to patients and their families from admission to discharge by working with a range of health professionals and departments. At this time, our services are available in Regina, Saskatoon, Prince Albert and Broadview” (Saskatchewan Health Authority 2023b). These initiatives suggest a willingness to work with Indigenous peoples on positive healthcare solutions on issues that affect them.

2: Research paradigm and literature review

2.1 Introduction

This chapter describes my research paradigm and reviews the literature on First Nation and Métis Northern healthcare in Canada. The literature review includes generalized and specific Social Determinants of Health affecting First Nations people in Canada, jurisdictions and policies surrounding First Nation health, and Indigenous elder health, access, and policy in Canada.

2.2 wâhkôhtowin as a research paradigm

I will use a Cree worldview, wâhkôhtowin, as a research paradigm for this study. According to Wilson (2008), research paradigms are "labels that are used to identify sets of underlying beliefs or assumptions upon which research is based" (33). These beliefs or assumptions guide the research process. A research paradigm is a lens through which the researcher views or wants the world to be seen, translated into their research. So, although I am not a Cree person, nor do I know the language, the elders, and Elders Haven Coordinator whose experiences are the core of this research, were all fluent Woodland Cree language (nehithawewin) speakers with a deep knowledge of wâhkôhtowin. Wâhkôhtowin plays a prominent role in wholistic health for elders in the north because of the importance of family and kinship relations in their culture, and to that end, it is reflected here in the discussion of the research findings and analysis.

The term wâhkôhtowin, in English, translates to kinship or having a good relationship with the Creator and one another (Cardinal and Hildebrandt 2000). Wâhkôhtowin is a way of seeing the world, animals, plants, and spiritual realms as interconnected and, thus, an inherent responsibility to interact within these realms positively (Wildcat 2019). The worldview of wâhkôhtowin also encompasses a broader lens of respect, reciprocity, and responsibility through relationality. Andrea Smith, an Indigenous reporter for The Tyee, reports on oral histories and lessons of wâhkôtowin she has learned from various Elders from Onion Lake First Nation. Smith states that she has learned that wâhkôtowin is viewed by many of the Cree people as a natural law to live together in a good way with the earth and to leave a world behind when you pass where your seven generations can do the same (Smith 2019).

Non-Indigenous people must understand how vital wâhkôtowin is in daily life and the wholistic health of northern First Nation and Métis elders. Meghan Eaker (2017) comments on

the worldview of relationality through wâhkôtowin as a way for non-Indigenous peoples to practice anti-racism in nursing through recognizing that we all have kinship responsibilities to one another (37-38). Additionally, Métis researcher Brenda Macdougall, in her seminal work on *Wahkootowin: Family and Cultural Identity in Northwestern Saskatchewan Metis Communities*, describes wâhkôtowin as a worldview consisting of values and norms based on family connectedness (Macdougall 2006, 434). This family connectedness is integral to good healthcare and health status for the elders in this research.

Relationality is core to the wâhkôtowin research paradigm in this thesis. As Aileen Morton-Robinson (2017) states, "Relationality is grounded in a holistic conception of the inter-connectedness and inter-substantiation between all living things and the earth, which is inhabited by a world of ancestors and creator beings" (71). Relationality carries with it respect, responsibility and reciprocity, which also constitute the pillars of wâhkôtowin and are carried within Indigenous social research paradigms (Moreton-Robinson, 71). Kovach (2009) comments on relationality as a responsibility between non-Indigenous researchers and the Indigenous community, with the responsibility dependent on the relationship itself. A way to uphold this relational responsibility is to give back. As Kovach states, "Responsibility implies knowledge and action. It seeks to genuinely serve others and is inseparable from respect and reciprocity" (178). Responsibility is defined as a way to give back, to serve others using the knowledge you have been gifted. With the knowledge gifted to me in this research and throughout my life, I feel more responsible for using it to give back to the elders and community. I feel that it is my responsibility as a citizen to continue to advocate for better access and policy changes in the Saskatchewan healthcare system.

The wâhkôtowin worldview includes motivations to actions from the past, present, and future. As described by Smith (2019),

> What we do, and how we act in the world, has a direct effect on everything around us . . . we have to consider our relations with everything as [we] walk upon the earth. Each step must be meaningful and, ideally, positive. Each action must reflect our responsibility to all creatures and the future (3)

In the context of responsibility and walking forward in a good way, this worldview is also important for everyone. Non-Indigenous peoples and their western systems and ideas have passed down harmful ideals and worldviews that need to be addressed and changed in order for future generations of both Indigenous sand non-Indigenous peoples to thrive and practice

relationality. The western health system needs to accommodate Indigenous ways of knowing and Indigenous health systems. The elders in this research all identify key values such as relationality and the need for cooperation and respect when working with others. They also express the desire to feel like they are heard by people working in the healthcare system, and for governments to provide sustainable resources to support the healthcare capacity for northern communities.

Wâhkôtowin highlights the importance of relationships and that they are integral to wholistic healthcare for elders, which is consistent with the elder's views and experiences in this research that emphasize the importance of families or community in their healthcare and life. Additionally, the elders commented on the importance of having someone they knew providing care who held similar views on language and relationships. These themes are consistent with other related literature, including Beatty and Berdahl (2011) who comment on the importance of strong family relationships in supporting elders close to home and with end-of-life decisions. Additionally, Allen et al. (2020) comment on the importance of community worldviews being involved in healthcare to "achieve success and advance wellness" (E209). Beatty and Weber-Beeds (2013) state that family relatedness is fundamental as a guiding worldview and a "source of practical support and advocacy for the elderly" (125). The theme of family advocacy and support is strongly emphasized in the findings of this research, with every participant commenting on the importance of family and relations.

2.3 Literature Review:

2.3.1 Social Determinants of health

Social determinants of health (SDH) are important to understand and incorporate into healthcare practice and research when considering the health of any individual. For example, in the north, access to healthcare is a big issue to be considered due to geographical location and weather. SDH are non-medical influences shaped by social policies that affect one's health (Braveman and Gottlieb 2014). According to Reading and Wein (2009), Indigenous SDH are split into three related categories: proximal, intermediate, and distal determinants of health. Proximal determinants of health represent the root of health concerns for Indigenous peoples in Canada. These proximal determinants are health behaviours, physical environments, employment and income, education, and food insecurity. Intermediate determinants are the origins of the proximal determinants. Healthcare and educational systems, community infrastructure, resources and capacity, environmental stewardship and cultural continuity are all intermediate

determinants of health. Distal determinants represent political, social, and economic contexts that create intermediate and proximal SDH. Distal determinants for Indigenous Peoples include colonialism, racism and social exclusion, and self-determination (Reading and Wien 2009).

This research addressed some proximal SDH, including the Elders Haven's healthcare systems and resources and capacity. It also discussed distal determinants of health, racism, and social exclusion in healthcare based on the literature. Each level of Indigenous SDH is interconnected; one cannot change without the other. The additional SDH factors such as income, geography and racial inequities faced by Indigenous peoples can lead to increased risk of ill health.

The most prominent health conditions facing many Indigenous communities today are rooted in the long history of colonialism and its continuing marginalizing impacts. These include effects from drug and alcohol abuse, cancer, higher rates of suicide, obesity, heart conditions, and diabetes (Beatty and Berdahl 2011; Finlay, Hardy, Morris, and Nagy 2010; Hotez 2010; Jacklin et al. 2017; Lavoie 2013). These conditions are exacerbated by Indigenous SDH, like racism and social exclusion, manifesting in barriers to health services and a lack of resource and capacity support. Allen et al. (2020) report that "racism, aggression, disrespect, differential healthcare, [and] language discontinuity" (E208) are barriers that Indigenous people face when accessing healthcare in Canada. Further, Beatty and Weber-Beeds (2013) state that the challenges and barriers that Indigenous peoples face when accessing healthcare are considerable because of federal and provincial jurisdictional gaps and insufficient resources for First Nations peoples in Canada (114).

Browne et al. (2016) comment on these jurisdictional and policy gaps as structural violence, which the authors refer to as "the disadvantage and suffering that stems from the creation and perpetuation of structures, policies and institutional practices that are innately unjust" (2). This structural violence is perpetuated by inequitable institutional reforms, like health reforms carried out by the federal and provincial governments to decrease healthcare expenditures. Browne et al. (2016) suggest that the reforms have led to "the loss of community-based social and health services," which in turn "disproportionality burden Indigenous peoples" (2). These jurisdictional boundaries reflect racism and social exclusion and contribute to the increased morbidity and mortality of Indigenous peoples in Canada compared to the non-Indigenous population (Browne et al. 2016, 3).

According to Wanda Phillips-Beck et al. (2020), racism persists in the Canadian healthcare system and “racial injustice is constructed through societal notions of white supremacy, racism, ethnocentrism and discrimination and their effects on First Nation health” (2). Phillips-Beck et al. report on several barriers to western medicine, including language, distance travelled, systemic racism, and stereotypes against First Nation People (10-12). Elders in this study also report all these themes (language, distance, perceived stereotypes) as significant barriers to Saskatchewan hospitals. Phillips-Beck et al. (2020) state that racism correlates with poor physical health and that their findings "suggest that direct and persistent vicarious racial discrimination are detrimental to health" (15). These findings of racial injustice are corroborated in the literature by Tang and Browne (2008) who report perceived racial profiling in diagnoses (115), Monchalin, Smylie and Nowgesic (2020), who report Métis women not getting the medication they needed because of their Métis status and past medical history (255), and Goodman et al. (2017) report Aboriginal peoples feeling dismissed and “treated differently” (89) in healthcare interactions. Further, Jennifer Sebring (2021) comments on the power relationships between patients and physicians where the invalidation or dismissal of the patient's health by the physician or healthcare providers is medical gaslighting and that it is prevalent in communities who face discrimination because of structural power inequities (1960). These findings from the literature raise issues of racial profiling, poor relations between Indigenous patients and non-Indigenous healthcare providers, and inequitable access and treatment in mainstream healthcare facilities.

Racism and social exclusion are distal health determinants that contribute to the intermediate determinants of health, such as land and environmental stewardship (Reading and Wein 2009). Reading and Wein (2009) describe environmental stewardship as "a major resource for the superior health enjoyed by Indigenous Peoples" (20). Reading and Wein suggest that there has been a transition from a healthy relationship to one of dispossession and disempowerment with the land since European contact, thus negatively affecting the health of Indigenous Peoples.

The First Nation values systems endured despite the racist colonial systems and discriminatory legislation such as the Indian Act. According to Sylvia McAdam, in her book *Nationhood Interrupted*, many Cree people consider themselves as part of the kinship system of the land, where the land and its resources are "critical and essential to the nêhiyawak [Plains

Cree] because, without these elements, Indigenous culture and pimâcihowin (livelihood) would not exist" (64). Traditional land use is central to the identity and wâhkôhtowin of the Cree people. The history of colonial legislation and policies sought to strip land rights and tear apart traditional family systems of the First Nation peoples which resulted land dispossessions and residential school policies. These legislations and policies detrimentally impacted their lives and kinship ties to their lands, but they continued to be resilient. In Cardinal and Hildebrandt's (2010) book, the elders state that the treaties negotiated after 1874 by their respective Nations with the British Crown were based on teachings and prophecies from their spiritual traditions and principles (6). An example of this is the doctrine of wâhkôtowin that talks about governing good relations (14). The concept of family is also seen as the organizing conceptual value or framework through which all relationships are created under treaty. So, in their eyes, the laws governing wâhkôtowin, or family relationships, reflect the spirit of the Treaty relationship (8). For example, one elder stated "We were taught to care for our old people, we were taught to respect them, we were taught to listen to their stories, because their stories spoke of life" (Elder Dolly Neapetung of Treaty 4, as cited in Cardinal and Hildebrandt 2010, 6).

Another example of colonial discrimination was the federal government administration of registering status for First Nations which impacted their rights and benefits. Allan and Smylie (2015) state that "The Indian Act is a race-based legislation that provides the federal government of Canada with the right to determine who can and cannot be an 'Indian'" (9). The Indian Act authorized the Canadian federal government to regulate and administer status to First Nation peoples, affecting their self-determination and perpetuating legislated segregation, and social and economic oppression. Colonialism and its impact on identity are widely acknowledged as the root causes of many mental health issues among First Nations peoples (Kirmayer, Brass and Tait 2000; Lavallee and Poole 2010). The Indian Act and the Indian Residential School (IRS) System set in motion many years of family and community trauma that is now challenging the healthcare systems. The residential school system has and continues to negatively affect the mental, spiritual, emotional, and physical health of many First Nation peoples. According to Lavallee and Poole (2010), "In order to understand how to heal the individual and collective identity of Indigenous Peoples we need to explore the colonial impact on identity" (275). They go on to reference Kirmayer et al (2000) who "argue that the attempted forced assimilation and resulting

cultural genocide of Indigenous people has left many people with ‘profound problems of identity and self-esteem’ (p. 6).” (Lavallee and Poole 2010, 275).

The residential schools separated children from the safety of their families during their formative years, placing them in unhealthy environments (Truth and Reconciliation Commission 2015b). The many years of residential school control damaged many children, their cultures, and their wâhkôhtowin (relational) ties. The actions of the government and churches will continue to take many years to resolve. The TRC report states that there have been countless testimonies of sexual, physical, spiritual, and emotional abuse at these residential schools (Truth and Reconciliation Commission 2015b). According to a scoping review by Wilk, Maltby and Cook (2017), the physical health outcomes of the residential schools included "poorer general and self-rated health, [and] increased rates of chronic and infectious diseases" (1). These physical health disparities continue with intergenerational health issues like diabetes (Mosby and Galloway 2017) and increased mental health issues amongst First Nation peoples (Bombay, Matheson and Anisman 2014).

Malnourishment is another issue that has been attributed to poor health status for Indigenous peoples. Mosby and Galloway suggest that malnourishment has had adverse health effects on future generations of individuals who have suffered from prolonged starvation (Mosby and Galloway 2017). In the case of the residential schools, malnourishment has been attributed to the later development of diabetes, obesity, and reproductive, neurological, psychological, and immune system complications among many First Nations Peoples (Mosby and Galloway 2017, E1044). Being severely malnourished as a child can lead to shorter stature, as the body lacks the vitamins and minerals to grow healthy and strong (Mosby and Galloway 2017). Mosby (2013) has also noted that scientists sometimes performed medical experiments with First Nations children in the residential schools, seeing the children as “experimental material” (148) instead of addressing the issue of malnutrition (Mosby 2013). These experiments consisted of increasing or decreasing the intake of various substances and measuring the changes in children's bodies by medical and dental examination, blood tests, and tooth extractions. These nutrition experiments did not ameliorate the student's health status and left behind fear and confusion toward medical staff (Mosby 2013). This mistrust toward western governments and their policies continues to linger in all areas and needs to be addressed.

Mistrust with institutional authority is an ongoing challenge. First Nation peoples often face many cultural barriers and lack of resources when accessing healthcare (Beatty and Berdahl 2011; Nelson and Wilson 2018; Redvers, Marianayagam and Blondin 2019). Some of these barriers include limited access to comprehensive specialized care, invalidation, long waiting times, communication issues, and encounters with unfriendly healthcare workers (Auger, Howell, and Gomez 2016; Cameron et al. 2014; Habjan, Prince and Kelley 2012; Nelson and Wilson 2018). These complex barriers can be best addressed by people in the western and Indigenous healthcare systems working together to create an equitable and safe healthcare system for everyone.

Indigenous scholars have argued that self-determination in all aspects of life is necessary to heal from the oppressive and colonial policies of the western healthcare system (Alfred 2009; Borrows 2001). In recent years, Indigenous peoples have sought self-determination over their community health services (Lavoie, Boulton and Dwyer 2010). According to Alfred (2015) and Simpson (2014), this self-governance requires reconnecting with land-based and intergenerational knowledge. This statement aligns with practicing wâhkôhtowin to increase wholistic health by reinforcing kinship ties with the land and the community. Additionally, research supports that self-determination increases the wholistic health of Indigenous peoples significantly as they choose the pathways to improve their access to primary care and health services (Allen et al. 2020; Auger, Howell, and Gomez 2016; Cameron, Courchene, Ijaz and Mauro 2019; Eni et al. 2021; Howell et al. 2016; Mashford-Pringle 2013). First Nation controls over their health and health practices is one of the most important aspects of wholistic health.

