



## INTRODUCTION

There are a range of concerns around obesity and its associated health risk for First Nations women. While there is a great deal of emphasis placed on understanding the biomedical causes and consequences of obesity, there is little known about the cultural, gendered and historical meanings or experiences of healthy body weight and healthy body image from the perspectives of First Nations women. In order to provide effective and respectful programs and services to rural First Nations women, it is crucial to understand the range of meanings that First Nations women give to the concept of the “healthy body.” What roles do culture, gender and history play in how the “healthy body” is perceived and experienced? As such, we explore the meaning of the “healthy body” from the perspective of First Nations women living in the rural communities of the Battleford Tribal Council (BTC) region of Saskatchewan. Grounded in a community-based participatory research approach, we began the first phase of a two-phase research program by holding a community consultation with six women from the BTC communities. In this paper, we identify three interconnected themes that resulted from the community consultation, which provide insight into the women’s perspectives of the “healthy body.” We conclude by describing our plans for phase two of our research with the women, which will provide them with creative opportunities to explore, document and discuss their understandings of embodiment and the meaning that First Nations women give to the concept of the “healthy body.”

## BACKGROUND

Miwayawin Health Services Inc. (MHS)—formerly the Battleford Tribal Council Indian Health Services Inc. (BTCIHS)—is a First Nations owned and operated health services organization that was established over 26 years ago to serve seven BTC reserve communities in Saskatchewan. It is based in the urban centre of North Battleford and provides primary health care services, in addition to a range of other services, including a community health program, head start programs, health promotion, home and community care, diabetes initiatives, school-based dental programs, and more. The communities served by MHS are primarily Cree, and both the Cree and English languages are spoken. These communities include Little Pine First Nation, Lucky Man Cree Nation, Moosomin First Nation, Mosquito Grizzly Bears Head Lean Man First Nation, Poundmaker Cree Nation, Red Pheasant First Nation, and

Sweetgrass First Nation. The populations of these reserves range from 500 to 700 people, with a total population of 4,121 people (BTCIHS, 2000; Katzmarzyk & Malina, 1998). All communities are within 90 kilometres of the medical facilities offered through MHS.

The Board of Directors and staff at MHS believe that community-level services should be designed and directed by First Nations people. In the 1990s, MHS initiated a three phase research program entitled DREAM (diabetic risk evaluation and microalbuminuria) (Tobe, 2004). The goal of the DREAM program was to determine the incidence of, and risk factors for, liver problems associated with diabetes and obesity (Anand et al., 2001). The DREAM studies screened 601 First Nations people from the BTC communities and found a high prevalence of diabetes and hypertension. They also found high rates of obesity where 73 per cent of people screened had a body mass index (BMI) greater than 27. While a BMI between 18.5 and 25 is determined to be in the healthy range, a BMI of more than 25 is associated with health complications such as diabetes and hypertension (Tobe, 2004). There is a linkage between obesity and diabetes in that people who have higher BMI calculations are at risk of seeing the onset of type 2 diabetes (Wing et al., 2001; Harris et al., 2002; Walker, 2003).

While the rates of elevated BMI among community members from the DREAM findings were concerning, the DREAM research contributed to an increase in community awareness about obesity, its related health risks and how to combat it through health management practices. It also contributed to positive changes in individual eating habits and improved relationships between the community and the medical staff (BTCIHS, 2000). Overall, the DREAM project was successful in contributing to a better understanding of community health issues in the BTC area and has generated tremendous pride within the participating communities.

For MHS, given the relationship between obesity and other health risks, the DREAM findings suggested a need to better understand healthy body weight. There was also a need to better understand concepts of healthy body weight and healthy body image from the perspective of community members. A focus on First Nations women was seen to be particularly crucial, since women are the primary caregivers in their homes and communities. For the director and staff at MHS, the questions became: Why do First Nations women struggle with weight issues? Is there something unique to BTC communities or for First Nations women?







and focus group. An initial analysis was conducted by the three researchers who attended and co-facilitated the community consultation. The CRA then categorized all of the initial findings into 12 main themes. These themes were then further analyzed by Poudrier and, with the help of a university research assistant, were consolidated into three over-arching themes. These results of the consultation and the corresponding themes are described in the following section.

