Contemporary Perceptions of Health from an Indigenous (Plains Cree) Perspective

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ABSTRACT
Currently, there is limited literature demonstrating awareness of how contemporary Aboriginal Peoples understand and define health, address their health concerns, and perceive barriers to obtaining optimal health. This knowledge is an important and essential first step in program planning for delivering effective health care for all aspects of health. An additional challenge is to effectively address and meet these needs in a timely manner which is critical to overall Indigenous wellness. The primary researcher, who is Indigenous (Plains Cree), wondered whether the social determinants of health were reflective and an appropriate framework to address the existing health disparities between Aboriginal and non-Aboriginal Peoples of Canada, and more specifically, the Plains Cree people from Thunderchild First Nation. This paper examines the results from a qualitative descriptive research study completed in Thunderchild First Nation, Saskatchewan. There were four predominant themes that were derived from the data: health was consistently described in relation to physical, mental (intellectual), emotional, and spiritual wellness; value of health; factors related to the environment; and factors related to economics. Collectively, there does appear to be a holistic perception of health, similar to the teachings from the Medicine Wheel. Pursuing and maintaining health included a combination of information and practices from both the western and Traditional Indigenous world. This data supports that the determinants of health may be an appropriate framework to address the health needs of Indigenous Peoples, and an appropriate frame for federal, provincial and local policy makers to implement structural changes necessary to decrease the health disparities between the Indigenous Peoples and the rest of Canada.

KEYWORDS
Aboriginal, determinants of health, First Nations, health, health beliefs, health perceptions, health practices, Indian, Indigenous, Medicine Wheel, racism.

There is an abundance of literature that describes the intolerable health disparities between Aboriginal and non-Aboriginal Peoples in Canada (First Nations and Inuit Health Branch, 2006; Health Canada, 2004; National Aboriginal Health Organization, 2005). However, there is limited awareness of how contemporary Aboriginal Peoples understand and define health, address their health concerns and more importantly, perceive barriers to obtaining optimal health. While there are a wide variety of Aboriginal Peoples in Canada with equally
various definitions of health, having this knowledge on a population basis is an important and essential first step in program planning for all areas of health and for delivering effective health care. The challenge to effectively address and meet health needs in a timely manner is critical to overall Indigenous wellness. The primary researcher who is Indigenous (Plains Cree) wondered whether the social determinants of health were reflective and an appropriate framework to use for health promotion and to address the existing health disparities between Aboriginal and non-Aboriginal Peoples of Canada, and more specifically, the Plains Cree people from Thunderchild First Nation.

Throughout this research project the terms Aboriginal, Indigenous, First Nations, and Indian were used interchangeably. The primary researcher’s preference is Aboriginal or Indigenous; however, the terminology is not consistent within the literature or with the participants who participated in this research project. Thus it is impossible to use only one term.

Historically, research in Aboriginal communities has not been a positive experience, therefore creating additional challenges for research (Schnarch, 2004; Smith, 1999). Smylie and colleagues (2004) assert, “culturally appropriate and community-controlled collaborative research can create pathways that avoid the old pitfalls of health research in Aboriginal communities” (p. 215). Further, “the theoretical and epistemological frameworks underlying Western scientific and Indigenous knowledge systems have fundamental differences. For these two systems to interface, knowledge translation methods for health science research must be specifically developed and evaluated within the context of Aboriginal communities” (Smylie, Martin, Kaplan-Myrth, Steele, Tait, & Hogg, 2003, p. 142).

Clearly, understanding the fundamental differences between western and Indigenous knowledge systems is essential, as well as understanding how Indigenous Peoples understand and define health, address their health concerns and, most importantly, their perceived barriers to obtaining optimal health in this contemporary setting.

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

**Purpose of the study**

The goal of this research was to provide a current overview of how contemporary Plains Cree people perceive health. Questions included: How do they define health? How do they address their health concerns? Where do they get their health information? How do they maintain health? What do they need to obtain optimal health? What are their perceived barriers in obtaining optimal health? Do they view health from a holistic perspective? Do they practice holistic health? Given Smylie and colleagues (2004) affirmation that, “the gaps in current health information are a major barrier to the effective planning and implementation of health-care services within Aboriginal communities” (p. 212), this is an essential first step to provide effective programming for Aboriginal Peoples.