Self-determination in healthcare is an ongoing development for First Nations and Métis peoples in the north who face distinct geographical and other healthcare challenges. First Nations and Métis peoples are working to develop more local healthcare options and access. Studies suggest that culturally relevant and safe access to healthcare is an ongoing challenge that needs to be addressed in the mainstream health system (Beatty and Berdahl 2011; Habjan, Prince and Kelley 2012; Rahaman, Holmes and Chartrand 2017). The north and its isolated living conditions and lack of access to proper care can create many barriers for Indigenous people who often need to be transported out of their homes to travel great distances for their healthcare needs (Beatty and Berdahl 2011; Nguyen et al. 2020; Oosterveer and Young 2015).

According to Hyett, Marjerrison and Gabel (2018), Indigenous methods and methodologies in research and particularly health research are becoming increasingly recognized and incorporated to increase research practices and outcomes (E616). The recent incorporation and significant benefits of Indigenous methodologies in health recognize that Indigenous peoples have the tools to address the concerns of their communities using a more wholistic healthcare approach that would increase positive outcomes and changes in healthcare practices (Eni et al. 2021; Fridkin, Browne and Kétéskwēw Dion Stout 2019; Greenwood 2019; Hadjipavlou et al. 2018; Katz, Enns and Kinew 2017; Rogers et al. 2019; Tu et al. 2019). Indigenous knowledge and wholistic healthcare practices must be further incorporated into the healthcare system to start to allow for more equitable access and use of healthcare.

A way Indigenous knowledge has been able to be more prevalent in healthcare is through the Health Transfer Agreements negotiated with the federal government. These Health Transfers have enabled First Nations to set up their local own health systems, but they have also been limited by underfunding and lack of flexibility as noted by Mashford-Pringle (2013). Most First Nations in Saskatchewan have developed their own healthcare systems notwithstanding the limitations of the health transfer agreements. The transfer of control of health services to First Nations has also provided opportunities for capacity building and more culturally responsive first level programs and services in the communities (Smith and Lavoie 2008). As each First Nation has specific health needs and approaches to their healthcare, the Health Transfers allow for culturally relevant and safe models of care unique to that First Nation. The Indian Health Transfer Policy was created to address gaps in policy and jurisdiction surrounding First Nation health in Canada and is only a first step towards self-determination in healthcare. Full control has a long way to go.

2.3.2 Policy and Jurisdiction

The Canadian health system is complex and has many interrelated components of jurisdiction divided between the federal, provincial, territorial, and municipal governments. It is fragmented and not coordinated. As a result of these moving parts, there are significant gaps in healthcare and access for Indigenous peoples in Canada as Indigenous people's care crosses jurisdictional boundaries based on status and living situations (Lavoie et al. 2011). The healthcare provided on-reserve is funded federally, whereas off-reserve care in Canada is the provincial government's responsibility. However, the barriers to access are different for status

and non-status First Nations, Inuit, and Métis people. Ambiguous interpretations of legislation and policy have created poorly defined jurisdictional and economic responsibility for First Nations health services, which results in fragmented funding and health services for First Nation peoples. This complexity has created a network of Indigenous health policies and jurisdictions that vary from one province or territory to another and one community to another, with 15 different healthcare systems in the country (Gouldhawke 2021).

The Royal Commission of Aboriginal Peoples Report (RCAP) identified the need to address the jurisdictional issues in healthcare and healthcare delivery as a priority advocating for healing in the communities (RCAP 1996). However, more care still needs to be provided to many Indigenous peoples in Canada, and healthcare services remain problematic (Adelson 2005; Lavoie, O'Neil and Reading 2008). Addressing and initiating change on these challenges is imperative to provide coordinated health services unique to the wholistic health requirements of Indigenous peoples in Canada.

The discussion on First Nations health jurisdiction is rooted in the early 1867 federal Constitutional legislation (The British North American [BNA] Act). As government evolved, the division of healthcare between federal and provincial jurisdictions created a patchwork of health systems. According to Lavoie (2013), the Constitution Act (1867) stated that First Nations "Indians" and Inuit were a federal responsibility (2). In terms of health, the federal government is responsible for the healthcare of registered Indians living on-reserve and covers some health benefits (the non-insured health benefits) to them wherever they live. The provinces generally provide healthcare off reserve. According to Beatty and Berdahl (2011), "Although provinces and territories provide healthcare services, the federal government is responsible to pay for status Indian and Inuit healthcare" (7). The Métis and non-status First Nations were not considered a federal responsibility until the Daniels Decision (2016), but what that means as far as health coverage and program eligibility is uncertain, and there is much work to be done. According to the Government of Canada website, the Daniels Decision does not change "eligibility for programs and services currently targeted to Status Indians" (Government of Canada 2022).

The federal government's obligations to First Nation people's healthcare as a Treaty Right is contentious. First Nations believe that they have a Treaty Right to health under Treaty #6 which refers to the Medicine Chest clause (Government of Canada 1964). First Nation peoples point to this section to support the fact that healthcare is a treaty promise. Even with this

legal document, the federal government states it provides healthcare to First Nations peoples as a matter of policy and practice, not because of Treaty or Constitutional obligation (Romanow 2002). Both provincial and federal governments tend to use this 'who pays' as a political football to dodge responsibilities for First Nations healthcare.

The history of First Nation healthcare is one of inequity with segregated federal Indian hospitals in early 20th century, but most were closed by the 1960s with the coming of medicare. According to Lux (2016), "responsibility for Aboriginal healthcare (and welfare) now shifted to the provinces" (193). The jurisdictional disputes that came with the administration of health insurance (Medicare) increased and led to many access disparities (Lux, 193). The First Nations continued to advocate for their Treaty right to health care in their communities. In 1979, the Federal Government enacted the Indian Health Policy which allowed First Nations to take over their health services.

The Indian Health Policy reflected the federal government's response to First Nations demands for more local control over their own healthcare systems and their communities. According to Health Canada, the objective of the Indian Health Policy 1979 was to "achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves" (Health Canada 2007). The Health Transfer Policy, which came out of the Indian Health Policy, is now widely used by individual First Nation communities across Canada as a mechanism of managing and controlling their own health services. This policy originated with the First Nations and Inuit Health Branch of Health Canada (FNIHB) in 1989 (Lavoie 2013).

To address some ambiguity of insured coverage for status First Nations peoples, the federal government created the Non-Insured Health Benefits (NIHB) plan. NIHB is a non-insured service for First Nations that covers limited health benefits and some medical drug costs. However, NIHB does not cover non-status First Nations and Métis peoples, who, before the Daniels Decision, fell under the provincial or territorial jurisdiction for health coverage as defined by the Canada Health Act in 1984.

2.3.3 Health Reforms

In the 1990s, reforms of universal healthcare sparked changes at provincial and national levels. These reforms focussed on changing the delivery of healthcare services to reduce the economic burden of healthcare from the provincial and federal governments (Penning, Brackley

and Allen 2006). The health reform emphasized people returning to their families or homes as soon as possible, reducing the economic burden of patient care on the healthcare system. This reform could be beneficial when there is an established health infrastructure to provide healthcare closer to home. However, many Indigenous communities need more infrastructure and resources to provide community healthcare and are less able to accommodate this health reform for enhanced community-based care. For some Indigenous communities, this reform sparked the change to update and revise the initial Transfer Framework Policy made in 1987.

In response to First Nation health reforms, the Northern Intertribal Health Authority (NITHA) was formed in Saskatchewan to address third-level health services (communicable disease control services such as TB control and surveillance). NITHA is a First Nation organization comprised of the Prince Albert Grand Council, Meadow Lake Tribal Council, Peter Ballantyne Cree Nation, and Lac La Ronge Indian Band. These partners joined in 1998 to set up a northern health delivery agency to provide third level services to address the Medical Health Officer's more costly and specialized healthcare services (NITHA 2023). Coordinating the northern COVID vaccination system and increasing COVID awareness was a recent example of third-level care offered by NITHA (NITHA 2023). Northern community healthcare centres generally provide the first-level (primary care) and second-level (coordination) health services.

The large multi-community Bands, like LLRIB, manage and deliver most of their health services through their community clinics. For the smaller reserve communities, sometimes the second-level services are provided by the Tribal Councils due to cost and coordination capacity issues. NITHA provides third-level services (specialized, CDC, TB Control) to the northern multi-community Bands and Tribal Councils (NITHA 2023). A contribution agreement with FNIHB funds these services for First Nations signatories of Treaty six in the north (NITHA 2023). The health reforms have steered some Indigenous communities toward creating different opportunities for access to care, like NITHA, and for providing better wholistic care for Indigenous communities. This wholistic care needs to extend to Indigenous elders whose population is growing, as they have specific healthcare needs.

2.3.4 Indigenous senior population and healthy public policy

The Indigenous population in Canada is growing (Statistics Canada 2018), and so is the Indigenous senior population. As this growing population ages, so do the needs for elder support in health (Beatty and Berdahl 2011; Habjan, Prince and Kelley 2012; Rosenberg et al. 2009).

This elder support requires familial and community support and integrating westernized healthcare and wholistic Indigenous health models for prevention and treatment of chronic illness (Beatty and Berdahl 2011; Habjan Prince and Kelley 2012).

In a publication by Shari Narine (2013), racism plays a key role in feelings of mistrust and stereotyping in the health system. Narine (2013) reports that a shift in the health care system is beginning with the understanding of topics such as cultural safety which could highlight SDH like poverty and intergenerational effects of residential schools. Elder's needs are compounded and intersectional as they can experience low socioeconomic status and face racism, ageism, and classism. As a result of this intersectionality, many First Nations elders feel they have fewer healthcare options that are safe to access (Beatty and Weber-Beads 2013; Habjan, Prince and Kelley 2012; Nelson and Wilson 2018). Additionally, Indigenous peoples experience significantly higher rates of chronic illness, addictions, suicidality, and depression than the average Canadian population, increasing their need for consistently safe and adequate care (Nelson and Wilson 2018; Richmond and Cook 2016).

Unfortunately, Nelson and Wilson (2018, 23) found that many First Nations people have reported delaying their medical visits until they have more severe symptoms because of mistrust and fear of being transferred great distances. Even if the elders do not need to travel off reserve for medical attention they need, there needs to be more recruitment, training, and retention of healthcare providers that have training to meet the complex needs of elders (Health Council of Canada 2013, 12), such as cultural safety. While there is no clear definition, cultural safety broadly has to do with addressing the colonial power relations in health systems and facilitating an environment that respects and honours Indigenous cultures and their autonomy and rights as patients to good quality healthcare (Brascoupé and Waters 2009, 12). In addition to demanding increased cultural safety to dismantle racism and discrimination in healthcare, wholistic health models stress the importance of family and community in health, especially the connection between youth and elders (Wexler 2011).

Unfortunately, elder familial and peer support on the reserve is decreasing because younger generations are leaving to find work and different opportunities (Habjan et al. 2012, 215). These circumstances lead to the increased need of the elderly Indigenous population to have healthcare workers on reserve or more available trusted workers off reserve. This increased need is a concern because the health needs of Indigenous elders, according to the Health Council

of Canada, are magnified by specific determinants of health (2013, 5). Additionally, most Indigenous seniors live on reserves, where they connect to the land and community. However, this means they are more likely to live in remote rural spaces, where it is more expensive and challenging to provide healthcare (Health Council of Canada 2013, 5). Because of specific SDH, Indigenous seniors' conditions could advance to severe cases, increasing the care they need and furthering the healthcare gap.

Beatty and Berdahl (2011) state that the most significant gap in healthcare for seniors is the exclusion of specialized care needs for the elderly population. Some examples of basic elder care needs include medical screening facilities, health clinics and health-promoting organizations (Shaw et al. 2015). Some healthcare options are available for seniors on reserve, like health clinics. Beatty and Berdahl (2011) state that although some services are available, they are underutilized. There are several barriers to why there is this underutilization, such as language, affordability, racism, jurisdiction, and problems navigating the health services system (Allen et al. 2020; Beatty and Berdahl 2011). This underutilization could be the result of insufficient funding for on-reserve care of elders and a lack of policies addressing these gaps.

Rosenberg et al. (2009) state that there is a lack of academic energy focusing on healthcare for Indigenous elders, and there is a need for an integrated, wholistic view in the healthcare policy of the elder population. Beatty and Berdahl (2011) further this statement by arguing that there needs to be a health policy change in the primary healthcare model for Indigenous seniors that supports more integrated and coordinated wholistic health.

Seniors or elder care homes are a precious resource to allow elders to receive care close to home. Beatty and Berdahl (2011) argue that these resources are the most pressing and beneficial implementation for rural First Nation elders and advocate for constructing and maintaining an elder care homes on reserve or close to their communities. The Stanley Mission Elders Haven is a great example of a community-run elder care home. The "Elders Haven" assists in wholistic health services for First Nation elders in the Stanley Mission and the Lac La Ronge area. Although there are limited beds, those who can receive care at the Elders Haven benefit greatly from this care. By prioritizing First Nation elders' and community healthcare workers' knowledge, this research aims to share lived experiences of elders in Stanley Mission and hopes to spark a policy change that increases self-determination in healthcare using the

relational worldview of wâhkôhtowin to stress the importance of wholistic care and familial support.

3: Methodology

3.1 Introduction:

This qualitative thesis is a case study of Stanley Mission elders' health and healthcare experiences and how these experiences can inform policies proposed and enacted to improve health access and care in hospitals in Saskatchewan. According to Powell (2020), qualitative research allows people in communities most affected by policy and service change to provide their perspectives through conversations. This approach highlights the voices and views of the Stanley Mission elder participants in this case study through a wâhkôhtowin lens. The data of this study comes from interviews with elders and the Elders Haven coordinator who were recruited using snowball and relational methods through networks in Stanley Mission. A literature scan on health access and policies of the SHA website provided information on its health programming and services. In *Applying Indigenous health community-based participatory research*, Manitowabi and Maar (2018) explain that snowball sampling occurs when the researcher consults with participants to get information from knowledgeable community members on the topic of interest (163). The Elders Haven coordinator assisted with the snowball sampling as they knew many elders in Stanley Mission and connected me with several participants.

3.2 Research design

Following Kovach's (2009) suggestion that "Within a qualitative research paradigm . . . one's methodological choice should encompass both theory and methods" (122), I used a case study methodology through a wâhkôhtowin lens to highlight the importance of kinship and responsibilities in health and healthcare. A wâhkôhtowin research paradigm recognizes the need for relationality and responsibility in research, which a qualitative case study design can accomplish. Case studies focus on a single phenomenon to wholistically examine a theoretical issue using multiple methods (Thomas 2019; Yin 1999). According to Simons (2020), the case study design is open to different methods to ensure the unique and complex case is understood. This unstructured design for methods allows for flexibility which has been beneficial in this research. This case study illustrates the story of elders from Stanley Mission and their healthcare experiences with hospitals.

Case studies consist of a purpose, research question, literature review, theoretical approach to the research question, research framework, and data collection methods (Thomas

2019). This case study provides a qualitative approach to understanding the phenomenon using data collection and analysis methods chosen and practiced by the researcher based on the specific case being studied. According to Simons (2020), "The purpose [of a qualitative case study] is to portray an in-depth view of the quality and complexity of social/educational programs or policies as they are implemented in specific sociopolitical contexts" (682). A qualitative case study emphasizes subjective experiences and participants' ways of knowing and their expert knowledge.

Stanley Mission elders are the experts on their health and give insights to health access issues in Northern Saskatchewan. Privileging these elders' lived experiences can help inform SHA policies to improve access to healthcare for northern First Nations and Métis people. This study asks the following research questions: What have been the experiences of First Nation and Métis elders from Stanley Mission regarding their health throughout their lives? And how do these experiences relate to the care and policies provided by the Saskatchewan health authority?

The literature review explained the unique health needs and root causes of many health concerns for First Nations and Métis people in Canada. This review frames the conversational questions asked in the interviews. The literature suggests that there needs to be a change in policy surrounding healthcare and health services, especially for those First Nations and Métis communities living in northern areas. The lived healthcare experiences and worldviews of the elders can be very valuable towards informing provincial healthcare services.