## RESULTS AND DISCUSSION

Although not all of the women who participated in the community consultation shared the same experiences and perspectives, we can identify three inter-related themes connected to their understandings of the “healthy body” within the context of BTC communities. These themes are: 1) the importance of Elder knowledge and traditional values in promoting community wellness; 2) the importance of understanding family history and the role of women; and 3) the need to better understand the practical aspects of purchasing and preparing healthy food. While these themes do not all relate explicitly to the concept of embodiment, the women’s discussion of the “healthy body” was primarily focused on broader socio-cultural aspects of health and wellness, as opposed to a narrower focus on the physical body.

### Elder knowledge and traditional values

All of the participants indicated that Elder knowledge—including the older women’s experiences as mothers and grandmothers and their understanding of traditional teachings—was a key consideration in all aspects of community and individual health and wellness. The importance of Elder knowledge and traditional values was conveyed in three ways.

First, some of the more senior women shared their stories about specific health experiences over their lifecourse. Three of these women discussed illnesses that they had been affected by in their younger years (i.e., diabetes, kidney disease, alcoholism). They all indicated that these incidents were a turning point for them, after which they began to take better care of their bodies and their overall health. Since they had all had partners and children to take care of when they were younger (sometimes at a very young age), the women felt that they had mistakenly neglected their own health needs while focusing on the needs of others. For example, one mother of eight said that a turning point in her life came with the onset of diabetes because of weight gain

during her pregnancies while her family was young. Because she was focusing on the needs of others and not on her own health, she became diabetic. This led her to focus on her health and she is now “taking better care of herself through diet and exercise” (personal communication, October 2005). She said that she knew that she could not care for others if she was sick.

All of the more senior women in the group suggested that their own experiences of overlooking self-care until later in their lives might be a valuable teaching for younger women. As stated by one of the group members, “We women should not wait for a health crisis before we start taking care of ourselves” (personal communication, October 2005). Another woman suggested that it is never too late to start exercising, and that she “didn’t want to use old age as an excuse not to lose weight” (personal communication, October 2005).

Second, the older women also shared some of their practical strategies for staying healthy in terms of maintaining a certain body weight, such as eating properly, being active at work and around the house, joining exercise groups, taking advantage of walking trails, learning about healthy body weight from homecare nurses, and participating in specific weight programs like Take Off Pounds Sensibly. Some of the women thought that it was important to eat traditional foods rather than highly processed foods (such as fast food and chips) in order to maintain a healthy weight. However, others felt that traditional foods should be eaten only in moderation. One woman said traditional foods could be fattening and that while she “loved traditional foods,” she commented that “you have to be careful when you eat them. Bannock is the worst!” (personal communication, October 2005). The younger participants in the group indicated that having children left them with very little time to exercise and cook healthy foods, but they also recognized that they could not be good caregivers or role models unless they focused on their own health. They felt that the teachings offered by the Elder women about self-care and their weight management at younger ages could help them to stay healthy and to be good role models for their own children and future generations.

Third, all of the women in the group expressed the idea that the values of holistic health were important to overall health, a positive body image and maintaining a healthy body weight. One woman said in Cree that it was essential to teach young people the traditional values of respect for others, self-respect, acceptance, and love. She felt that these values were given to everyone by the Creator,





in many communities, women are primarily responsible for the family through their roles as mothers and caregivers to Elders. Women are also seen as the central to the maintenance of the family and cultural values. More specifically, in BTC communities, women are seen as central to the health of families not only because they create and sustain life, but because they are the primary care providers and they hold the core of the family together. Women are also central to the transmission of cultural values regarding self-respect and respect for the broader community. For these reasons, the group felt that it was especially important to recognize women in their endeavours to maintain their own health or healthy body weight. This recognition would then have positive implications for families and for the community.