**METHODOLOGY**

There were two philosophies that influenced this study. Initially, guided by the recent emergence and growing acceptance of Indigenous paradigms and methodologies to facilitate research and the increasing commitment to engage in collaborative and respectful research with Indigenous Peoples, the primary researcher used the *Kaupapa Māori* methodology as her preliminary research framework. This methodology has been and continues to be used by and in research with the Māori, the Indigenous Peoples of New Zealand. Here the gestalt of the methodology was applied to the Plains Cree people of Thunderchild First Nation. After thematic analysis was begun, the researcher realized that the Medicine Wheel was an appropriate framework to provide structure for the categorization and analysis of the data since the participants’ responses’ consistently fit within the four quadrants of the Medicine Wheel.
Kaupapa Māori Methodology

Considering the history of traditional western approaches being utilized to conduct research in Indigenous communities, and the current literature clearly describing the experience as primarily negative, the primary researcher recognized the importance of using an Indigenous methodology/philosophy. After evaluating predominant philosophies and methodologies used in nursing research, she chose to use Kaupapa Māori as an example of an Indigenous methodology to provide the framework to guide the research questions, interaction with participants, and the overall research process. While some would argue that Kaupapa Māori is really a philosophy, not a methodology, in order to remain true to the original authors, the primary researcher refers to the Kaupapa Māori as a methodology. Smith (1999) described Kaupapa as a “plan, a philosophy and a way to proceed…and embedded in the concept of Kaupapa is a notion of acting strategically, of proceeding purposively” (p. 2). Further, she states the Kaupapa Māori has become a way of “structuring assumptions, values, concepts, orientations, and priorities in research” (p. 2). In addition, the five working principles of the Kaupapa Māori methodology were congruent with the primary researcher’s (Plains Cree) personal philosophy and approach to conducting research within an Indigenous community. Further, these principles were in alignment with the ethics of research involving Indigenous Peoples as outlined by the Indigenous Peoples’ Health Research Centre (Ermine, Sinclair & Jeffery, 2004) and National Aboriginal Health Organization (Schnarch, 2004).

There are five working principles of Kaupapa Māori research that provide the basis for the methodology: the principle of Whakapapa, the principle of Te Reo, the principle of Tikanga Māori, the principle of Rangatiratanga, and the principle of Whanaungatanga (Smith, 1999).

The principle of Whakapapa is defined as “a way of thinking, a way of learning, a way of storing knowledge, and a way of debating knowledge” (Smith, 1999, p. 7). She describes Whakapapa as the “most fundamental aspect of the way we think about and come to know the world” (p. 7). There are three inter-related issues: the way of thinking about Māori people in general, having a deep and thorough understanding of Māori society; recognition that Whakapapa principles may still be in operation when Māori people are outside their community; and third is related to the role of Māori researchers “…being a Māori researcher does not mean an absence of bias, it simply means that the potential for different kinds of biases need to be considered reflexively” (Smith, 1999, p. 8).

The principle of Te Reo is related to saving and revitalizing the Māori language. This principle includes “sharing knowledge and the results of research so people can become better informed and make better decisions,” and this practice “has another consequence further down the track of promoting different forms of literature in Māori ” (Smith, 1999, p. 10).

The principle of Tikanga Māori, the third principle, is about “being able to operate inside the cultural system and make decisions and judgments about how to interpret what occurs” (Smith, 1999, p. 10). Smith explains that Tikanga is regarded as customary practices, obligations and behaviours, or the principles that govern social practices. When translated into practice this has direct implications for research. How researchers enter the research community, negotiate their study and methodology, conduct themselves as a researcher and as an individual, and engage with the people requires a wide range of cultural skills and sensitivities. Translation into practice requires researchers to be respectful and culturally appropriate when engaging with Indigenous communities.

The principle of Rangatiratanga, the fourth principle, is related to control over the agenda for research, addressing Māori concerns, and ensuring a collaborative research process between the Māori and the researcher (Smith, 1999). The principle of Whanaungatanga, the fifth principle, is concerned with social relations. For researchers, this principle is generally regarded as an organizational principle, a way of “structuring supervision, of working collaboratively, a way of connecting with specific communities and maintaining relationships with communities over many years” (Smith, 1999, p. 12). Smith further explains, a Whanaungatanga is “an extended family” (p. 12).

