INDIGENOUS KNOWLEDGE, SOCIAL RELATIONSHIPS AND HEALTH:
COMMUNITY-BASED PARTICIPATORY RESEARCH WITH ANISHINABE
YOUTH AT PIC RIVER FIRST NATION

(Thesis Format: Monograph)

by

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Abstract:

Canada’s First Nations youth endure a disproportionate burden of health inequalities. While patterns of First Nation’s youth health point to distinctly social causes (e.g., lacking social support, violence and addiction), research has not adequately explored how the quality of local social environments influence First Nations youth health. Drawing from 19 in-depth interviews with Anishinabe youth, this community-based project utilized an Indigenous Knowledge framework to explore youth perceptions of health, social relationships, and the ways they interact. This research centred around four main objectives including: 1) understanding how Anishinabe youth define health & well-being; 2) exploring youth perceptions of social relationships; 3) examining how social relationships influence health; and, 4) understanding how culture shapes health. Findings suggest that youth definitions of health differ across individual, family and community levels. Youth perceive social relationships as fundamental for the provision of social support, and that good relationships influence healthy behaviours (e.g. youth participation in ceremonies). Over time, it appears that loss of Indigenous Knowledge figures strongly in the declining relationship between health and social relationships of youth (e.g. changing ways of interacting). Despite the loss of knowledge and changing lifestyles of the community however, youth spoke about meaningful connections to the land, and they identified the importance of cultural teachings related to Indigenous knowledge (e.g., moral values such as respect for land/elders) in their everyday lives, social relationships, and health behaviours.

Keywords: Ojibways of the Pic River First Nation, Health, Social Relationships, Indigenous Knowledge, Youth, Anishinabe.
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1. INTRODUCTION

This research provides a qualitative investigation of Anishinabe youth’s perceptions of the relationship between health and social relationships. This was done in collaboration with the community of Pic River First Nation, located along the Northern shores of Lake Superior. The overall aim of this thesis is to better articulate the role of Indigenous Knowledge in youth’s perceptions of health and social relationships.

Across Canada, processes of environmental dispossession – processes by which Indigenous people’s access to their traditional lands and resources are reduced or severed (Richmond and Ross, 2009) - are deteriorating Indigenous Knowledge in First Nation communities, thereby changing the meaning and function of social relationships. These changes are considerably affecting the health of First Nation communities, as the moral values underpinning the ways people have traditionally interacted with one another is changing over time. This thesis examines these issues through a case study with 19 Anishinabe youth at Pic River First Nation. The contemporary nature of this community has been shaped by unique forms of environmental dispossession, including water contamination and residential schools. Community Elders express deep concerns that, over time, these processes have posed threat to the maintenance and transmission of Indigenous Knowledge from Elders to youth, and they worry about what this means for the future generations of the community. To date, very little Canadian research has examined First Nations’ youth perspectives on health and well-being, and no studies have explored these issues in the context of Anishinabe youth. An examination of the ways youth understand how this Indigenous Knowledge is changing over time is important as it provides a way of understanding the lived experiences of people in unique social and environmental contexts.
This is so as these lived experiences strongly shape the way community members relate to each other, and with the land, and it also underpins the development of cultural norms and moral rules. Understanding how Indigenous Knowledge works in the everyday lives of youth may provide insight about why the social and health conditions of the communities are the way that they currently are, and it may also provide youth-centred information that can be useful for developing strategies to preserve Indigenous Knowledge.

1.1 Research Context

In Canada, it is widely recognized that Aboriginal people\(^1\) have barriers to accessing healthcare and suffer from higher rates of morbidity (i.e. diabetes, tuberculosis) and early mortality (i.e. suicide, accidents) (Browne et al., 2005; Wilson et al., 2002). Canada’s First Nations endure a disproportionate burden of health inequalities, many of which can be linked to processes of colonialism and other forms of environmental dispossession that have significantly reduced the quality of their local social environments, including violence and unemployment, among others (Adelson, 2005; Richmond et al., 2007; 2008). At present, 48% of the Aboriginal population is less than 24 years of age compared to 31% in the Canadian population (Statistics Canada, 2006). These statistics outlines two very different demographic distributions; while the Canadian population is aging, the Aboriginal population is young and quickly growing (Statistics Canada, 2006; Kirmayer et al., 2003). Given the breadth and currency of these health disparities, long-term goals (e.g. those that focus on preventative and protective health) must be developed

\(^1\) Aboriginal peoples are defined as “the descendent of the original inhabitants of North America. The Canadian Constitution recognizes three groups of Aboriginal people – Indians, Métis and Inuit” (INAC, 2010).
now to prevent future on-going health and social crises within the Aboriginal population, in particular through burden on healthcare, as well as social and economic policy.