3.3 Definition of a case study

A case study wholistically analyses a single phenomenon in detail with one or more methods. As Thomas (2019) states that these phenomena are the 'cases' which can be persons, periods, projects, policies, events, or institutions. A case study aims to illuminate a more significant number of cases, in other words, a population (Gerring and McDermott 2007). Thomas (2019) states that although a case study's relatively small sample size has presented some concerns about relatability in qualitative research, a case study is meant to add to an ever growing body of knowledge from different forms of case evidence. Simply, a case study is illustrative and provides an example and tells a story to inform the bigger literature. The study here is illustrative of a sample of Stanley Mission elders and their experiences in the healthcare systems, and their voice is both relatable and reliable. The researcher has to understand the case, attempt to wholistically portray and understand the research and contribute to the growing

knowledge of the phenomena or population (Cousin 2005; Thomas 2019). A case study creates a set of guidelines that distinguish between the population of the case and other larger population groups. This distinction is important in research with First Nation and Métis people because everyone's lived realities are unique. Even if some communities share elements of culture and experience, having detailed documentation focussing on a specific case is important to create and add to a growing knowledge resource.

This research benefits from using a case study framework because of the importance of the distinctions it enables. As Thomas (2019) states, case studies present a view of inquiry that elevates the complexity and interconnectedness of life. This approach connects well with the wâhkôhtowin worldview following relationships and wholistic health. This interconnectedness is a step toward looking at research from various angles instead of seeing research as one-dimensional. Thomas expands on this, stating that case studies allow for viewing the research from several directions to create "a more rounded, richer, more balanced picture of the subject . . . a three-dimensional view is observed and appreciated" (2019, 6). Participants' knowledge guides this three-dimensional view with which the researcher can connect others' experiences and their own (Thomas 2019). This relational connection ties heavily into wâhkôhtowin, where relationships are integral to wholistic health.

According to Simons (2020), case studies allow for flexibility in reporting to best fit the intended audience's needs. This flexibility in my project extends to ethical reporting, where the participants are encouraged to be involved in the reporting and editing process of the case study. This relationship demonstrates responsibility in a wâhkôhtowin worldview to ensure the elder's stories are told in a way they deem useful and truthfully illustrated in the analysis.

3.4 Ethics considerations and approval

The ethics process was intricate as I facilitated the research during the COVID-19 pandemic and had numerous ethical engagements and considerations. At the beginning of the research process, there were considerations of this research being conducted online or over a video conferencing platform, which could lead to vulnerable cybersecurity measures. There were also concerns from elders when using technology to share their views and experiences. Additionally, there were the ethical considerations of conducting research in person, with me coming from an urban space, being in closer contact with many individuals, and increasing the likelihood of COVID-19 exposure.

Research ethics were submitted to the Research Ethics Board (REB) of the University of Saskatchewan and approved after a lengthy process of submitting for virtual interviews and amendments for a hybrid in-person/virtual approach. I only went into Stanley Mission to research after I received community and REB behavioural ethics approval from the University of Saskatchewan ethics board. Before entering the community, I also received a certificate for the TCPS 2 CORE online course for research ethics. At the time of research, I had self-isolated for two weeks and was triple vaccinated before entering the community. In addition, I obtained a negative test result less than forty eight hours before conducting my research and wore personal protective equipment when entering buildings in the community.

Considering the adverse history between white researchers and Indigenous peoples, ethical protocols while conducting research with First Nation and Métis peoples were paramount in data collection and analysis for this thesis. Along with and following the TCPS 2 Chapter 9 and OCAP requirements, local protocols were followed by asking prior permission from each of the elders to interview them, and a gift was given to each in thanks for agreeing to share their stories.

As Kovach (2009) explains, "Ethical protocols in research . . . protect against previous extractive approaches to research" (127). Research has an inherent power hierarchy between the researcher and the participants, as the researcher has final control over the research design, data collection and analysis (Kovach 2009). I have attempted to reduce this unequal power dynamic by using the wâhkôhtowin paradigm that upholds reciprocity and respect in research. I transcribed the interviews and returned them to the participants for review before data analysis began. Before the interviews started, I went over the consent forms (see appendix A) with the elders and told them that I was happy to review their interviews and the write-up after the data analysis. This research approach took time and effort that every researcher should commit to when doing research with Indigenous peoples to ensure their voices are their own and that they feel they are represented well in the research. I had worked this review into my research protocol and timing to ensure the elders were happy with their contributions. As the protocol is centred around respect, it applies to all aspects of the research journey, and I will reach out and ask permission from these elders in the future if this research is published or presented, as the heart of this research is their experiences.

3.5 Data Collection methods and analysis

As this research was conducted during the COVID-19 pandemic, when rules and regulations about socialization were frequently changing, there was limited time that I had when conducting the research. After receiving permission from the Chief of the Lac La Ronge Indian Band (LLRIB) to conduct this research, we contacted the Elders Haven coordinator who is also a registered nurse (RN) for the Elders Haven. I sent the Elder Haven coordinator an information letter that she could give to elders to inform them of this research. Two elders were recruited through the snowball referral method, or purposeful sampling by the Elders Haven coordinator. Purposeful sampling, according to Harsh (2011), "requires access to key informants in the field who can help in identifying information-rich cases" (66). This sampling technique allows for more detailed oriented and less generalized data. Kovach (2009) explains relational sampling as a quality of Indigenous inquiry where research participants are chosen based on their pre-existing relationships and for a specific reason (126). The relational aspect was included in this snowball sampling method. The Elders Haven coordinator had a longstanding relationship with two elders in this study and accompanied me to their interviews. She could choose elders for this research as she knew who would be comfortable and able to participate, and other elders knew my supervisor well, and she was able to recruit them to this project.

I interviewed the Elders Haven coordinator to gain insight into the inner workings of the Elders Haven and health access in the community from a healthcare worker's perspective. The elders in this study were all First Nations or Métis peoples who live or have lived in Stanley Mission. After we had completed these interviews, the Elders Haven coordinator invited us to a community lunch, where we met another interested research participant. The elder expressed interest in speaking with me about her experiences with healthcare access. Another elder was similarly recruited with relational sampling,

The interviews were conversational, where I sat down and chatted with elders about their experiences of health care. Simons (2020) believes that unstructured interviews are deemed the most effective in qualitative case-study research. According to Kovach (2009), "An open-structured conversational method shows respect for the participant's story and allows research participants greater control over what they wish to share with respect to the research question" (124). As my priority in this thesis was to ensure the elder's experiences are reported on ethically, allowing them to share what they wanted was important. According to Webber-

Ritchey, Simonovich, and Spurlark (2021), conversational approaches to interviewing offer a way to explore personal experiences and develop contextual knowledge on a specific topic. This conversational approach fits well with wâhkôhtowin and the importance of understanding the elders' experiences with their health and healthcare.

Several questions were posed as a guide for the interviews and were sent to the elders before the interview started (see appendix B). These questions centered around the elder's stories and prompts to reflect on their hospital experiences. The interviews flowed like conversations as people would chime in with their opinions, lived experiences and shared stories. This deeper knowledge from conversations supports data to go beyond the collection of measurable characteristics and develop an in-depth understanding of specific lived experiences (Lincoln and Guba 2013; Wilson 2008).

The elders were welcoming and prompted the conversational method of these interviews, with many personal anecdotes, stories and histories woven throughout. These oral histories and anecdotes have personalized the research findings to deepen the understanding of the case and incorporate the past and future to better understand the present. These histories and relational stories also connect deeply to wâhkôhtowin through shared personal, familial, spiritual, and historical connections.

When the interviews started, I explained the consent forms and discussed their participation in the research and the recording of the interviews. I clarified that there would be an ongoing consent process and that they could edit their transcriptions to add or remove anything they wished with updates on this research throughout the following months leading up to my thesis defence. After this, I explained that when I have written the thesis, I will write an executive summary and send it to them. After I answered any questions or concerns, they signed the consent forms to their involvement in the interviews and their confidentiality. The interviews were approximately forty-five minutes to one hour and were audio recorded. As a thank you for their participation, and part of a reciprocal relationship, I offered each of the elders a small gift in exchange for their gifts of knowledge that guided my research.

Data analysis was conducted as a thematic grouping by sorting transcripts into related themes. After I sorted the themes, I sent them to the elders and Elders Haven coordinator to review. I received communication back from one elder, who asked if we could sit down and go through her contributions. I was able to meet with her and ensure that the themes from the

interviews matched her true experiences and we wrote the discussion points from her interview together.

4: Research findings and discussion

4.1 Introduction

A multi-method research approach was taken in the data gathering for this project. A literature scan was initially done on elder care, and Saskatchewan Health Authority (SHA) policies. Additionally, five conversational interviews with elders and a healthcare worker in Stanley Mission were conducted to determine their experiences and health priorities. Some research data was collected and analyzed simultaneously through listening and writing major themes in my research journal. After transcribing the interviews, I compared what I had written in my journal with the themes in the interviews. The themes were sorted into distinct groups by understanding the intentions of the elders and grouping them together, which was challenging. Kovach (2009) comments on thematic sorting, stating that "Interpreting meaning from stories that do not fragment or decontextualize the knowledge they hold is . . . challenging" (131). To remedy this challenge, I have included the background and discussions surrounding each participant's experience by approaching this section in a more descriptive and storied form of research findings. The related SHA literature follows the discussion on each major theme and how the literature responds to these findings.

To help illustrate the inter-relationality of each theme, a graph was created with the major themes to represent a circle (Figure 4). In the center of the circle is "Northern Indigenous Elder Health Experiences" (Figure 4) because the interviewed elders shared these themes and expressed their interrelatedness in their health journeys. The Minor theme charts are included at the beginning of all the Major theme findings and discussions. These charts have the Major theme in the middle and a fraction out of five to show in how many interviews these Minor themes were discussed. The Minor themes create a more detailed findings and discussion section by describing the unique experiences of each of the elders, and the Elders Haven Coordinator (Elders Haven coordinator).

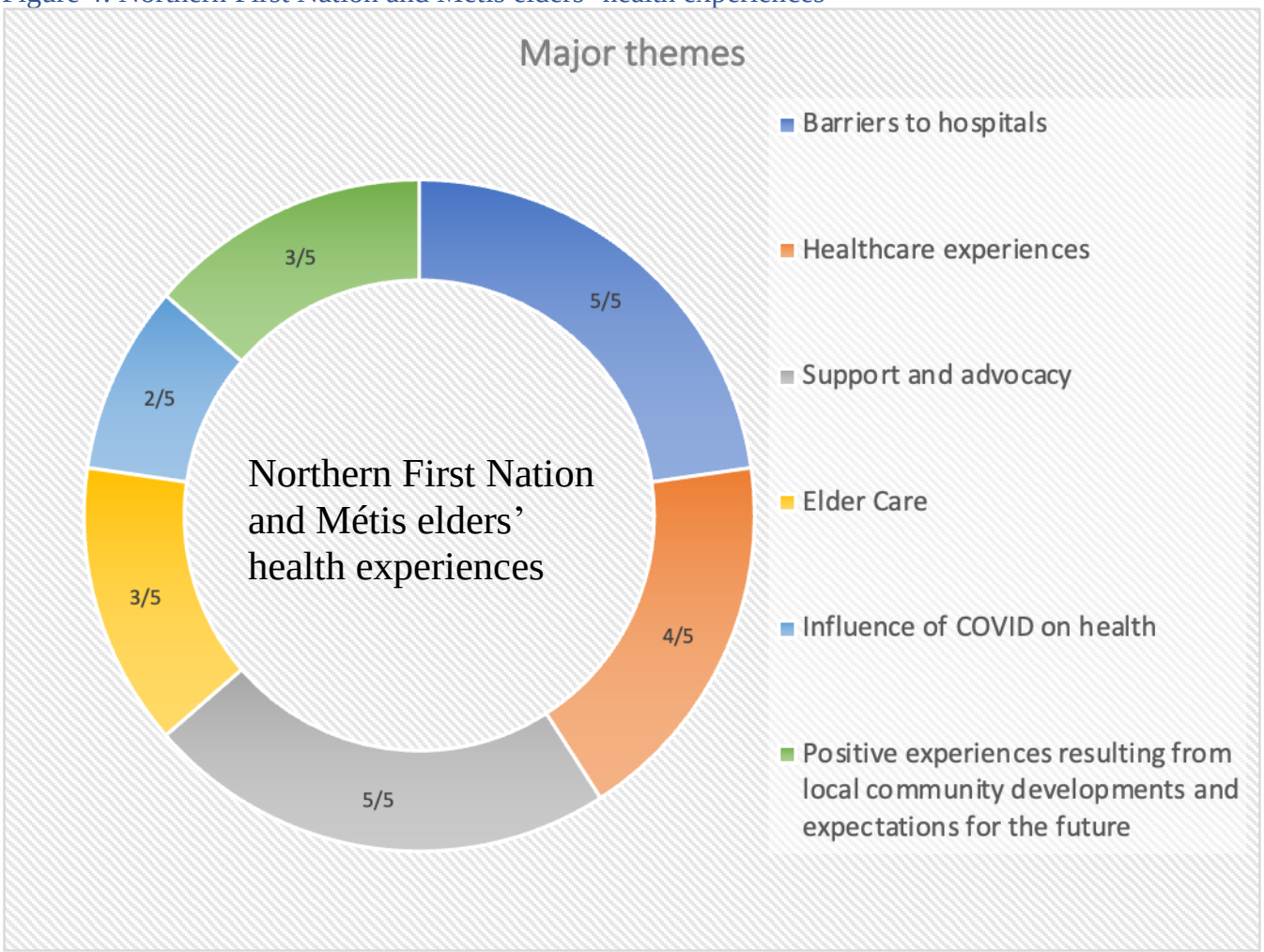
In this research, Minor themes are reflected in the literature, like communication barriers, long wait times, transportation, lack of traditional food and medicine in western health and difficulty supporting healthcare practitioners in northern spaces. Other themes arose, like mental health for First Nations elders during COVID, increased pressure on Indigenous community health workers, and positive outcomes and expectations for community and self-health that are less widespread in the literature. The conclusion will follow this chapter, where I will discuss the

importance of the findings in informing elder care programs and policies and discuss some limitations of this study.

4.2 Major Findings

The interviews were analyzed after the participants had time to review the transcripts as part of an ongoing consent process. The major themes are elements that are directly related to wâhkôhtowin, as they are centred around relations and kinship and showed that the first and primary contact for healthcare for these elders are their families and local healthcare. As mentioned, some of these themes are prevalent in the literature. However, there has not been enough done to address these themes of barriers in Stanley Mission. The following discussion stresses that family and local healthcare must be close and relevant for elders to receive the best care.

Figure 4: Northern First Nation and Métis elders' health experiences

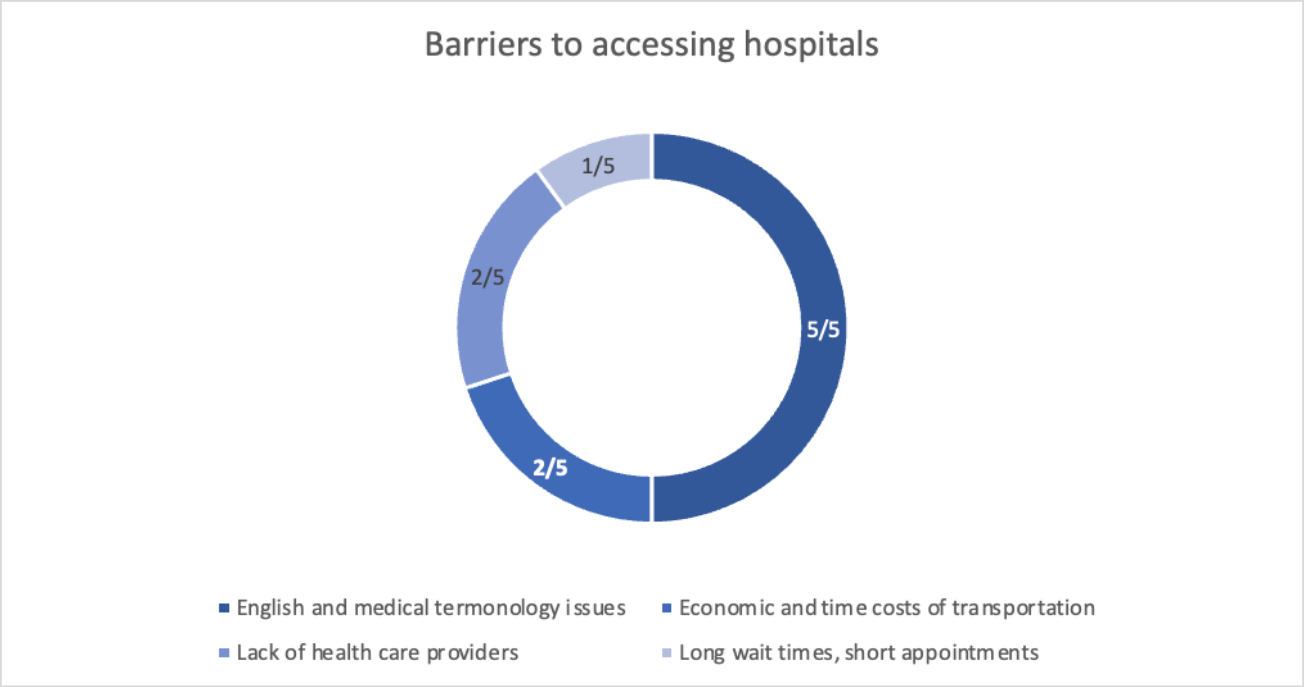


4.3 Barriers to hospitals

The barriers identified in these interviews to accessing medical care in hospitals include English and medical terminology issues, problems with transportation, lack of healthcare providers, long wait times, and short appointments (Figure 5). These barriers highlight the need for close-to-home and family care for these elders and community members of Stanley Mission. There have been reports on these themes in literature, and the SHA recognizes all of these as barriers to northern and Indigenous health.