In the spirit of the Kaupapa Māori methodology, the primary researcher approached her band to discuss the possibility of collaboratively working on a research project that she required in order to complete her Master’s in nursing. The primary researcher is a band member of Thunderchild First Nation and has been practicing as a Registered Nurse (RN) in a variety of health care settings since 1985. The primary researcher shared with the Health Board her beliefs that:

- Statistics alone do not provide a complete representation of the current state of Aboriginal health and are not sufficient evidence on which to base effective intervention and health programming.
that they were pleased with the research process. An indication of interest and offered support for participating in any other research project with the primary researcher, an indication of the Chief and Council expressing interest and offered support for participating in any other research project together. Many of their initial suggestions centered around identified health deficits, but they were very interested to approach health from a strength perspective.

The primary researcher continued to apply the principles of Kaupapa Māori to the conduct of the study. The Band’s letter of support was included in the university ethics approval application to demonstrate a parallel and collaborative process between the primary researcher and the community. For the interviews, the participants were offered the option of having a Cree translator and, in line with local Cree custom, each participant received tobacco and a blanket to honour their knowledge and participation. The primary researcher met with each participant to discuss the initial interview and offered the opportunity to add or delete from the transcript. Lastly, the primary researcher met with the Chief and Council to share and discuss the results and dissemination plan for the research project. In addition, following this project, the Chief and Council expressed interest and offered support for participating in any other research project with the primary researcher, an indication that they were pleased with the research process.

• The statistics are symptoms of deeper underlying issues that need to be self-identified and addressed; the statistics represent one aspect of Aboriginal health with an emphasis on the deficits, and do not include strengths and many of the resilient factors present in Aboriginal Peoples and their communities.

• Western philosophy and perspectives have dominated the delivery of health services and programming in Aboriginal communities.

• The community has had minimal if any involvement in the issues being addressed as priorities in their communities.

• Indigenous peoples have their traditional ways of knowing and defining health and this perspective has been long overlooked and in the opinion of the researcher is most relevant to provide effective programming and intervention.

• Programming needs to be congruent with the target audience’s culture, priorities and self-identified areas of concern.

In the meetings with the Chief and Council and the Health Board during the planning of the study, they offered suggestions about their concerns and planned the research project together. The Band’s letter of support was included in the university ethics approval application to demonstrate a parallel and collaborative process between the primary researcher and the community. For the interviews, the participants were offered the option of having a Cree translator and, in line with local Cree custom, each participant received tobacco and a blanket to honour their knowledge and participation. The primary researcher met with each participant to discuss the initial interview and offered the opportunity to add or delete from the transcript. Lastly, the primary researcher met with the Chief and Council to share and discuss the results and dissemination plan for the research project. In addition, following this project, the Chief and Council expressed interest and offered support for participating in any other research project with the primary researcher, an indication that they were pleased with the research process.

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Crengle (2006) discussed a unique characteristic of the Kaupapa Māori methodology, in that it “replaces ‘victim-blaming’ theories and analytic frameworks…looks at environmental factors that influence outcomes rather than the ‘problems’ of the individual” (p. 2). Given the primary researcher’s interest in determining whether the determinants of health were an appropriate framework to address the existing health disparities between Indigenous and non-Indigenous Peoples of Canada, this methodology appeared to be an appropriate lens to guide the research process.

The Kaupapa Māori methodology provided a culturally congruent approach to plan and conduct research with the Plains Cree in Thunderchild First Nation as the gestalt of the methodology is parallel to the recommendations by provincial (Indigenous Peoples’ Health Research Centre) and national organizations (National Aboriginal Health Organization) who have developed a research protocol to use with Indigenous Peoples in Canada.