Women’s roles and experiences around the “healthy body” were also discussed in connection to sexuality and their relationship with male partners. Some of the women suggested that their partnerships with men played a crucial role in terms of defining their body image and influencing their self-esteem. They indicated that their body image was negatively influenced by a range of sexist remarks made by men that suggested that only thin women were attractive. Some women also discussed the notion that “First Nations men like their women bigger” (personal communication, October 2005). It was suggested that this preference for heavier women was not because it was more attractive to men, but because it was based on the men’s fears of inadequacy and jealousy—that some men felt that if their female partners were heavier, they would be less attractive to other men and, therefore, less likely to stray from the relationship. On the other hand, a few of the women indicated that they were not concerned about how their male partners perceived their body weight. They felt that their husbands loved and supported them as partners, no matter how much weight they carried. While there was no consensus about any body size or shape that was attractive or concerning to First Nations men, it was clear that the intersections between sexual partnerships, self-esteem and body image were indeed seen as important and very complex issues.

### Healthy food and health programming through Miwayawin Health Services (MHS)

For the women in the group, food preparation and storage, healthy eating and health programs were all related to achieving a “healthy body.” Some women felt that staying healthy was connected to having a more traditional diet, while other women suggested the best diet was one that

balanced both traditional and modern diets and excluded highly processed foods. The women acknowledged that there was a mix of traditional and contemporary diets consumed by people in their communities. They felt that it was important to ensure that traditional food, such as deer meat, was safely handled and stored. One woman talked about how after a successful hunt, there would sometimes be inadequate freezer space to safely store the meat.

The women strongly suggested that because the “healthy body” was connected to a healthy diet, the affordability and availability of food was very important. For example, the women discussed the fact that highly processed and convenience foods were expensive and unhealthy, while other foods, such as fruit and vegetables, were not quite as expensive. Highly processed foods (or take out foods) are also very quick to prepare for families. Referring to differential socio-economic and marital circumstances among people, the women discussed situations where single working mothers might opt for foods that they know are less healthy. One woman suggested that women often cope with overwhelming responsibilities and time constraints by eating fast food rather than to taking the time to cook healthier meals. Additionally, there was also the concern that even when healthy food was prepared, the food was not always very appealing to other family members. Indeed, healthy food that was affordable and appetizing was seen as important to health and the “healthy body.” Purchasing, preparing and storing healthy food was very much connected to the broader context of women’s lives.

In discussions about the “healthy body” and food, the women acknowledged the important role of MHS in the provision of related services and education programs. Some women indicated that they were not well aware of the range of services offered. Others felt that they were well aware of the programs and that they often participated in them. There was also some discussion, however, about the practical aspects of some programs offered through MHS. For example, one woman noted that while there was a great deal of information available about healthy food options, there was not a great deal of information on how to prepare newly suggested healthy foods, such as eggplant or lentils. Even if they could find and prepare so-called healthy foods, some women wondered if their family would eat them. This led to some suggestions around having more programming around food preparation. This also led to deeper questions, but little discussion, about the meaning of healthy food in the current context and ways to better understand the relationship between contemporary processed foods, traditional foods and newer healthier foods.