All the barriers found in these interviews are prevalent in the existing literature. However, this case study discusses the unique experiences of elders living in a northern community concerning these barriers. The most frequented hospitals by these northern elders included the La Ronge Hospital, the Victoria Hospital in Prince Albert, and hospitals in Saskatoon.

Figure 5: Barriers to accessing hospitals



4.3.1 English and medical terminology issues

A barrier that was present in every interview was the barrier of language and communication. Many people in Stanley Mission speak the Woodland Cree language (nehithawewin) as their first language, which causes significant barriers to explaining symptoms and understanding care instructions and diagnoses. Even if these elders can physically access

care, this language barrier can deny First Nation and Métis elders proper hospital care if there is little understanding of what is needed and provided.

One elder explained that although she spoke English well and worked in the health clinic in Stanley Mission for many years, she still does not understand some jargon in hospitals. Another elder explained that the language and communication barrier was the first thing he noticed when walking into the hospital. He stated that it was not only in English, but they were explaining his care using medical jargon he did not understand. He had to ask the doctor to repeat himself and explain what was happening with his healthcare. Another elder stated that when she saw people speaking Cree and trying to explain symptoms, the health professionals would speak English back to them, neither understanding the other. This language barrier could considerably affect healthcare quality, but it is manageable.

Elders proposed various ways to reduce this language and communication barrier. One suggestion was to have an interpreter fluent in English, Cree, and medical jargon, at the hospital. An elder explained that there used to be an interpreter at a hospital he went to with his father. The interpreter re-explained what the doctor was saying and ensured he and his dad understood what was being said. He wonders what has changed and why there are no interpreters in the hospitals anymore.

The Elders Haven Coordinator explained that there used to be an interpreter who lived in the community and would go with people to the hospitals for years, but she is no longer there, and the position has been left vacant. Another elder suggested that someone fluent in Woodland Cree, English and medical jargon should live in the community and always go with people who "need somebody to go with them, to speak for them" (A, interview, October 12, 2022). If implemented and readily accessible, these suggestions would be beneficial in reducing this communication and language barrier that affects many people in Stanley Mission and First Nation communities in the north.

4.3.2 Economic and time costs of transportation

Travelling from Stanley Mission was another common barrier to accessing hospitals from Stanley Mission. All the elders commented on the long drive from Stanley Mission to La Ronge Hospital (1hr), Victoria Hospital in Prince Albert (3.5 hr) and Saskatoon hospitals (~ 5 hr). Although there are transportation services available to these elders, if they are not readily accessible, it can create a lot of medical complications for them. Transportation barriers were not

limited to distance alone. The research findings suggest that barriers to timely service included cost, critical medical conditions, inclement weather, and stabilization time.

Ambulatory services in Saskatchewan are covered for many people through provincial government funding based on eligibility criteria. The cost of land ambulatory services can be a deterrent for using this emergency transportation for people who are not covered by the non-insured health benefits (NIHB) Program. The issue of cost was raised with families sometimes feeling the need to drive their family member to the hospital or going along to provide support.

Different assistance programs are geared towards different groups of people to subsidize emergency transportation. These assistance programs include the Senior Citizens' Ambulance Assistance Program (SCAAP), the family health benefits and the Northern Medical Transportation Program (northern air medical evacuation services policy). These are all provincial programs based on eligibility criteria. Each program provides monetary assistance to various health resources, including emergency medical transportation. These programs are only available to people who are not "the responsibility of another provincial or federal agency" (Government of Saskatchewan 2020). Because First Nation peoples, under the Constitution and Indian Act, are the responsibility of the federal government, status First Nation seniors are not covered by many provincial medical assistance programs. There are many contentious jurisdictional issues. The literature shows that the province and federal governments argue that the other is responsible for healthcare costs. The province gets annual federal health transfer funding to cover healthcare for SK citizens. However, the provincial government argues that First Nations (status) are federally covered, but the federal NIHB is limited and only covers a few things. First Nation peoples are often left in the gap with no health benefit coverage.

The Non-Insured Health Benefits (NIHB) program is a federal insurance program providing health benefits to First Nation peoples in Canada. This program ensures various health-related needs, including travel, accommodations and meals when accessing healthcare (Government of Canada 2023). According to Quinonez and Lavoie (2009), the situation of what is covered is unclear as the jurisdictional boundaries are still unsettled, "individual and structural uncertainty can lead to contradictions in jurisdictional oversight and governance, complicating the rights and responsibilities of all parties, hindering service delivery, and potential improvements to Aboriginal health" (52). The jurisdictional issue of who is and who is not covered remains a barrier when accessing emergency transportation for many in the North.

Although NIHB can be beneficial, ongoing access to certain benefits has been a criticism of this program. According to McBain and Morgan (2005), "healthcare personnel report that FNIHB constantly shifts the parameters with respect to the circumstances when travel costs are covered - a strategy that results in considerable confusion and frustration for patients and caregivers alike" (125). Although NIHB covers status First Nation peoples, the shifting of coverage is a barrier to applying for and accessing assistance for coverage. In addition to shifting parameters, NIHB only covers status First Nations, so Métis and non-status individuals accessing healthcare in the North do not have transportation coverage and must access services by other means or pay for the service.

In Stanley Mission the ambulances are driven from the La Ronge Hospital and take an hour to drive to Stanley Mission after being dispatched. This barrier with seasonal road conditions in the north is reflected in an earlier study on issues with healthcare delivery in the North including telehealth, geography, and jurisdiction by McBain and Morgan's study (2005). They state that nurses reported, "travel by ambulance is constrained by poor roads and time. The nearest ambulance is an hour away and then another three hours are required to get to a larger center" (125). These time and infrastructural barriers pose significant problems that may be hard to resolve given that the province is already experiencing ambulance shortages and long wait times for emergency medical services' responses (Sciarpelletti 2022).

As a result of long wait times, an elder shared that she feels that many people die on the way to the hospital because it takes too long to get there. The elder stated, "A lot of people die on the way [to La Ronge] because of the distance they have to go, and it was too late for them to get to the hospital" (D, interview, October 12, 2022). When asked about transportation time, another elder stated that northern people had to travel to Prince Albert or Saskatoon for their serious health needs. She stated, "Then I think about all that time that was consumed travelling. . . that must have been just dreadful for some people, but they couldn't say anything. They just had to bear with it until they arrived at the hospitals" (E, interview, December 3, 2022). According to these elders, the time it takes to travel from Stanley Mission to a hospital has and continues to lead to suffering and, in some cases, claims lives. This barrier will only increase if transportation issues are not resolved. The Stanley Mission population is growing, and more people will require access to emergency health services in the future.

Transpiration issues in the north need to be resolved and are an important health determinant. According to one elder in Stanley Mission, "What I always wanted to see is an ambulance here because our reserve is expanding" (D, interview, October 12, 2022). She stated that she has and will continue to advocate for this in community health meetings. She thinks having an ambulance on reserve would cut the wait time to get to a hospital in half. People could call the ambulance and get to the La Ronge Hospital in an hour instead of two or three, significantly reducing the time the patient is in critical condition. In the Stanley Mission case, the only alternative to driving to the hospital is air travel, and this is a common experience in the north.

Air travel is available only to people who need urgent care, and the situations can create anxieties for families. Some elders shared experiences of being flown from the La Ronge hospital to a Saskatoon hospital for emergency care. One moving experience shared with me was that the elder was losing too much blood and needed urgent medical attention. She needed to be flown to and stabilized in Saskatoon, but it was two o'clock in the morning, and there were no lights on at the airstrip in La Ronge. The doctor contacted the fire and emergency departments and asked all the trucks and vehicles to drive to the airstrip. All the emergency vehicles lined up, side by side, and turned their headlights on so the plane could take off in the middle of the night. There were significant barriers to flying out that night, but the doctor found a way to quickly get this elder in the air to fly her to Saskatoon. This story is an incredible example of healthcare providers using all available resources to provide the best care for patients.

Access and barriers to air transportation, are always weather dependent and often call for innovative safe solutions. This weather dependency can pose many problems, especially weather conditions that can change instantly in northern Saskatchewan. An elder recalled in one instance running into weather problems when she was flying back from Saskatoon to La Ronge with her baby. She stated that the pilot could not land, and the plane circled and eventually had to return to Saskatoon. They were able to fly back the next day. The elder said that she was relieved they did not land in La Ronge that night and was thankful the pilot turned around, and she was scared for her and her baby's life. Stories like hers illustrate the impact of inclement weather on health transportation in the north. Poor weather conditions can often delay peoples access to emergency services.

4.3.3 Lack of healthcare providers

A theme that was present in two of the interviews was the lack of specialized healthcare providers in Stanley Mission. More doctors were needed to support nursing and other healthcare. One elder commented she would like to see more doctors providing care for the community. The elder stated that nurses "gave as much care as they could for the people, and then, of course, if something developed that needed a doctor, there would be an arrangement to fly people out" (E, interview, December 3, 2022). She would like to see community members attending medical school and returning to work in the community as doctors to minimize this gap in healthcare delivery. Her example illustrates the need for doctors in the community, especially people who grew up in Stanley Mission. They would already have an in-depth knowledge of health and healthcare practices, the community, people, and language. If more doctors were fluent in the Cree language and were familiar with the community, healthcare would feel more accessible to the elders.

The demands of community-based healthcare can often overwhelm healthcare providers. This barrier has been prevalent in Stanley Mission and is still a concern, especially with healthcare worker burnout due to the COVID-19 pandemic, a situation that is common to the province and across the nation. The Elders Haven Coordinator a Registered Nurse (RN), also worked during the pandemic. She said she was overworked and stated that all the nurses were "working all the time" (A, interview, October 12, 2022). She decided to return to working in home care with elders and still has the clinic calling her to cover shifts and patients they cannot provide care to because they are also overwhelmed. This experience is a common theme in the literature. The hiring and retention of specialized caregivers like nurses in northern communities has been a noted gap (Auditor General of Canada 2017; Geddes 2017). There is, however, minimal discussion on reasons behind First Nation healthcare worker retention and burnout and this needs to be addressed.

4.3.4 Long wait times, short appointments

The last barriers discussed to accessing hospitals were long wait times and short duration appointments. Long wait times are explained in the literature as being perceived by Indigenous peoples as being deliberately disrespectful or neglectful (Nelson and Wilson 2018, 24; Wright et al. 2019, 3940), but the waiting times explained in the interviews were mainly due to hospital disorganization. One elder said he drove five hours to Saskatoon for cancer treatment to be told he was given the incorrect appointment time or date and felt that they were really disorganized.

The elder told us that he would have to return to his hotel room and wait several hours for his appointment. He explained that sometimes he would return to his appointment, and they were not ready, so he would have to wait longer in the waiting room. He also mentioned that when he finally gets into his appointments, the doctor did not take the time to explain anything, and he felt confused and had many unanswered questions. This is a common experience of many elders both in the literature and in the study. The elders support an approach to healthcare that allows for longer appointment times, as they have had experiences with short appointments. All of this speaks to their perception of the quality of care in the hospitals where people need to feel listened to and cared for.

4.3.5 SHA Literature: Barriers

In an in-depth analysis of many SHA websites and affiliated links, there have been barriers mentioned in different documents, although not extensively. Many barriers reported are centred around cultural safety when in the hospitals. The SHA Indigenous Health Working Group Transition Team (IHWGTT) (2018) recognized the gaps in healthcare service delivery in the North, such as transportation and language barriers. Additionally, the IHWGTT point out that the current barriers to healthcare access "demonstrate that health care is not truly universal in Saskatchewan" (IHWGTT 2018). Collaborative innovations are being increasingly explored. One example is the Wellness Wheel model of care, which is essentially a mobile wellness outreach clinic intended to improve access to care in Indigenous communities in Saskatchewan (Pandey et al. 2020). This is a community-led approach. This clinic works with local healthcare centers in Saskatchewan Indigenous communities and offers collaborative clinical teams to work with community healthcare teams. The main point is to support the increase the health service capacity in communities. This is a model that may be well worth looking at throughout the province.

To address the barrier of transportation, the 2022-2023 SHA roadmap (a financial document) approximates an $11 million increase in the budget to support the stabilization of Emergency Medical Services with additional paramedics, ambulances, and funding in 27 communities across the province (Saskatchewan Health Authority 2022, 9). If some of this budget was allocated to the La Ronge Hospital and smaller communities like Stanley Mission, this could improve transportation access from more remote communities. However, there are no details on which twenty seven communities these funds were allocated to nor the amount that

will be contributed to each community. This step attempts to address transportation barriers, but there are more details that need to be given to accurately judge if this money will make a difference for people in the north.

The Saskatchewan Health Authority IHWGTT (2018) has proposed to work with Health Canada to address the jurisdictional challenges of the NIHB program. This collaboration will aid in the need for coordination between federally and provincially funded health services. One suggestion proposed by the SHA was to address the cost barrier of accessing medical care and non-insured benefits. If this is followed, then the barrier of payment for ambulances and other non-insured services for status First Nation peoples could be reduced, making emergency services more affordable for status First Nations people, especially in remote communities.

To address the communication barrier that this study and many others have reiterated, the SHA should have accessible translators and interpreters available in all hospitals. As part of the SHA, the First Nations and Métis Relations (FNMR) team offer interpretation services in several Indigenous languages (Saskatchewan Health Authority 2023b). These services, unfortunately, are not available in all hospitals. Having a translator in these hospitals would be a significant step for access. As many elders in northern Saskatchewan First Nation communities do not speak English as their first language, translators must be stationed in the hospitals and clinics northern First Nations and Métis people access more frequently.

I could not find information on the SHA website that explains how translation services can be accessed or requested in hospitals. On their website, the FNMR state that they seek out Indigenous peoples in the hospitals to offer them specified care (Saskatchewan Health Authority 2023b). The elders in this study did not mention these services being provided to them. These questions about services provided would be beneficial to ask other Indigenous people who have accessed the Saskatoon and Regina hospitals and the FNMR members to see if they believe this program is a success or what could be done to further its success.