**Medicine Wheel**

Using a process of thematic analysis, it quickly became apparent to the researcher that the Medicine Wheel was not only an appropriate tool to categorize the data but also a methodology in itself. The Medicine Wheel is “an Aboriginal framework in a visual shape of a circle divided into four quadrants; each quadrant represents a direction along with the teachings for that direction” (Roberts, 2005, p. 92). The Medicine Wheel is “one of the basic symbols of the world view of First Nations …among many prairie First Nations” (Sevenson & Lafontaine, 2003, p. 190). Although the Medicine Wheel symbol has different meanings and expressions for different First Nations, some of the principles are quite universal (Absolon, 1993; Sevenson & Lafontaine, 2003). Sevenson and Lafontaine (2003) affirm “that everything is related to everything else, that things cannot be understood outside of their context and interactions, and that there are four aspects to the human condition—the physical, the emotional, the mental and the spiritual” (p. 190). Sevenson and Lafontaine (2003) state their “description is taken largely from the Plains First Nations but the major elements, although they may be expressed differently by other First Nation and Inuit peoples, are basic concepts similar to all” (p. 190) (See Figure 1.). Even though Sevenson and Lafontaine ascribe the Medicine Wheel to the Plains First Nations, there are differing opinions as to the origin of the Medicine Wheel. The primary researcher approached a Cree Elder, Roger Fox, to discuss the origin of the Medicine Wheel and anticipated he would concur that the Medicine Wheel originated with the Plains Cree.
Indigenous people. Elder Fox explained that the Creator created First Nation Peoples first and that he gave each First Nation special gifts and different ways/ceremonies to grow spiritually and communicate with the Creator. He asserted that many First Nation Peoples have knowledge of and use the Medicine Wheel in different ways. He explained that the grandfathers share teachings with all First Nation Peoples, and once a teaching has been shared, there is no ownership and it becomes communal knowledge for that community (R. Fox, personal communication, November 19, 2008).

Participants

There are many different tribal groups of Aboriginal Peoples and this research examined one of the Plains Cree. Thunderchild First Nation is approximately 85 kilometers northwest of North Battleford, a small city in West-central Saskatchewan, Canada. It is located directly across the North Saskatchewan River from the town of Battleford. Together, the two communities are known as the Battlefords. Thunderchild First Nation has a population of 2,014 registered members, with 1,007 people resident on-reserve (Indian and Northern Affairs Canada, 2005). The closest emergency health services, including hospital services, are located in Turtleford, approximately 19 kilometers from the community.

Fourteen participants were involved in the study, all band members of the Thunderchild First Nation. Band membership is controlled by the Thunderchild First Nation Citizen Act (2004), which is governed by the local Citizenship Committee. Parental or grandparental lineage as a band member of Thunderchild First Nation is essential, and exceptions to this rule are determined by the local Citizenship Committee (W. Angus, personal communication, November 27, 2008).

Eleven of the participants resided on reserve, two in an urban area and one in another province. There were six females and eight males ranging from 19 to 71 years old. Four of the 14 participants were Elders with equal representation from both genders (two females and two males). As a band member, the primary researcher had initial entry into the reserve. Participants were recruited by word of mouth, posters, purposive, and convenience snowball sampling.

The level of education varied from grade four to graduate studies. Eight of the 14 participants had completed post-secondary education. Five of these eight participants had obtained degrees in various fields. Four of the six participants who had not received post-secondary education worked in the trades and domestic science (e.g., housekeeper, cooking).

RESULTS

How do the Plains Cree people address their health concerns?

The participants’ health practices varied when they were sick. In general, the participants each had a routine they followed when they were sick. Their responses fell into two categories: preventative and secondary practice. Preventative practice
included taking vitamins, getting a flu shot, and going for a yearly physical. Secondary practices included, waiting without doing anything, waiting and trying a herbal remedy, going to the doctor, and going to the hospital.

In this study, six participants talked to their spouse or partner first, five talked to a family member first, and three of the participants didn’t talk to anyone when they were sick. If the participant had a partner, they talked to their partner first, and then a family member. If there was a health professional in the family, they were the first family member the participant would contact.

Where do the Plains Cree people obtain health information?

Most of the participants obtain their health information from a variety of sources. The commonly utilized resources in descending order were: the media, listening to the radio and reading pamphlets/posters (eight participants); consulting with health professionals (seven participants); family and friends (seven participants); job or university (three participants); community health center (two participants); and a health food store (one participant).

There did seem to be a common pattern. The majority of the participants shared they either read information or consulted with a health professional if they had a concern. The next step was to discuss the information with a family member or a friend. The only time this order was different was if a family member was a health professional. If the family member was a health professional they were consulted first or right after reading literature.

How do Plains Cree people maintain their health?

The themes derived from descriptions of how the participants maintain their health were similar to the themes generated from their definitions of health. Participants talked about practices related to physical (exercise, nutrition, hygiene, and having adequate sleep), mental/intellectual (abstinence from drugs and alcohol, positive attitude), emotional (limit stress), and spiritual wellness (spiritual connection, attending and participating at ceremonies-Sweats, learning traditional language). Employment also contributed toward them being healthy and maintaining their health.