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## REFERENCES

- Anand S. S., Yusuf, S., Jacobs, R., Davis, A. D., Qilong, Y., Gerstein, H., et al. (2001). Risk factors, atherosclerosis, and cardiovascular disease among Aboriginal people in Canada: The study of health assessment and risk evaluation in Aboriginal peoples. *The Lancet*, 358, 1147–1153.
- Assembly of First Nations. (2005, November). *Agenda for restoring and improving First Nations health*. Retrieved June 15, 2007, from <http://www.afn.ca/cmslib/general/L3.pdf>
- Battleford Tribal Council Indian Health Services. (2001). *Battleford Tribal Council Indian Health Services: Overview April 2000. Home Care Plan*. North Battleford, SK: Author.
- Crossley, N. (2004). Fat as a sociological issue: Obesity rates in late modern, "body conscious" societies. *Social Theory & Health*, 2(3), 222–253.
- Ellerby, J. H., McKenzie, J., McKay, S., Gariépy, J. J., & Kaufert, J. M. (2000). Bioethics for clinicians: Aboriginal cultures. *Canadian Medical Association Journal*, 163(7), 845–850.
- Fleming, T., Kowlaski, K. C., Humbert, M. L., Fagan, K. R., Cannon, M. J., & Girolami, T. M. (2006). Body-related emotional experiences of young Aboriginal Women. *Qualitative Health Research*, 16(4), 517–537.
- Giles, B. G., Haas, G., & Findlay, C. S. (2005). *Incorporating First Nations health perspectives and traditional knowledge into health risk assessment models*. Final report submitted to the Assembly of First Nations. Retrieved June 15, 2006, from University of Ottawa Web site: [http://www.ie.uottawa.ca/English/Reports/AFN\\_AHRAM\\_II\\_FCM\\_%20Final%20Report28July2005\\_PM.pdf](http://www.ie.uottawa.ca/English/Reports/AFN_AHRAM_II_FCM_%20Final%20Report28July2005_PM.pdf)
- Harris, S. B., Zinman, B., Hanley, A., Gittelsohn, J., Hegele, R., Connelly, P. W., et al. (2002). The impact of diabetes on a cardiovascular risk factor and outcomes in a native Canadian population. *Diabetes and Research Clinical Practice*, 55, 165–173.
- Katzmarzyk, P. T., & Malina, R. M. (1998). Obesity and relative subcutaneous fat distribution among Canadians of First Nation and European ancestry. *International Journal of Obesity*, 22, 1127–1131.
- Lorber, J., & Moore, L. J. (2007). *Gendered bodies: Feminist perspectives*. New York: Oxford University Press.
- Macaulay, A., Paradis, G., Potvin, L., Cross, E. J., Saad-Haddad, C., McComber, A., et al. (1997). The Kahnawake Schools Diabetes Prevention Project: Intervention, evaluation, and baseline results of a diabetes primary prevention program with a Native Community in Canada. *Preventive Medicine*, 26, 779–790.
- Marchessault, G. (2003). Body shape perceptions of Aboriginal and non-Aboriginal girls and women in Canada. *Canadian Journal of Dietetic Practice and Research*, 64(2), S114.
- National Aboriginal Health Organization. (2005). *First Nations Regional Longitudinal Health Survey (RHS) at a glance: Selected findings from the First Nations Regional Longitudinal Health Survey, 2002/2003*. Retrieved February 27, 2006, from [http://www.naho.ca/firstnations/english/documents/RHSataGlance\\_000.pdf](http://www.naho.ca/firstnations/english/documents/RHSataGlance_000.pdf)
- Paquette, M., & Raine, K. (2004). Sociocultural context of women's body image. *Social Science and Medicine*, 59, 1047–1058.
- Prairie Women's Health Centre of Excellence. (2004). *Ethical guidelines for Aboriginal women's health research*. Retrieved June 15, 2006, from <http://www.pwhce.ca/pdf/ethicalGuidelines.pdf>
- Reading, J., & Nowgesic, E. (2002). Improving the health of future generations: The Canadian Institutes of Health Research and Institute of Aboriginal Peoples' Health. *American Journal of Public Health*, 92(9), 1396.
- Royal Commission on Aboriginal Peoples. (1996). *Royal Commission on Aboriginal Peoples*. Retrieved June 15, 2006, from [http://www.ainc-inac.gc.ca/ch/rcap/rpt/index\\_e.html](http://www.ainc-inac.gc.ca/ch/rcap/rpt/index_e.html)
- Saskatchewan Women's Secretariat. (1999). *Profile of Aboriginal women in Saskatchewan*. Retrieved June 15, 2006, from <http://www.swo.gov.sk.ca/D057-ABW.pdf>