Some literature on the SHA website addresses the low number of primary care providers on reserve (IHWGTT 2018; Saskatchewan Health Authority 2019). In the *Roots of Hope* document (2019), it states that

> Local community surveys reported that participants wanted providers (doctors and nurses) who were resident in their community compared to visiting/itinerant services. Concerns were also expressed about access to emergency response services as a result of

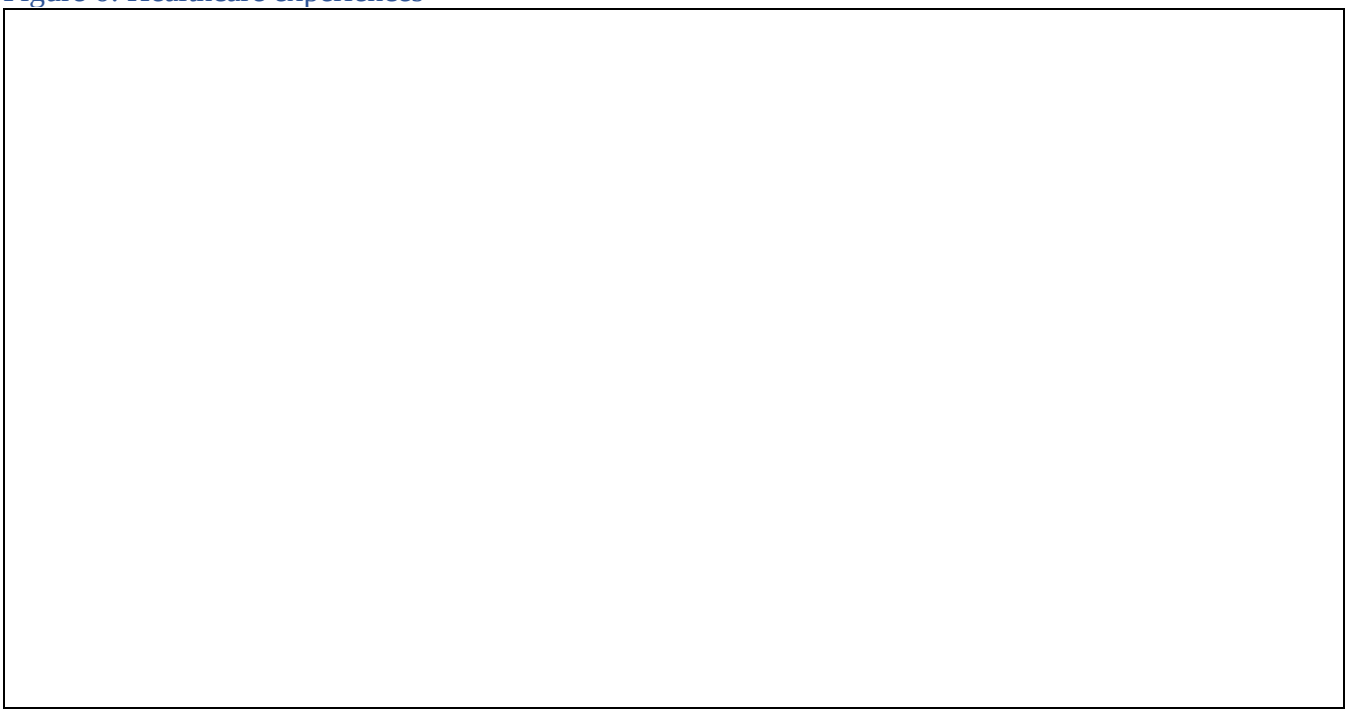
> distances and or perceived slow responses. Medical transportation was also identified as a concern although specific issues were not explained (6).

In another example, (Sajid et al. 2020) suggested that an integrated care approach among specialized practitioners could be a way to take the burden off healthcare providers who are providing wide array of healthcare services. This is basically advocating for a cooperative, wrap around or case management approach among various healthcare providers and specialists. The elders in this case study also talked about the importance of people working together to improve elder care in the communities.

4.4 Healthcare experiences

Healthcare in this section refers to both westernized care and traditional or ancestral healthcare. Contrary to my expectations, most elders had not accessed a hospital for years, as the clinic and healthcare in Stanley Mission have been sufficient for their needs. Following relationality between community members, lots of the healthcare in Stanley Mission is given and reciprocated within the community. In three of the four interviews with elders, only one had explicitly needed hospital treatment within the last year. The elders would rather stay close to home to receive healthcare rather than travel to a hospital. The elders in this study report that they go to the health clinic in Stanley Mission for most of their treatments and checkups if possible. These statements further reinforce the benefit and need for community-based healthcare services. The healthcare experience themes and their frequencies throughout the interviews are presented in figure 6.

Figure 6: Healthcare experiences



4.4.1 Hospital experiences

The elders talked about both positive and negative experiences of accessing healthcare in hospitals. An elder recounted a negative experience when she was rushed out of Stanley Mission because her liver was failing. She stated that she woke up one morning at home feeling okay but then felt unwell after a while and had to lie down. Later, her daughter came for a visit and noticed she looked sick and had a high fever. They rushed her to the clinic, then later was taken to a Hospital, where she was told she had a few hours to a few days to live. She was then given an IV medication that seemed to have worsened her condition. The elder felt that that the nurses and staff had misdiagnosed her symptoms by assuming she had liver conditions from over-consumption of alcohol. She told me that the medication drove her crazy and she could not tell if she was dreaming or not. In this case, her daughter was with her and helped her get the care she needed. She was able to get the treatment she needed, then she went home.

Another example of a similar case was when an elder felt like their health concerns were minimized and dismissed by a health practitioner. An elder spoke with the doctor to tell him she felt she was developing pneumonia, as she had pneumonia before and knew how her body initially reacted to this infection. She knew she had a lung biopsy scheduled for later that day and did not know if pneumonia would negatively interact with this procedure. Her doctor did not

diagnose her and told her he could not detect any signs of pneumonia. He told her to "come back when [she] was really sick"(B, interview, October 12, 2022). The elder later went on to have a lung biopsy and stated that she almost died because of it. She explained, "they went in to get my biopsy of my lung, and they almost killed me. My pneumonia just spread like wildfire after that" (B, interview, October 12, 2022). In this instance, the elder did not feel listened to, and she felt that the doctor should have considered her opinions with her health which would have prevented the extra stress that she encountered. This story could suggest an example of medical gaslighting where a patient feels that their views are invalidated by a practitioner (Sebring 2021). Trust is really important, and elders go to the healthcare facilities wanting help for their sicknesses, but when they feel what they say is not taken seriously, it can affect their overall healing journey and influence their views about the healthcare system.

Another elder talked about a time when a relative felt like she received inadequate treatment at a Hospital. The elder explained that she and her relative were travelling from Stanley Mission when her relative's health quickly declined. The elder asked her relative if they were all right, and her relative stated that she was okay and just needed some juice. After they stopped and bought some juice, the elder's relative stated that she felt much better but should still go to the hospital, just in case. They were hours away from the hospital, and her relative's condition had worsened by the time they arrived at the emergency room. The relative finally got in to see an emergency doctor. Her relative felt that the doctor assumed she had been consuming alcohol or drugs because of her shaking and lack of balance. This bewildered the elder because she knew her relative did not drink or take recreational drugs. Because of this, she worried her relative would not receive proper care for their condition. In the end, her relative stayed in the hospital, receiving care for diabetes for a week. This length of stay was the only confirmation the elder received that her relative was in an acute condition and needed care. This example of Indigenous people feeling stereotyped is a common theme in healthcare literature and it was raised various times throughout the interviews.

This last story illustrates a common theme in Indigenous healthcare. The theme of feelings of discrimination and invalidation of Indigenous peoples in Canada is widespread in literature (Cameron et al. 2014; Geddes 2017; Goodman et al. 2017; Tang et al. 2015). These experiences are examples of how the elders in this study perceive the negative experiences with the Saskatchewan healthcare system which they believe should be changed. It was important for

them that they felt heard by the health care providers in the hospitals. Taking some time and extra steps to talk to the elders would have helped them feel better and in their mind, get better care. They felt their treatment exacerbated their illnesses. It was so important for them to have family there to speak up for them. Perhaps, cultural safety training and workshops (Goodman et al. 2017; Hole et al. 2015) could better improve these kinds of negative perceptions and situations experienced by Indigenous elders.

Some elders also had positive experiences with hospital care. One elder explained that although she had not accessed hospitals for a while, her experiences of hospitals and healthcare away from home were all positive. She explained that she had experienced complications in hospitals before, and although what happened was not positive, the doctors did all they could to support her. In one case, the elder initially went to the La Ronge Hospital for serious health complications, and the doctor arranged for her to fly out almost immediately to a hospital in Saskatoon, and she was able to receive the care she needed. In another case, one elder told me that once, she had to be driven by ambulance to the hospital with heart palpitations. She stated that she received care and stayed overnight. The next day, a healthcare worker asked her to walk around, and because she had no complications, she was sent home. In another experience, the elder said she got sick and experienced significant blood loss and lost consciousness when travelling to the La Ronge hospital by ambulance. Then she was flown to Saskatoon. She got better in the hospital and then rode to Prince Albert on a bus where her son picked her up to drive her home. In all these cases, patients felt positive because they were able to get the medical help they needed in a timely way. Most access hospitals because of serious conditions and in that state feel vulnerable and obviously feels safe when family is around and where they feel that healthcare providers are listening to them and taking good care of them.

4.4.3 Traditional medicine

Traditional medicine is used frequently with the elders and in the community of Stanley Mission to support a healthy lifestyle and treat sickness. One elder stated that she received traditional medicine like prayer and tobacco for her cancer from community members while simultaneously receiving treatment in the hospital, "whatever she can get her hands on," (C, interview, October 12, 2022) her husband stated. Another elder told me that, like her parents, she has more trust in medicine from the earth, which she states is cleaner and chemical-free. This

elder also said that she uses several earth medicines for her heart and COVID-19 cures and prevention, along with staying current on her vaccinations.

Many elders use ancestral medicine in combination with mainstream medicine treatments to relieve or cure their illnesses. An elder commented that she uses traditional medicine for COVID-19 treatments and stated that she did not experience side effects from COVID-19 when she tested positive. She claims that this is because she was updated with her COVID-19 vaccinations and continued to use her traditional medicine, both as prevention and treatment for the effects of COVID-19. This elder stated that a family member would bring her traditional medicines for her COVID-19 and heart condition treatments. This traditional medical approach to treating and preventing COVID-19 has been seen across the globe in Indigenous communities (Ola 2022).

An elder told us she was up to date on her COVID-19 vaccinations, but she explained that many community members were wary of getting their vaccinations because of the chemicals that are used in them. This thought process is justified, considering past experiences with trial vaccinations conducted on First Nations people and Indian Residential School experimentations (Mosby and Swidrovich 2021; Richardson and Crawford 2020). According to Mosby and Swidrovich (2021), views of COVID-19 vaccinations amongst Indigenous peoples remain wary due to distrust toward the western medical system based on experimentations on Indigenous peoples and in Indian Residential Schools (IRS). The elder in this example discusses a mistrust in vaccine ingredients and their potential harmful effects and some community members chose not to get vaccinated and opted for traditional medicine treatments instead.

Traditional food and medicine are important to the wholistic health of the First Nation elders in this research. The theme of traditional medicine was prevalent in the interviews when discussing the elders' healthcare and status. Both traditional and western treatments were used for illness and prevention and were supplied by the community and family members. This supplying of medications is an example of relational responsibility and reflects the wâhkôhtowin worldview of kinship responsibilities, where community and family members contribute to the elders' well-being.

4.4.4 SHA literature: Cultural Safety

Cultural safety is frequently mentioned on the SHA website. A cultural responsiveness framework (CRF) (FSIN 2013) is one of the main publications addressing cultural safety

concerns in hospitals. Some barriers are discussed with suggestions of steps to reduce them. There are three directions outlined to address the barriers they mention, First Nation community-based health and wellness systems, developing a common ground, or ethical space, for engagement of 'mainstream' and First Nation worldviews, and transforming the western healthcare system to be more culturally responsive (FSIN 2013). In the discussion of each of these directions, there are suggestions how to achieve these goals moving forward. This framework was distributed amongst First Nation and 'mainstream' healthcare providers in hopes of gaining feedback.

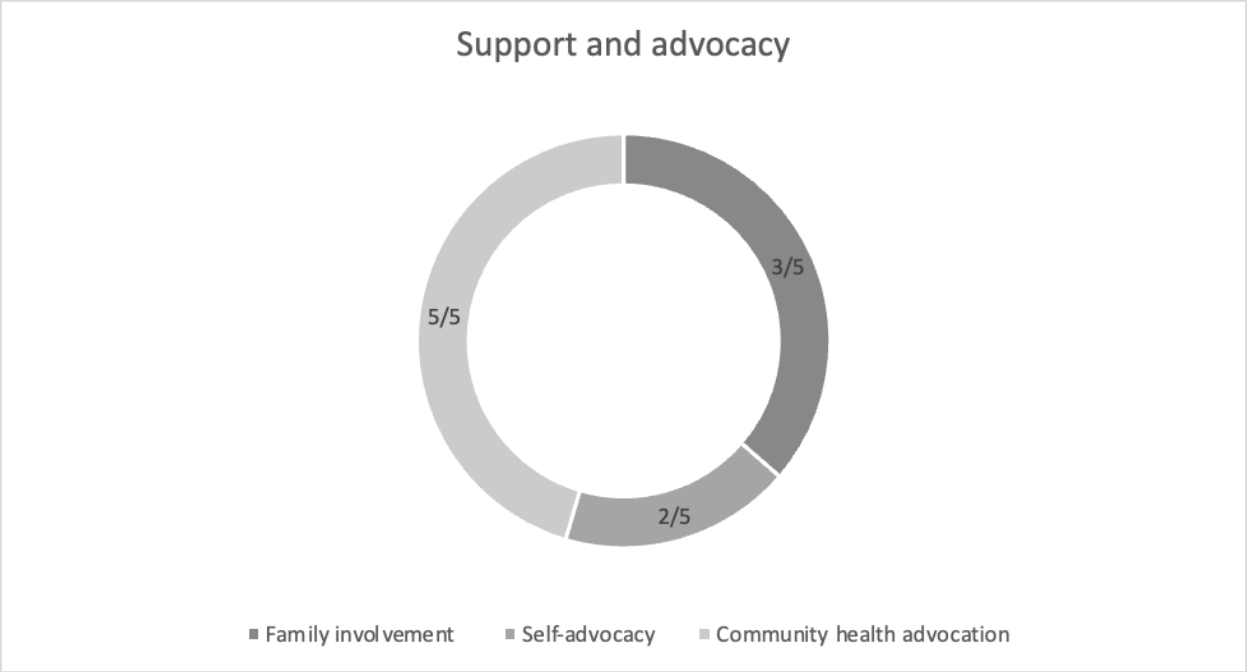
This framework brings issues of racism and discrimination in healthcare to the forefront. This report states that there needs to be more extensive cultural safety training for healthcare professionals and better training in medical school to expose future physicians to the unique healthcare barriers Indigenous Peoples face in mainstream healthcare (FSIN 2013). Culturally safe care and education are addressed in Strategic Direction three, where one objective is to foster education in culturally safe care. Several actions are suggested in the CRF document, like "embedding culturally appropriate and safe practice as a requirement of health practitioner accreditation," (24) and having workshops led by First Nation peoples to understand better and respect First Nations culture. I have not found any follow-up meetings or implementations of the CRF on the SHA website as of yet. This point is important because yearly reporting is one of the Calls to Action that SHA seeks to honour.

Cultural safety also encompasses aspects of traditional medicines concerning their importance in First Nations health and wellness. Training about traditional medicines is important for First Nation communities. There are actions suggested, such as promoting the sharing of traditional knowledge and educating health professionals on the importance of integrating traditional medicines into models of wholistic healthcare (FSIN 2013).

4.5 Support and advocacy

The theme of support and advocacy was present in every interview and took many forms. In many cases, elders described essential health support from their family and community. This support and advocacy reflect the wâhkôhtowin worldview of relationality and responsibility, as in every interview, family and community support was highlighted as essential. Family and community involvement in healthcare is fundamental for ongoing positive health experiences for these elders. The Support and Advocacy themes found in this study are presented in Figure 7.

Figure 7: Support and advocacy



4.5.1 Family Involvement

Most of the elders emphasized the cultural importance of family support in all settings, including hospitals. Family involvement was prevalent in each interview when elders commented on the support they received in either accessing hospitals and health services, providing care at home while they were in the hospital, or aftercare. One elder commented that her husband provides her with the most support, "It has been a good life. Gratifying. Always support here, from way, way back" (E, interview, December 3, 2022). She claims that even though sometimes he could not support her in emergency visits and travelling physically, he did support her by taking care of their children and working to support the family economically. Several other elders also said their partners supported them, especially in aftercare, claiming that one would ensure the other had eaten enough and drove them to their appointments. These examples illustrate the importance of kinship relations and family support, or wâhkôhtowin, in elder healthcare.

In another illustrative experience of family advocacy, an elder was rushed to the hospital and needed emergency services. This elder believed that she was given an incorrect diagnosis and treatment that worsened her condition. Her daughter saw her in the hospital and demanded the attention of the overseeing nurse immediately. The daughter explained to the nurse that her

mother never drank, and she did not have alcohol-induced liver failure. The elder stated that three hours after receiving a different medication, she was feeling better. Advocacy for health by family members is critical in these vulnerable situations. This need for family advocacy needs to be better addressed and respected in hospital settings in order fully support equitable healthcare for elders.