Given the strong revival in Aboriginal spirituality and the general lack of awareness and knowledge by non-Aboriginal peoples, a very brief description of a Sweat and the importance of learning traditional language is discussed.

A Sweat Lodge is shaped like the back of a turtle and constructed of wood branches, covered by a canvas type of material or blankets to create complete darkness within, similar to a woman’s womb, with a small space for entrance. The Lodge is heated by about 20 hot stones that have been specially prepared prior to the ceremony. There are specific customs and rituals based on the Elder/Shaman leading the ceremony. A Sweat has four rounds interspersed with three short breaks. During the rounds there is drumming and singing led by the Elder and participants follow the singing. Aung (2006) articulates his experience of attending Sweats and describes the physiological sweating “which one experiences in the enclosed darkened space within the context of the intense heat …stimulates a profuse kind of sweating …which seems to ventilate one’s negative energy throughout the singing and the heat, while at the same time maintaining, regenerating and enhancing one’s positive energy, from the past, present, and future” (p. 21). It is almost impossible to describe the experience of attending a Sweat. However, Aung equates his experience as the ancient aphorism goes, it must be “experienced to be believed and … it be must believed to be experienced” (p. 22).

Learning traditional language has become a priority for many Indigenous Peoples. Fiddler and Sanderson (1991) discuss the limitations of the written tradition and translation into the English language, noting that the “spiritual, emotional, social, and physical aspects often associated with the setting, mood, spirit, and purpose of the teachings cannot be captured in the written form” (p. 3). In addition, the original meaning also “gets lost in the translation and much of the written form addresses only the intellectual and analytical aspects of understanding knowledge” (Fiddler & Sanderson, 1991, p. 3). As a result of the loss in translation, Elders stress the importance of learners to seek the Indian Elders, medicine people and spiritual learners to experience a more meaningful, holistic and internal knowledge of the Indian worldview and culture (Fiddler & Sanderson, 1991).

The activities described as contributing to their health were the same activities, which if not practiced, contributed to them being unhealthy. Participants are aware of their unhealthy behaviours. They freely shared with the researcher the behaviour they were trying to change to become healthier. Further, participants perceived that trying to change behaviour, for example trying to quit smoking, moved them toward keeping themselves healthy.

In addition, the majority of participants (nine of the 14) shared that their concerns about health had changed in the past five years related to aging (three), change and decrease in health care services (four), increased knowledge (four),
and medical condition (one). Essentially, the majority of participants expressed they were more aware of their health as they were getting older, as their knowledge regarding health increased and as a result of their personal medical condition(s). The participants described these factors as the impetus to preserve and improve their health. This theme did not seem to be related to generational differences as participants who had indicated there had been a change in their feelings about health ranged in age from 26 to 71 years old. Similarly, participants who denied a change in their feelings about health in the past five years ranged from 19 to 66 years old.

What do Plains Cree people need to obtain optimal health? Barriers?

Almost all of the participants identified that health is interdependent on several factors. Further, the issues and concerns were directly related to their personal experiences with health. Participants were asked to picture themselves being the healthiest possible they could imagine, and asked what would have to happen for them to achieve that optimal health. The participants answered this question by discussing factors related to physical, mental, emotional, and spiritual wellness, economics, environment, and politics.

Physical

Physical factors identified as necessary to obtain optimal health included regular exercise. One middle-aged woman stated she needed “things to exercise with” such as a “treadmill.” Another middle-aged man stated, the “Band should spend more money on sports…the community needs an all-purpose facility like a sports complex with a pool.” Nine of the 14 participants talked about nutrition, their eating habits and the changes they would need to make to achieve optimum health. One middle-aged man, discussed the importance of traditional diet and advocated the necessity to “go back to the old peoples’ diet” as “they didn’t have diabetes.” This same participant was also concerned about “eating all this stuff injected with who knows what.” Another middle-aged man suggested to help improve the nutritional status of people in the community, the “Health Center should give out multi-vitamins for adults once they reach a certain age.” A middle-aged woman expressed concern about her appearance and would like to have access to skin care products. Another male Elder talked about the importance of being “clean” as part of being healthy. Two of the participants talked about pain as a barrier to optimal health, and both shared they would like to be “pain free.”