4.5.2 Self-Advocacy and after care

In addition to family, supporting the capacity to advocate for oneself in healthcare were common in these interviews. Elders want the autonomy and dignity to look after themselves for as long as they can at home. One elder advocated for herself by deciding when to return home from the hospital. She said that she was told that she had a few hours to a few days to live and that she was going to die in the hospital. She refused to believe that and said, "no, I do not want to die here, and I am not going to die. Take me home" (B, interview, October 12, 2022). She was driven home, where the community was waiting for her to pray with and for her. After a while, she could still not care for herself and had to get her family to help her do daily activities like dressing. She decided that although she had care from her family, she did not want that life for herself or her family. She returned to the hospital, received treatment on her terms, and returned home soon after. When she returned, she sent her sister, daughter, and caregivers home. Now, she and her husband care for each other, with her family visiting frequently. This elder advocated for her health and claimed agency over her treatment plan and life. She tries to eat nutritious food as much as possible and continues to be active in the community.

These stories suggest that supporting the capacity for elders to maintain dignity and care in their home communities is important. Community healthcare and family are important. Elders who had received hospital care sometimes reported complications when they got home. Aftercare, after being released from hospitals, is an area that needs to be part of the healthcare system. The elders' experiences highlight the importance of community-based and family care in the north.

4.5.3 Community health advocates

Community engagement and opportunities for elders' participation in community events can be an important part of elders health and wellbeing. Elders mentioned enjoying participating in various community health initiatives and other cultural activities. One of the elders I spoke with led culture camps with teachings involving traditional food systems and language teachings.

One elder I spoke to was on the Elders Council for the LLRIB and is proposing ideas to reduce barriers to access western healthcare for Stanley Mission residents. Another elder I spoke with first supported teachers at the school, then became a teacher in her community. She promoted and continues to promote secondary education and believes that everyone has the right to an education. Advocating for, supporting, and participating in the betterment of the community is advocating for community health.

Being actively involved in healthcare is another pathway to advocating for community health. The elders haven coordinator is an example. She advocates through her work because not only is she acquainted with the community's needs, but she and her coworkers also provide patient-centred care that is above and beyond their duties. She stated that sometimes the elders need family support to go with them to their medical appointments outside the community, but when that is not available, she and her staff often go instead of family members. She and the team at the Haven treat these elders like their own grandparents and provide continual culturally safe, patient-centred wholistic care for them.

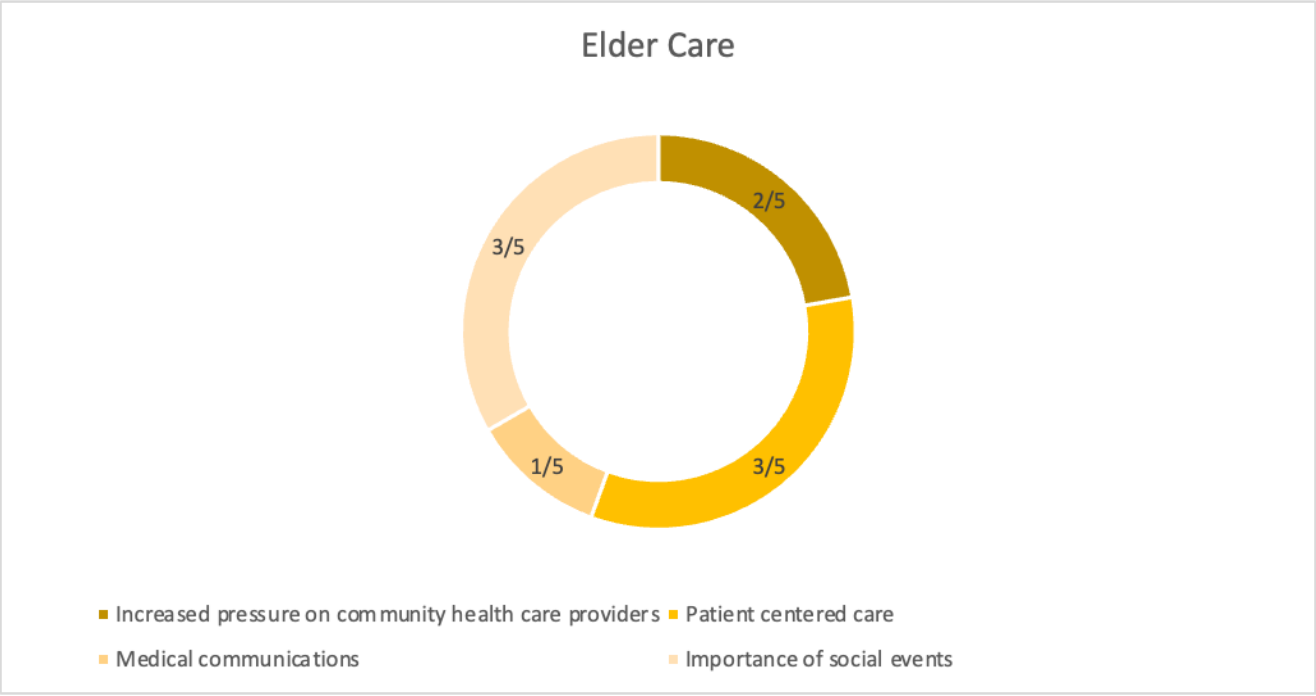
4.5.4 SHA literature: Support of First Nations self-determination

In the FSIN Culturally Responsiveness Framework document (CRF), there is an objective of fostering education in culturally responsive healthcare with the suggested action of supporting "First Nations community determined and directed health research initiatives that are designed, implemented, and evaluated in a way that meets local First Nation's needs" (FSIN 2013, Section II). A literature review conducted by the SHA (Sajid et al. 2020) reviewed several health systems that provide integrated care to First Nations and Indigenous peoples. Many of these care models promote individual self-determination by accepting and integrating traditional knowledge and medicine into mainstream healthcare. An example of this integrated care could be how the First Nations and Métis Health Services (FNMH) try to contact each Indigenous individual admitted to the hospitals to provide them with available and specialized support. These supports include communication between the healthcare team and patients, including traditional care practices, and support for the patient during admission and healthcare planning. This advocacy can support self-determination in health by ensuring the patient's needs are understood and taking steps to ensure these needs are met.

4.6 Elder care

The Elders Haven was created to address the elder care needs of Stanley Mission and surrounding communities in a facility close to home for the elders and provides culturally safe patient-centred care run by the community for the community. Ensuring elders are cared for close to their families connects to the relationality and responsibility pillars of wâhkôhtowin. The Elders Haven embodies these pillars by providing culturally safe, patient-centred care run by the community for the community. The elder care themes found in this case study are presented in Figure 8.

Figure 8: Elder care



4.6.1 Increased pressure on community healthcare providers

One of the themes that emerged in this research that needs to be covered more extensively in the literature is the increased pressure on community healthcare providers, especially First Nation healthcare workers. This theme arose in conversation with the Elders Haven coordinator when she was discussing the breadth of her role and the Haven's resources. There are eight residential beds that are being used and a three-year-long waiting list at the Haven. The Elders Haven coordinator explained that the population of elders is growing and that "our elders are getting older" (A, interview, October 12, 2022). To accommodate this increase of

elders requiring care, the Haven needs to expand and develop to meet the community's needs. However, expanding would mean increased staffing resources at the Haven. Currently, there are 20 people who work at and for the Elders Haven, including nurses that also work at the health clinic. Of the 20 workers, only two are full-time health aides, five are permanently on as casual workers[7] (who work part-time continuously), and the rest are casual workers (who work part time when needed). There is also a diabetes nurse who attends to the people with diabetes in Stanley Mission twice a month. The Elders Haven coordinator explained that there are two licensed practical nurses (LPN) who work there as well, but one is going to work partially for the health clinic now because they are short-staffed. Because of this short staffing, the ECH explained that sometimes the staff at the Elders Haven do home care visits and some staff clean the elder's living spaces if the family is unable to do so as part of home care. During home visits, the staff can monitor the care the elders need.

As the ECH shared her experiences, I wondered how many duties she is responsible for. She is fluent in Woodland Cree and a translator for many elders and community members. She is also an RN, she splits her time with the clinic when they need additional support, does home care visits, and she plans and organizes elders' socials. On top of all these duties, she coordinates the hiring, staffing, upkeep, and scheduling of the Elders Haven. Although this seemed to be a usual occurrence for her, she acts as much more than a coordinator for an elder care facility. She stated that she sees the elders she cares for as her own grandparents, and sometimes steps in for support when the elder's family is unable to do so. The Elders Haven coordinator embodies values of relationality and responsibility of wâhkôhtowin in her work, but as a result, is faced with increased responsibilities to perform tasks that are usually outside of the scope of an elder facility coordinator. The Elders Haven is vital for both elder care services and social gatherings and this highlights its need and value amongst community members. There needs to be more support given to the Elders Haven and the health clinic because elders need care close to home that is provided by healthcare workers who understand their unique health needs.

4.6.2 Medical communications

In addition to monitoring clients through home visits and in beds in the Haven, RNs at the Haven can access patients' electronic medical records (EMR) to be kept up to date on their health status. Initially, the Elders Haven coordinator said that the Haven did not have access to

[7] FNIHB term that was used by the Elders Haven coordinator to describe staffing at the Elders Haven

these records and now that they do, continuing care is more accessible. The ECH claims that their services improved after being connected with the EMR because they can check new diagnoses and prescriptions. This information is vital with new diabetics, as the diabetes nurse will be informed and will see the new patients when she comes to speak with those new patients and explain the concerns and care for diabetes. Although having access to EMR may be a useful resource, the Haven is still unable to access clients' mental health records to see if they are supposed to be taking any other medications or interventions for mental health. The advantage of accessing the EMR was seen to have improved the care given to elders in Stanley Mission and makes continuing care more accessible in their community.

4.6.3 Patient-centred care in the Elders Haven

The Elders Haven uniquely provides culturally safe and patient-centred care in the community. One of the reasons the Haven is so successful is because of the community workers and Elders Haven coordinator s that devote time and effort to ensuring the Haven provides the best care possible. There are three levels of care that the Haven provides, levels one, two and three. According to the Elders Haven coordinator, Level one is assisted living, where the elder can live independently, requiring minimal healthcare interventions. Level two is partially dependent, where the elder needs substantive care and support from healthcare workers. Level three is when elders can no longer care for themselves and need continuous care. The Elders Haven coordinator stated that the elders at the Haven are in one of the three levels of care. The nurses and staff at the Haven have developed and provided a community-centred patient care model to address all three levels of care.

Patient-centred care is specific to the patient and provides care based on the individual's particular healthcare needs. According to Blount (2019), patient-centred care promotes the patient's involvement in their care. This case study highlights a positive example of local controlled elder healthcare that help reduce some of these barriers identified in the literature.

An example of patient-centred care was when the Elders Haven coordinator spoke about patients with "do not resuscitate" (DNR) orders. DNRs instruct doctors or healthcare workers not to perform CPR on an individual if their heart stops. The Elders Haven coordinator explains that these orders are challenging for the elders and their families to discuss or agree upon since it is a sensitive topic. She has observed that when doctors speak with the elders and their families about DNRs, the elders sometimes refuse to speak to them. The Elders Haven coordinator explains that

when the doctors approach the elders, "the elders shut down. They don't want to talk about that [DNR orders]" (A, Interview, October 12 2022). The elders do not see the doctors as people they want to discuss this sensitive topic with. So, although this care is available for them, some of the elders in Stanley Mission do not feel comfortable accessing it.

One way this DNR order care is created accessible for elders in Stanley Mission is through the Elders Haven coordinator. The Elders Haven coordinator is fluent in Woodland Cree and is well-known and trusted because of her relationships with the elders and their families in the community. She told me that when she approached elders about DNRs, they were more receptive to the conversation and disclosed their hesitancies to her. The Elders Haven coordinator explained that these hesitancies could come from being away from their families in their last days, and elders disclose, "I don't want to go to the hospital. It's not safe. I just want to stay home. I want to be comfortable. I do not want to be in pain" (A, interview, October 12, 2022). After listing the concerns of the elders going to the hospitals for DNRs, the Elders Haven coordinator casually said, "yeah, so I just do what they want" (A, interview, October 12, 2022). The Elders Haven coordinator embodies patient-centred care as she speaks with elders in a way that few would be able to, listens to their concerns and lived experiences, then finds a solution. This solution is to *do what they want*.

The importance of First Nation community health workers should be highlighted more in the literature, especially for elder care. I have not found examples of First Nation healthcare workers practicing patient-centered care on the SHA website even though this research shows that these community health workers are sought after because community members often feel more comfortable with them as healthcare providers. However, according to Mihychuk, the chair for a report titled *The challenges of delivering continuing care in First Nation communities: report on the standing committee on Indigenous northern affairs* (2018), some community members who become healthcare workers do not return to their communities due to lack of support, housing, and on average lower salaries than other comparable careers (43). Micychuk also suggests that education should be closer to home, and that First Nations healthcare workers should be provided with accessing support that is comparable to healthcare workers in urban spaces. The elders in this research recommend having community healthcare workers for many reasons including communication and pre-existing relationships built on trust, relations, and mutual respect.

4.6.4 SHA literature: patient-centred and elder care

The SHA website outlines the definition and the document's philosophy, core principles, and initiatives set in place to ensure a patient and family-centred approach to healthcare (SaskHealthAuthority 2023d). Through the documents I have researched, SHA states that they are committed to patient and family-centred care. According to the SHA, patient-centred care is "grounded in mutually beneficial partnerships with patients, families, support persons, clients, residents and their health care providers" (SaskHealthAuthority 2023d). The SHA states that these relationships are formed in hospitals. They are building blocks to creating a care approach that guides planning, delivering, and evaluating services to ensure a people-centred approach to healthcare.

The success and use of these care approaches are tough to measure. The initiatives of the SHA people-centred care are to have accountable care units, connected care in Health networks, family presence policy, guidelines and restrictions, patient family leadership councils, public experience surveys and a partnership with the Saskatchewan Centre for Patient-oriented Research (SCPOR) (SaskHealthAuthority 2023d). More information should be provided on the importance patient-centered care in elder care facilities in Indigenous communities. In this research, some of these initiatives are addressed like connected care in health networks and the family presence policy (SaskHealthAuthority 2023d). The other initiatives, however, were absent in the experiences shared by the elders in this research. The elders did not mention the Patient Family Leadership Council or the public experience surveys. From the experiences of the elders in this research, more integrated patient, and family-centred approaches to healthcare that the SHA outlines, would contribute to better wholistic healthcare in hospitals.

In a literature review by Sajid et al. (2020), the barrier attributed to a lack of staff and support was limited funding. There needs to be more financial support for places like the health clinic and Elders Haven to hire staff to address the areas that are organized by one or two people working there. A great example of this need for a diverse team is what the Elders Haven coordinator does to coordinate the Haven. She promotes and practices cultural safety, and she is an interpreter, translator, and home care registered nurse. She supports elders in attending appointments and treatments, organizes social events for the elders, and runs the Haven. I have not found any papers, presentations or announcements acknowledging the many responsibilities Indigenous healthcare workers have when working in their community, nor if they feel pressure

to take on more responsibilities because of their relationship with the community members. There is a level of care given by Indigenous healthcare workers in their communities that is incomparable because the Elders Haven coordinator is much more than a nurse in this community and embodies patient-centred culturally safe care.

There are documents on the SHA website expressing the need for COVID-19 interventions and continued support for elder care facilities. One of these documents outlines a 2022-2023 financial plan for the SHA and designates $5 million to support the La Ronge and Grenfell long-term care facilities to continue development and progress (2022-2023 SHA roadmap). Additionally, the Victoria Hospital Foundation donated several iPads and communication devices to long-term residents in Prince Albert (Saskatchewan Health Authority 2021). The Elders Haven in Stanley Mission will not likely receive funding from the SHA for their elder care home as it is on-reserve and not under provincial jurisdiction.