One of the older women specifically stated she wanted her “knee to get better” so she could resume her normal activities.

Mental (Intellectual)

Eleven of the 14 participants talked about factors related to mental wellness that would need to be addressed for them to reach optimal health. Six of the participants discussed issues related to abstinence from alcohol and substance use. Five participants talked about how they would have to quit smoking. One young male stated he would “have to stop my bad habits like drinking,” and another male Elder shared the importance of “staying sober” as part of being healthy. Nine of the participants talked about factors related to attitude. One middle-aged male stated “you have to want to live, have goals, hope.” Another middle-aged male explained how he approached every day as a new day. One middle-aged man was quite adamant as he asserted “sickness is related to mental health issues, we need to understand that” and he continued, “the question is how many people understand or care to understand this?” The need for counselling and attending workshops was also discussed. One middle-aged woman shared, “I would need to deal with trauma I have experienced.” Another middle-aged man shared he had attended “Journey conferences, Inner Child Workshops…learned how cellular process works within your system to understand where sickness comes from.” He shared an example, “cancer can develop from abandonment” and it is necessary to “get the mind to think in different ways.”

Emotional

The need for motivation was addressed. One young female shared, “[I] have to be motivated but I don’t know how.” The need for a positive attitude about changing your outlook on life, included “the way you see yourself and other people, widen your perspective toward things, to be more open-minded,” was mentioned by a young woman. One middle-aged female talked about the importance of “being happy in [the] present situation and having healthy relationships,” and described a healthy relationship as one that will “enhance who you are, instead of draining you.” One young female talked about dealing with stress and being able to set limits with family and friends. She shared, “stress and anxiety is what causes me the most problems…I would need to set clear boundaries with family and friends so I’m not running all the time.” She explained she was constantly “running” and doing things for others and how something “still gets missed.” One middle-aged female shared “I would have more of myself to give if I was healthier.” Four participants
talked about the importance of being connected and able to spend time with family. Another older female explained she needed “love, caring, sharing, to feel important” and to “feel valued.”

**Spiritual**

Spiritual factors identified as necessary to obtain optimal health included spiritual growth, being grateful and the value of learning one’s traditional language and culture. One of the middle-aged males stated “a totally healthy person had mind, body, spirit in tune” and “my spirituality is lagging.” He shared he has been “exposed to different religious concepts and now beginning to find mine (own) in the natural world.” Another middle-aged male discussed the importance of “giving thanks, and to be grateful for each day.” One of the male Elders asserted that “language and culture” need to be intact because language and culture “defines who you are.” He continued to elaborate, “our young people don’t have a clue who they are, they don’t know their culture” and “this is what they should know, they should know who they are.” Another male Elder shared, “they need to know who they are and be proud; they will go a long ways.”

**Economic**

Participants discussed factors related economics including financial stress, employment and changes in health services as impacting their ability to reach optimal health. One middle-aged female stated she needed “to have basic needs met.” She gave examples of “clothing, house, stuff for house, furniture.” The importance of employment was also discussed. One middle-aged male stated he needed “steady employment.” Another middle-aged female explained she needed “a job to pay for [her] own needs.” A female Elder wanted to be able to work “at home and not have to travel to another community.” A middle-aged male, said he needed “a job” and that he would “feel depressed at home when can’t buy things you need, get depressed, get into drugs…more jobs are needed in the community.”

Participants also expressed concern about the decreases in health coverage and finding an equitable solution to deal with the decreases. A middle-aged man said, “Medicare does not cover what it used to,” and gave the example “Tylenol or Dimetapp.” Specifically, there was concern about accessing health services such as physiotherapy, the decreased health coverage for prescriptions and hearing aids, and decreased financial support for traditional ceremonies. One of the older women shared she had been without a hearing aid for over one year because she had lost it and had to wait one more year to qualify for another hearing aid. She was coping the best she could under the circumstances. One male Elder said, “Sundance needs …to be sponsored…it is my culture.”

**Environment**

Factors that were analyzed to be environmental tended to be issues that the individual person had less control over with individual activities. Thus these factors were different than activities previously identified as contributing to or maintaining health. Cleaning up the environment, racism and the prenatal period were mentioned as barriers to obtaining optimal health and wellness. Specifically, water pollution was identified as a concern that needs to be addressed immediately. One Elder said, “I used to drink slough water and no problem…now everything is getting so damn polluted, have to buy water to feel safe.”