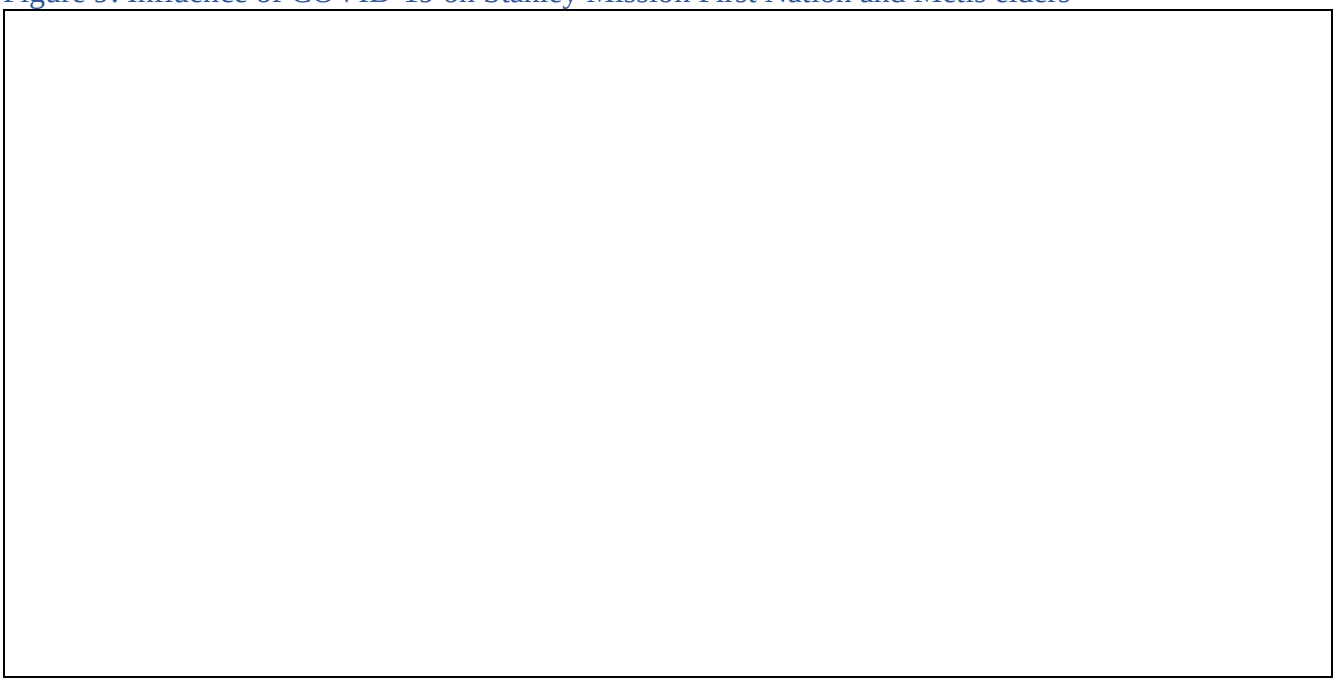
A show of the importance of the Haven was when the community (Northwest Company) supported the Haven during the COVID-19 pandemic by donating an iPad for the elders to video call their families. The Stanley Mission General Store donated an iPad to the Haven so the elders could communicate and see their loved ones (The Northwest Company 2023). According to the Northwest Company's article, the owner saw the work put into the Haven and its benefits for the community and donated an iPad to improve the feelings of isolation the elders were experiencing at the height of the pandemic. This donation exhibits the relationships between the community and the Haven and highlights the thoughts of community members that the elders in the Haven are respected and valued.

4.7 Influence of COVID-19 on health

COVID-19 has impacted everyone in one way or another but has affected some people more than others. According to a Report from the Government of Canada (2020), health impacts have been worse for seniors, racialized populations, and healthcare workers. These impacts were evident in most of my conversations with these elders and the Elders Haven coordinator. The themes in these conversations centred around angst and concern about the new restrictions and unknown facts about the virus, the feeling of isolation, and returning to the new normal in a quasi-post-COVID time. This theme relates to wâhkôhtowin, as many of the concerns and feelings of isolation were centred around family and the responsibility to keep their families safe and healthy. There were concerns about who would get the virus, and sometimes the measures to

ensure everyone was kept as safe as possible led to isolation. The elders could not see their families, which contributed to feelings of isolation, especially if that elder did not live with anyone. Post-COVID life is looking positive in Stanley Mission, with events and social nights held by both the community and through the Elders Haven. These themes surrounding COVID-19 are presented in Figure 9.

Figure 9: Influence of COVID-19 on Stanley Mission First Nation and Métis elders



4.7.1 Angst, concern, and vaccine hesitancy

The Elders Haven coordinator stated that before COVID, they held socials for the elders so that they could gather, have conversations, eat traditional food, play games and dance. These socials stopped because of COVID-19, as the health guidelines and new rules implemented by federal and provincial health authorities had strict laws on social gatherings. The Elders Haven coordinator stated that many elders were feeling lonely when these restrictions were put into place, and that there was unease and fear concerning how severe the virus was.

The fear that the pandemic brought into many people's lives was, and in some cases still is debilitating. Everyone was bombarded with rules, regulations, laws, warnings, and suggestions that were outside of the scope of normalcy. These new suggestions and rules were changing daily and were different for each province and community. This fluctuation, uncertainty, and insufficient access and research on proper personal protective equipment fostered division and fear within communities and families. The Elders Haven coordinator explained that there was a

fear of contact between people at work and home in the initial stages of the pandemic, mainly because most of the community members had no idea what this virus was, how it was transmitted and its mortality rate. Although many lost loved ones to this virus, many elders I interviewed did not react adversely to contracting COVID and were more affected by the isolation and loneliness of quarantine and physical distancing rules.

4.7.2 Isolation

Isolation and loneliness are considerable adverse developments during the pandemic. The Elders Haven coordinator explained that when COVID-19 hit, elders would come to see her at the clinic and tell her, "I just want to get out of my house., that's why I come here". This theme was further supported by another elder's experience living alone and being unable to see her family. She said that the first two years of the COVID pandemic was “the most devastating time I have ever spent in my life” (D, interview, October 12, 2022) because she could not see her grandchildren and that all her visits with her family were through a window or on phone calls. She explains that these window visits and phone conversations were "nothing like holding them [her grandchildren]" (D, interview, October 12, 2022).

Isolation among seniors/elders is found in the literature, with studies commenting that there has been an increase in senior isolation since COVID (MacLeod et al. 2021; Oi-Yee Li and Huynh 2020; Rasnaca, Niklaas, Rezgale-Straidoma and Lina 2022). This isolation was caused by staying away from family members to decrease the risk of contracting COVID-19. In a literature review, MacLeod et al. (2021) comment on how elders have a higher risk of social isolation and that the COVID-19 pandemic has compounded and worsened social isolation amongst elders (5). MacLeod et al. (2021) also state that several technological interventions have been available to elders and in some care homes, such as smartphones and calling resources. These resources have contributed positively to lessening the elder's isolation (10).

This research qualitatively details the experience of northern First Nations and Métis elders in Saskatchewan during the COVID-19 pandemic and how the elders coped with feelings of isolation, loneliness, and views of the vaccine. The geographical distinction is important because these elders are already isolated in northern living spaces, and some rely on family and community to stay engaged and healthy. The ECH supported some of the elders through this unprecedented time. These examples highlight the importance of family and community in healthcare for these First Nation and Métis elders in Stanley Mission.

4.7.3 The 'new normal’

Although the pandemic has been and continues to be trying for many elders in Stanley Mission, some changes have supported returning to the new normal after the pandemic. The Elders Haven coordinator explained that the socials had started up again hosted a Halloween party with future plans to host a jigging contest, bingo, dances, and meals. The Elders Haven coordinator explained that she believes these socials encourage socialization and lessen the isolation and loneliness caused by COVID. I was invited to a fall lunch social by the Elders Haven coordinator, where we ate at a long table with some other community members. I listened to many people speaking Woodland Cree, teasing, joking, and laughing with one another. The community members seemed to be excited to be together again. There were still sign-in sheets and COVID rules, that some community members monitored to ensure that people were safe and able to continue to socialize.

An elder told us that since the restrictions had lifted, she could finally visit with and have her grandchildren over at her house. She explained that having her grandchildren felt like a great stone had been dropped, that she was overjoyed she could see them and hold them again.

4.7.4 SHA Literature: Indigenous-specific COVID-19 measures

There were minimal resources detailing an Indigenous-centered approach to COVID-19 measures or recovery. However, a webinar was presented by Dr. Jolee Sasakamoose entitled "Utilizing the cultural responsiveness framework to develop a strengths-based, trauma-informed evaluation" (Saskatchewan Health Authority 2021). The topics that were addressed included:

> 1)Increase awareness, knowledge and use of responsive techniques in Indigenous contexts 2) promote traditional approaches and local innovation to evaluate practice with Indigenous Peoples and programs 3) develop understandings and employ responsive evaluation techniques to support Indigenous peoples' full participation 4) consider using Indigenous peoples' developed or approved evaluation and research techniques inside the SHA and 5) Facilitate Indigenous peoples' self-determination by engaging them in the program development and evaluations process.

These are great initiatives and suggestions, but the elders in this research did not mention experiences with them.

Additionally, fearmongering was spread throughout the province during the height of the pandemic. The Elders Haven coordinator explained that people thought they would be "dropping like flies". (A, interview, October 12, 2022) because of the information shared about the virus. After time had passed, the Elders Haven coordinator said that the virus had less of a death toll

than was initially expected. An elder mentioned that some First Nation peoples were not as comfortable with vaccinations because of the uncertainty of ingredients, or “chemicals” (C, interview, October 12 2022) in them. It is essential to keep an open mind when addressing vaccine mandates in the Indigenous community and practice cultural safety when promoting vaccines and COVID-19 protocols.

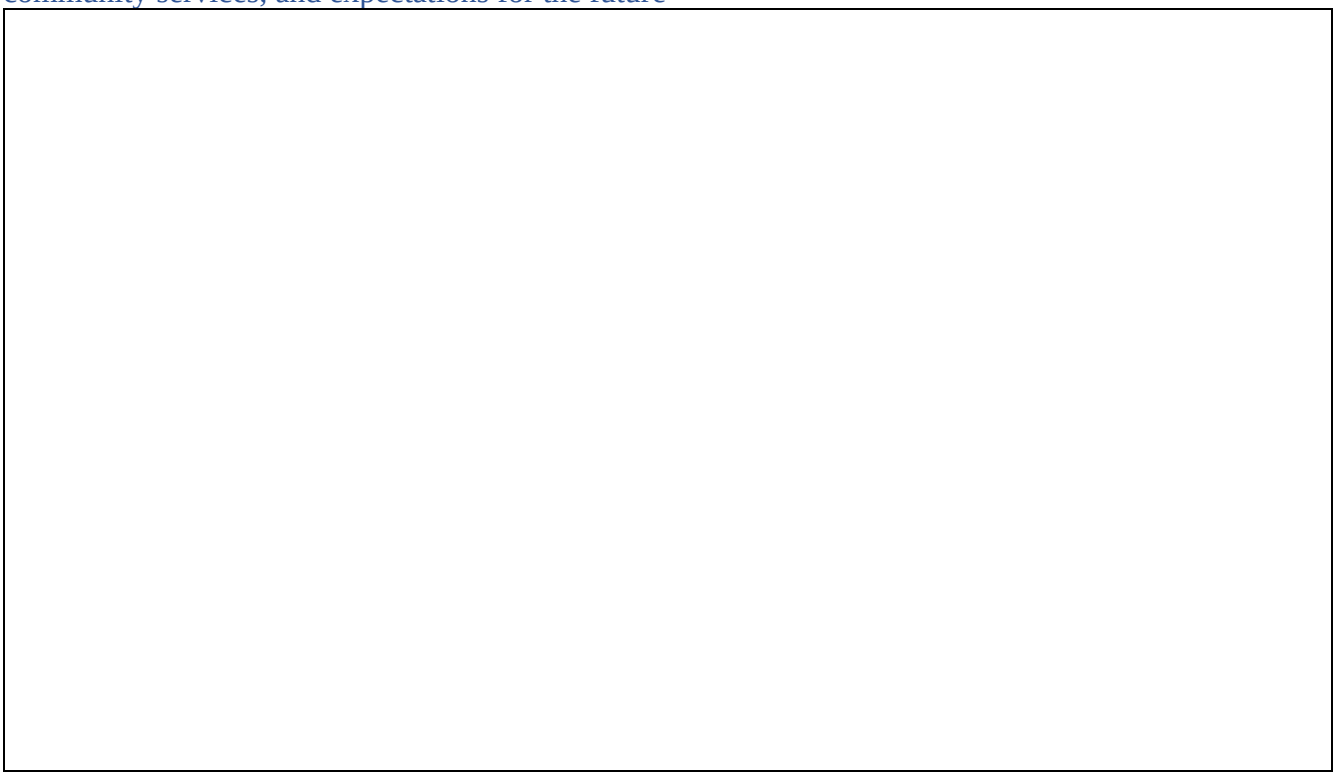
The SHA has announced they are committed to a positive recovery from the COVID-19 pandemic. A good way to know how patients feel about the measures put in place and accessibility is through hearing about their experiences (Fick, Sanjoy, McGarry and Imeah 2020). The SHA also has invested $95 million "to sustain ongoing COVID-19 measures to continue protecting Saskatchewan people in the transition to Living with COVID" (2022-2023 SHA roadmap). There needs to be further detailed information on how this money will be distributed to ensure people have equitable access to these services.

A survey by Fick, Sanjoy, McGarry and Imeah (2020) gathered information about experiences and access to healthcare during the pandemic. This survey was developed to help the SHA understand patients' experiences with virtual care, healthcare services, visitor restrictions, communication strategies and patient health. This survey highlighted the patients' experiences and concerns and identify areas of improvement for the SHA. There were 2589 surveys submitted, but less than 4% were submitted by someone who identified as Indigenous (Fick et al. 2020). Of this percentage, 27% were First Nation, and 73% were Métis (Fick et al. 2020). This survey is an excellent idea for patient feedback. It did not, however, include a representative sample of the Indigenous population to understand their unique experiences with the pandemic and vaccines.

4.8 Positive experiences from local community developments and expectations for the future

This final theme discusses the elders’ past and present experiences, and future hopes and expectations for their health and Stanley Mission healthcare. The following paragraphs will detail the elder's experiences of Stanley Mission, how much the town and community have changed, and their hopes for the youth in the community's health and involvement. This section will also share how the elders view their health and their outlook on their future health. These positive experiences and outlooks are presented in Figure 10.

Figure 10: Positive experiences from local community developments in healthcare and community services, and expectations for the future



4.8.1 Personal health

One elder detailed her life history on how she grew up and became a mother to several siblings at a young age. She told me about her experiences in the north, how travel was difficult to and from her home, and the lack of support in raising these children until she met her husband. These stories astounded me, especially considering her highly positive outlook on life and health status. This woman continues to be a bright light for her family and everyone she mentors. She always encouraged youth to pursue their dreams and supported many children and youth through tough times. She stated she retired twice but could not shake her desire and responsibility to contribute positively to her community. She was an active elder and attended meetings and conferences where she stated that she felt like a university student, and that she was always learning.

Another elder recently received good results that declared that her cancer metastases had either shrunk or stabilized, and she was very happy. She had a positive outlook on her condition and future health. Another elder was outside, tending to his lawn, when we showed up for the interview. He said he stays active by completing tasks around the house and working outside. Another two elders stay healthy and active by being engaged in the community and mentally

engaged by learning and contributing to policy making and decisions. All the elders had a positive outlook on their health, had goals and hopes for the health and wellness of their communities and were actively involved in supporting and making these goals a reality.

4.8.2 Community health

An elder claimed that Stanley Mission has changed over the years and that there have been positive changes in families and with youth becoming educated in the community. She stated that she knew of only four to five people employed in the community years ago because of the lack of employment opportunities, but that many more people are employed now and have pursued an education.

This increase in education could be related to Stanley Mission becoming self-administered in 1999 (Stanley Mission Health Services 2023). In 2017, Stanley Mission received a grant for a land-based learning program and was met with positive feedback from students and an increase in attendance in school (Atter 2020; Hill 2018). An elder commented that she sees "many Indigenous people in various categories of service in health and education," (D, interview, December 3, 2022) which she states has changed the health status of the community and that adults now are positively role-modelling for the younger generations.

Of the elders I interviewed, their experiences in hospitals were few. Many elders told me they had not accessed a hospital in years and that their health status and wellness was positive. They said that they have not had many health concerns and relate this positive health status to the support and care they have received from their families and community. For most of their health-related issues, the elders had accessed the local health clinic with a unique healthcare vision and management of health services for wholistic care. There was a sense of responsibility the Elders Haven coordinator felt when delivering culturally safe and patient-centred care that highlight the importance of having culturally safe, patient-centred healthcare accessible close to home for these elders.

4.8.3 SHA Literature: future Indigenous-centered health initiatives

As discussed, several Indigenous-centred documents have outlined cultural responsiveness frameworks and barriers in healthcare. There have been suggestions on SHA documents to create a policy framework that encompasses the similarities and differences among Indigenous Peoples to create a more specific care toolkit (IHWGTT 2018). The measures of distinction between Indigenous Peoples in the toolkit are where they live in Saskatchewan (North

or South) if they live in remote, rural, or urban settings, how they identify and languages spoken, English fluency, and eligibility for NIHB (IHWGTT 2018). If these distinctions are put into consideration as soon as people get to the hospitals and are given additional support as needed, they could reduce the barriers perceived by the elders in this research. Having and addressing these considerations is part of a patient-centred care model because they consider different SDH that individual First Nation people and Métis and communities face. To make this happen, the IHWGTT suggests that more Indigenous people need to be in leadership positions within the SHA to produce and deliver culturally appropriate initiatives that enhance Indigenous healthcare (IHWGTT 2018). The hiring of Indigenous peoples into this space would address one of the Truth and Reconciliation's (TRC) Calls to Action, which the SHA strives to fulfil (Indigenous Health Working Group Transition Team 2018).

The SHA states that it is committed to addressing the TRC calls to action and creating a better healthcare system access and experiences for all people of Saskatchewan. This commitment needs to be outlined and detailed in the 2022-2023 SHA roadmap to provide information on how the SHA plans to fulfil this commitment. Further, I have not found publications that outline investments into Indigenous health leadership, northern First Nation and Métis access to hospitals or healthcare, or funding allocated for cultural safety programming or training in the SHA. So, although many significant initiatives are being generated and suggested, out of the $4.424 billion SHA has in its budget for this year (2022-2023 roadmap), these initiatives do not seem to be reflected in this budget from the SHA website.

4.9 Research limitations

One of the significant limitations of this research was not getting the operational approval for research with the SHA likely due to busy schedules. Initially, this research was supposed to include insights from senior administration who oversee Indigenous policy and events in the SHA. Interviews with these people could have been helpful in that they would be able to give me current information about policies and projects supported by the SHA and where the gaps in my information and research are. Additionally, there may be other documents that I have missed that were published with the SHA addressing the themes in this paper that were not published on the SHA website. As a result of this inability to speak with members of the SHA, this study has a limited discussion section on up-to-date information on the SHA policies and projects concerning Indigenous health.

Another limitation of this research was the COVID-19 pandemic and how this pandemic limited the time I was able to spend in the community. Research with Indigenous peoples should be centred on having a strong, continuing relationship with participants. Although I was able to have a continuing communication some of the research participants, the Elders Haven coordinator was in contact with two elders for me. This limitation concerns the community's remoteness and access to different communication tools (some did not have cellphones or email addresses).

Another limitation of this research is that it was done over a short period of time. This limited time issue is because I submitted my ethics application during a time of high COVID-19 restrictions with the University Research Ethics Board creating different research guidelines in relation to the pandemic. Additionally, community COVID-19 ethics, as discussed in the ethics section, had to be followed. There were different times when Stanley Mission was open to visitors and then would abruptly close its gates due to a COVID outbreak. These restrictions and precautions are necessary for the community's safety, especially as they do not have immediate access to emergency medical care. These factors contributed to a year-long wait to conduct interviews with the community and the times lined up in mid-October when I was first cleared by the LLRIB Chief and elders in Stanley Mission, then the University of Saskatchewan to conduct these interviews in person. This wait, although necessary, was long, and the research was initiated just before a significant storm in the north, which made travelling to Stanley Mission dangerous. More time with the participants would have been beneficial.

The last limitation of this study is the small number of research participants. However, there was also a positive side to what each had to share and collectively contribute. The qualitative approach to this case study yielded a deeply contextual and experiential story of healthcare realities for elders in the north that is an excellent snapshot that could inform policy. Although each of these elders had lived in the same community, each of these community members had different interactions and lived experiences when asked about their self-reported health and access to hospital care. Although this broad spectrum is to be expected as everyone has a unique life history, there were new themes found in each interview.

5: Conclusion and further research

5.1 Conclusion

Through a wâhkôhtowin research paradigm that upholds relationality and responsibility, this research used a case study approach to explore the perspectives of First Nation and Métis elders from Stanley Mission on their experiences with their health and healthcare services. A literature review identified hospital barriers and gaps in access and services, and this information was used to guide the conversational interview questions. I have explored the experiences I was gifted in these interviews in relation to the Saskatchewan Health Authority (SHA) website information. The SHA mentions some of these barriers and acknowledged the different healthcare needs of Indigenous peoples in Canada, although there could be more detail and in depth analysis provided on several themes that arose in this research. Overall, this proposed research voiced the experiences of Stanley Mission elders and what does and does not work for them regarding their health and healthcare practices.

This research's Major and Minor themes centred around a worldview of wâhkôhtowin, where most positive care and experiences have come from support or health access from family and community. Having healthcare available in the community, provided by community members, works for these elders because community health workers live and see through a community-based care lens, where everything is connected and matters in health. The community health workers not only tend to the physical health needs of these elders but provide access to traditional medicine, familial support, community events and translation services. All of these contribute to a wrap-around wholistic healthcare service that the Elders Haven provides for the elders and the community members of Stanley Mission.

When more than community care is needed, many of these elders face barriers to accessing hospitals where advanced medical care is provided. Community health workers and health professionals see through a community-based care lens that contributes to the wrap-around wholistic healthcare service provided by the Elders Haven, a reserve-based elder care facility in Stanley Mission, SK. Although the healthcare workers and health professionals at the Haven provide outstanding healthcare to elders, this research suggests the Haven will also benefit from having more sustainable, long-term financial, and infrastructural resources.

Facilities like the Elders Haven are vital for First Nation and Métis elders because of the various barriers they face when accessing hospitals. The elders' lived experiences and barriers to

hospital services suggests that the health policies and jurisdictions of the federal and provincial governments, and hospitals themselves, need to better integrate to support the needs of Indigenous Peoples. Elders want and need to be able to stay close to home to receive continuing care. If elders cannot stay close to home for the care they need, they need to be made to feel welcome and safe in hospitals and other health care facilities.

5.2 Further research

Many suggestions and research findings are readily available to ameliorate Indigenous Health in Canada, but some do not have measurable outcomes or updates on using these findings. Many areas of further research would benefit and do benefit from these research findings. There needs to be clarification on First Nations and Métis health jurisdictions across Canada to ensure elders do not fall through the gaps that jurisdictional ambiguity has created. There also needs to be better monitoring and reporting of culturally safe care to gauge how well various frameworks and policies are being used and if they are making a difference. Additionally, this study was limited to Stanley Mission area participants. A comparative case study could be helpful with another rural/remote First Nation community to explore the influence of having elder care close to home versus having to travel significant distances for elder care. This research of the lived experiences of Stanley Mission elders accessing healthcare in hospitals is significant in that it can help inform both current SHA health policies and further research.

5.3 Research Significance

This research leads to a better understanding of access and other challenges in healthcare that Stanley Mission elders face while accessing provincial healthcare in Saskatchewan. This research is significant because northern First Nations and Métis peoples have unique experiences that contribute to the overall healthcare experiences of Indigenous peoples in Canada. It includes suggestions from First Nation and Métis elders based on their lived experiences.

The evidence in this research bolsters understanding that everything matters in health and that family and community members provide the most beneficial and barrier-free wholistic healthcare these elders experience. The findings of this case study could help inform the SHA by highlighting key barriers in hopes of reducing negative interactions and experiences northern elders face in hospitals. Additionally, this research highlights the importance of increasing cultural awareness of First Nation and Métis elders' specific needs. Overall, this thesis helps to

broaden the understanding of what works and what does not regarding healthcare for northern elders.

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Appendix A: Participant consent form

Participant Consent Form

You are invited to participate in a research study entitled: Rural Medical Support for First Nation Seniors: Experiences in Prince Albert and Saskatoon Hospitals

Student Researcher(s): Adele Bibault, Masters student in the Indigenous Studies department at the University of Saskatchewan. Contact Adele at arb274@usask.ca or her work phone at 1(306)716-7387

Principal Investigator/Supervisor: Dr. Bonita Beatty, Professor of Indigenous Studies, University of Saskatchewan. Contact Dr. Beatty at (306) 966-6975 or bonita.beatty@usask.ca

Purpose and Objective of the Research:

This research aims to understand the experiences of Stanley Mission elders in the Prince Albert, and St. Paul's hospitals in Saskatchewan. Receiving information on these experiences, the intention of this research is to better understand the racial and cultural barriers between the Stanley Mission First Nation and more urban, provincially funded health care. This study will report on these barriers in hopes of reducing negative interactions and experiences in these hospitals and increase cultural awareness and access to hospital services. The exposure of these barriers will help stop the negative cycle of racism in westernized hospitals and provide access to a more patient centred approach to health. Additionally, the research could be used to support and inform the Stanley Mission Reserve "Elders Haven" facility in their ongoing developments.

Procedures:

- The meeting will consist of a semi-structured interview and conversational interview that will be conducted face to face. With permission of the interviewee, the session will be recorded. If recorded, the student will transcribe the recordings. You can also request to have the recording turned off at any time without providing a reason. If the participant chooses not to be recorded, the student researcher will take field notes od the interview to record the conversation.
- The interview will last around 1 hour. If the participant wants to end the interview early for any reason, it can be ended at any time.
- The location of the research will be in a conference room at the Elders Haven in a room where COVID physical distancing protocols can be followed.

- After your interview, and prior to the data being included in the final report, participants will be given the opportunity to review the transcript of their interview, and be given the option to add, alter, or delete information from the transcript as they see fit. If there is new information or next steps being taken in the research and publication, all the research partners and participants will be notified and asked again for consent. Participants will be able to remove their data and participation until one month after the interview process has finished. If partners or participants wish to remove their data after the month deadline has passed, they can opt for confidentiality pf identity in the study. If no revisions are received after the deadline, the sara will be used as is.
- The student researcher (Adele Bibault) will be responsible for all the interview transcriptions. These transcriptions will be stored in a password protected file and will be sent back to the participants after they are finished in a feedback loop. Please advise me how often you would like an update on the study and progress, and I will make a list of people and their preferred method of communication.
- Feel free to ask any questions or clarifications via email or phone about this consent form during or after the consent process, and if you have any questions regarding the procedures and goals of the study or your role.

<u>Funded by:</u>

- The Social Sciences and Humanities Research council (SSHRC). There is no potential conflict of interest concerning where the funding is accrued from.

<u>Potential Risks:</u>

- During any point in this interview, if you feel uncomfortable sharing your experience with hospitals in Prince Albert and Saskatoon, please let me know. We can stop the interview or go to the next question. You are more than welcome to have someone else present in the interview.
- Risk(s) will be addressed by: Stopping the interview if the participant wishes and having a community member or health professional there for support and reassurance, should they choose.
- If a participant feels they need counselling or other services after the interview is done, the researcher will refer to the services provided from the Stanley Mission Health Services Inc. though the Elders Haven coordinator.
- There is the added risk of being exposed to more people from different places in the time of COVID-19. There may be a risk to your close family and friends, or your 'bubble' in participating in this research. To minimize this risk as much as possible, the COVID-19 protocols of the Saskatchewan Health Authority as well as the Stanley Mission First Nation will be followed for the duration of the interview.
- This room has been sanitized since the last person was interviewed and the researchers will be wearing appropriate PPE and always following physical distancing guidelines during the interview. Adele Bibault will have confirmation of a negative rapid COVID-19 test before speaking with you and has complete COVID safety training through the University of Saskatchewan.

- The researcher will go over a safe covid protocol with the participant before the interview begins. It is expected this protocol be followed throughout the interview.

Potential Benefits:

This research will add to the growing literature surrounding Indigenous health inequity and collaboration. It will be a first-hand account of the health system for Indigenous communities from two perspectives. I hope that these two research perspectives may inspire the westernized health community to invest in ways to welcome Indigenous seniors by incorporating their knowledge to promote a supportive environment when they need medical attention. This support could build trusting relationships between Indigenous seniors and westernized health care. These trusting relationships will help enlighten the non-Indigenous communities as to the issues and truth about the current Indigenous health care system and how it can be ameliorated, bettering both parties. Additionally, this research could help inform Stanley Mission Elder care.

Confidentiality:

- Please note that although we will make every effort to safeguard your data, we cannot guarantee the privacy of your data, due to the small sample population in your community.
- The translator will have signed a confidentiality agreement before participating in this study and translating the consent form to you.
- We request that participants do not take any unauthorized recordings of the content of a meeting or a data collection session.
- The data collected in this research will be used for the student researcher's master's thesis and for research conferences and publications in peer reviewed journals.
- Although the data from this research will be published and presented at conferences, the data will be reported with participant confidentiality so that it will not be possible to identify individuals. Moreover, the consent forms will be stored separately from the data so that it will not be possible to associate a name with any given set of responses.
- Because the participants for this research project have been selected from a small group of people, some of whom may be known to each other, it is possible that you may be identifiable to other participants based on what you said, however, unless requested otherwise, the researcher will remove any identifiable information and keep participant information confidential.
- There will be a list of people who have chosen to have their identity confidential during this study. To protect this confidentiality, this list will be stored separately from the research data until the study is presented in August 2022.

Please put a check mark on the corresponding line(s) to grant or deny your permission:

I grant permission to be audio recorded	

Please only select one option below:

I wish for my identity to be confidential	

I wish for my identity to be confidential, but you may refer to me by a pseudonym. The pseudonym I choose for myself is: _____	
You may quote me and use my name	
I would like to be acknowledged for contributing to the research	

Storage of Data:

- The recordings will be stored on the student researcher's home computer during the interviews. This is a password-protected research-dedicated computer with access restricted to the student researcher. Immediately after the interview, the student researcher will upload the recording to the Principle Investigator's USask OneDrive and delete the recordings from the student researcher's computer.
- The Principle Investigator will store the recordings on an external password-protected hard drive in a locked cabinet in their USask office. They will also back up the recordings on their USask OneDrive. The data will be stored for a minimum of five years post-publication, as per University of Saskatchewan guidelines.
- Consent forms will be stored separately from the data collected.
- After the data is collected and with your consent the raw data will be sent as a paper copy to Stanley Mission Health Services Inc./Elders Haven. After the data has been analysed, it will be sent back again to the Stanley Mission Health Services Inc/Elders Haven as well as the SHA.

Right to Withdraw:

- Your participation is voluntary, and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort up until one month after the interview process is finished. After that date, your information that you have given and updated throughout the study may be published.
- Should you wish to withdraw within a month of the interview process, please email Adele Bibault and your information will be deleted from the researcher's files and removed from the research. If you chose to withdraw after this date, your experiences can still be used in the study, but your information will remain confidential.
- Your participation or non-participation or withdrawal will not affect your access to any services, employment or how you will be treated.

Follow up:

- There will be a constant feedback loop throughout the research process. I will be writing up the interviews then sending them back to you for anything you would like to add or delete. We will talk about timeline, and you can choose when and how often you would like to be updated on the project. After the paper is written, there will be a short

overview of what the research says and has found, like an executive summary. The full final paper will be available to participants online.

- After the transcriptions or when edits are sent to the participant, the participant will have two weeks to send them back to Adele. Once the two-week time period is up, Adele will assume you have no edits and continue with the data and/or project as is.

Questions or Concerns:

- Contact the researcher(s) using the information at the top of page 1.
- This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office: ethics.office@usask.ca; 306-966-2975; out of town participants may call toll free 1-888-966-2975.

Continued or On-going Consent:

- If follow-up interviews are necessary, oral consent will be requested at the start of the follow-up interview and it will be noted in the interviewer's research journal.

Signed Consent:

Your signature below indicates that you have read and understand the description provided. I have had an opportunity to ask questions and my questions have been answered. I consent to participate in the research project. A copy of this consent form has been given to me for my records.

_____	_____	_____
Name of Participant	*Signature*	*Date*

_____	_____
Researcher's Signature	*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Oral Consent:

I read and explained this consent form to the participant before receiving the participant's consent, and the participant had knowledge of its contents and appeared to understand it.

_____	_____	_____

Name of Participant	*Researcher's Signature*	*Date*

Appendix B: Interview questions

Potential Conversational Interview Questions for seniors of the Stanley Mission First Nation

1) When were you last at a hospital in Saskatoon?
2) What hospital did you go to?
3) Why did you go to this hospital and not another?
4) Have you had many negative experiences at these hospitals?
5) If you are comfortable answering this, why have you been admitted to hospitals in Saskatoon?
6) If you are not comfortable answering the previous question, did you go to a Saskatoon hospital because the treatment needed was not available to you on reserve?
7) What types of barriers did you experience inside of the hospital?
8) Did you feel you were treated differently than other patients in your same position?
9) If yes, how so?
10) When you go to hospitals, what do you wish was provided for you?
11) How can health care workers make you feel more comfortable and supported in this hospital?