Dealing with racism continues to be a concern for some of the participants in the study. There were perceived differences in the treatment of Aboriginal and non-Aboriginal Peoples in the health care system. Specific comments were made related to the perception of substandard ambulance service, referral for special tests such as a MRI and medical appointments when compared to non-Aboriginal patients. One of the male Elders said, “I’ve always seen these problems, even being off the reserve.” He shared, “being Native or Aboriginal they just give you a pill or a band-aid,” and “the white society they get the main things that help them like MRI…I can’t even get one.” One female Elder shared “I really noticed the care difference…they are not treated the same as the white person.” She gave an example using the local ambulance service and a recent incident that had occurred in the community. She explained, “they take a while and also when they arrive at the scene…our people are not treated…the way it should be…one of our Elders died like that.” This participant felt the emergency services were slow to respond, lacked proficiency and, most importantly, compassion, when they provided care to members of Thunderchild First Nation. She continued, “this Elder told them she couldn’t move and they made her stand up, apparently she had a broke hip” and they made her climb up on the stretcher. This participant felt this Elder would have lived had she been treated properly. The same female Elder also talked about her experiences of accompanying her sisters when they had appointments with their doctor. She explained, “with my sisters the doctors will be writing a prescription before they have finished telling their problem,” and “with me I will ask what causes this, I always make the doctor explain to me.” She concluded her comment with “physical appearance makes a difference how you will be treated.”
One of the middle-aged male participants discussed health in relation to the prenatal period. He declared, “right from the time you are developing in [your] mother’s stomach will determine much of the life outcome, either I’m disadvantaged from the get go or right in the pack to make my life what it can be…so it starts from the parent, parents.” He finished his comment by saying, “go from …one month to one year …influence, upbringing, education, or experiences put before you that shapes the kind of life you will have and starts directing you in a way you don’t know.”

**Politics**

Lastly, politics at the local and federal level were mentioned. At the local level, there were perceptions of a need for increased communication between the Thunderchild First Nation Band administration and the community members. At the federal level, the long standing issues around the treaties were identified as needing to be addressed and resolved. Statements included, “let us live on Treaty 6 the way the older Elders made the Treaty,” and Indigenous Peoples need to resume being autonomous. One participant said, “let us be free...and stop telling us what to do.”

**Do Plains Cree people perceive and practice health from a holistic perspective?**

Individually, approximately half of the participants perceived health from a holistic perspective when answering the initial questions. However, the knowledge of holistic health was apparent in all of the participants when asked what would have to happen for them to achieve optimal health; they readily responded using a holistic perspective that included factors from physical, emotional, mental, and spiritual wellness. The Plains Cree people of Thunderchild First Nation appear to support the concept of Aboriginal people having a holistic perception of health that is similar to the traditional teachings of the Medicine Wheel.

**Definition of health**

Following the thematic analysis, the researcher sought to combine the perceptions into a definition of health from the Plains Cree perspective. The majority of responses from the participants suggest there is a perceived combination of factors necessary to define their meaning of health and to be healthy. Almost all of the participants identify that health is interdependent on several factors. Further, the issues and concerns were directly related to their personal experiences with health.

To define health from even these few participants was challenging, since the perspectives were so varied, and the researcher wanted to find the most accurate reflection of health from the perception of the participants involved in this study. From the data collected, the researcher defined health as “a state of physical, mental (intellectual), emotional, and spiritual wellness, that includes economic and political independence.” Participants clearly valued health and perceived their current status of health as impacting their ability to enjoy the daily activities of living and healthy lifestyles.

**DISCUSSION**

A definition of health as outlined above is useful, but provides little support or guidance for interventions that might address health needs or eliminate barriers. Two philosophies had guided the conduct and analysis of this project. While the Kaupapa Māori methodology is an Indigenous methodology, it did not arise from Canadian Aboriginal Peoples. However, using their principles was positive for all concerned in that the process of the research flowed well, the data resulting from the study was rich, and the partnership with this band has been developed and can be sustained through additional research. Therefore, this study supports that the Kaupapa Māori methodology can transfer to another Indigenous group.

Despite the variation in the participants’ responses, their perceptions and needs related to health and wellness consistently fit within the four quadrants of the Medicine Wheel. Mussell (2005) describes the Medicine Wheel as a “symbol used to represent the dynamic system of the mind, body, emotions and spirit, and the needs related to each of these aspects that must be met for the development of human potential” (p. 115). He further describes these needs “as requirements for survival and personal growth” (p. 115).

The Medicine Wheel had already served as a framework for the categorization of data, and provided a holistic approach to the analysis. In addition, using concepts from the Medicine Wheel is “becoming a popular health-teaching model for a variety of disease entities” (Roberts, 2005, p. 92). This Indigenous holistic model has quickly gained acceptance and is being used in a variety of health care settings to deal with diverse issues (Dapice, 2006; Mussell, 2005; Roberts, 2005). After completing this research project, the researcher now views the Medicine Wheel as an Indigenous methodology that can be applied to diverse issues related to health and wellness.
**Relevance and significance of research**

These findings are similar to studies completed by both Hakim and Wegmann (2002), and Roberts (2005). According to Hakim and Wegmann (2002) when they asked what participants did to keep themselves healthy, “the common response reflected themes of western medicine.” Most of their participants talked about “exercise, eating right, and going to the doctor on a regular basis” and “spiritual or religious beliefs seemed to be universal patterns for all of the groups” (p. 169). It appears the participants in Hakim and Wegmann’s study focused on physical and spiritual practices to maintain health. From the current data it is apparent that the participants in this study are combining practices from the western world and from their traditional (Cree) world to be healthy and to maintain their health. This is consistent with Roberts’ (2005) research, that shows “living in and taking from both the traditional Woodland Cree knowledge system and the Western knowledge system has been a recurrent theme” (p. 120).

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

**Determinants of health**

The determinants of health concept originated from the Lalonde Report (1974), and since then has been expanded to include a larger context to evaluate and improve wellness and health. Currently, the Public Health Agency of Canada (PHAC) (2003) lists the following as key determinants of health:

- Income and social status.
- Social support networks.
- Education and literacy.
- Employment/working condition.
- Social environments.
- Physical environments.
- Personal health practices and coping skills.
- Healthy child development.
- Biology and genetic endowment.
- Health services.
- Gender.
- Culture.

One of the drivers of this study was that the primary researcher wondered whether the Social Determinants of Health were reflective of and an appropriate framework for addressing Aboriginal health concerns.

While this could be viewed as a western tool, one of the key reasons why the primary researcher embraced the social determinants of health as being congruent with the data was that the participants did not focus just on contributions to health that were under their direct influence, such as exercise, nutrition and the like. Rather, they identified that environmental, societal, historical, and political factors also influenced their level of health and well-being and recognized that their actions had to overcome that which they could not control. The primary researcher was thrilled to see congruency with a broad framework that is accepted by most Canadian health professions.

While some may argue that spirituality and racism are not determinants of health, the primary researcher would respond that spirituality is a strong component of Indigenous culture and that racism is indeed a part of the present social environment. As noted above, both culture and social environments are included in the list of the determinants of health. The determinants of health as expressed by PHAC may evolve over time. For example, the World Health Organization (WHO), in participation in the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance in South Africa, urged the conference to consider the link between racial discrimination and health (WHO, n.d.). Based on this and future research, racism may well be seen as an appropriate addition to the determinants of health, increasing their applicability in a variety of global environments.

While health services is listed as a determinant of health, several of the participants noted the difficulties in accessing needed care, particularly dental care, diagnostic tests, and appointments with specialists. Investigation by this researcher indicates some policy disparities that do exist in terms of accessibility to health care, contributing to increased marginalization of an already vulnerable group. Using the determinants of health and the principles of the Canada Health Act would suggest that these disparities need to be addressed, and the accessibility of health care to be more equitable across all Canadian populations.
CONCLUSION

The participants clearly viewed health from a holistic perspective, and were strongly aware of both what they required to attain and maintain their health, and the personal and structural barriers they faced in achieving optimal personal wellness. This study resulted in a definition of health that can further be tested with other Aboriginal groups. While the links are general in nature, these data support the determinants of health as a potentially culturally congruent frame for federal, provincial and local policy makers to implement structural and programmatic changes with Aboriginal groups. The results of this study also encourage a continued testing, evolution and possible expansion of the determinants of health so that they may be a culturally adaptive framework that can be used with diverse populations.

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