Historically, Aboriginal health research has focused almost exclusively on describing patterns of health problems and conditions such as rates of morbidity from various illnesses and diseases, and with considerably less attention paid to understanding the ‘root causes’ of these health disparities (Link and Phelan, 1995), such as social, environmental and economic processes. Further, little research in this wider literature has focused on solutions (Gracey et al., 2009; Young, 2003; Waldram et al., 2006; Wilson et al., 2008). From the social epidemiological literature Link and Phelan (1995) argue that greater attention must be focused on understanding the fundamental social conditions that lead to health disparities, rather than scrutinizing individual actions, or worse, blaming individuals for their behaviours. This is particularly important in the Aboriginal context as researchers have identified that local social environments strongly influence the health of Aboriginal people (Frohlich et al., 2006; Richmond et al., 2007; 2008; Richmond, 2009). Only when the social, environmental and economic conditions of Aboriginal people are acknowledged and improved, will health begin to thrive (Newbold, 1998).

Understanding the First Nation community context in Canada is central to understanding the foundations of First Nation social relationships. In Canada, there are 615 First Nation bands, 127 of them located in Ontario (INAC, 2011). A quarter of these First Nation communities are considered small in size and remote (INAC, 2011). Size, geographic location, and cultural values of communities influence the nature of social relationships in each particular community.

In the Aboriginal research context, a participatory paradigm is beginning to shaping the way health research is done, mainly through community-based participatory research.
In the past, health research was often done ‘on’ communities involved, rather than ‘with’ communities (Wilson et al., 2008). This lack of collaboration between researchers and Aboriginal communities resulted in findings that have not always been beneficial for the communities, and in some cases this research has caused harm, for example with reference to genetic testing (Schmidt, 2001; LaDuke, 2005). This shameful legacy of research with Aboriginal people was formative to the development of the Canadian Institutes of Health Research’s Guidelines for Health Research involving Aboriginal Peoples (CIHR, 2007). This Guideline is one significant step toward redirecting Aboriginal health research, and its main objective is to ensure that local communities and their health and social needs are central to research conducted in their communities. This thesis was conceptualized and operationalized within the spirit of the CIHR Guidelines. This means that great consideration was taken to ensure that the research was ethically sound, protective of the community, and also mutually beneficial to researchers and the community. This was important for achieving trust with the community and for reassurance that research is undertaken with good intentions. The research reported in this thesis marks a departure from the way research has traditionally been completed within the greater field of health geography.

1.2 Research Problem and Objectives

While contemporary patterns of Aboriginal health point to social and economic causes (e.g. addictions, poverty) (Wilkinson et al., 2003; Waldrum et al., 2006), Aboriginal health researchers have not adequately explored how local social environments influence health using an Indigenous Knowledge framework, nor has the role of environmental
dispossession been examined as it affects the quality of local social environments.
Additionally while some researchers have drawn from biomedical perspectives to describe
the health conditions of First Nations youth, for example in the case of diabetes prevalence
and age of onset (Harris et al., 1996), only a small base of literature has aimed to
qualitatively understand the unique social dimensions that determine the health of First
Nations youth (Young, 2003). The growing youth population and the special social and
economic demands of the population demonstrates a need to increase this area of research.
While the links between the local social environment and health has been explored among
Aboriginal adults (e.g. social support), these relationships have not been explored in the
youth context (Richmond, 2007; 2009). Furthermore, the special interaction between
Indigenous Knowledge, social relationships and Anishinabe youth has not been examined.

In order to learn more about the ways Anishinabe youth health is related to social
relationships, and fostered by local cultural values related to IK, this research explored four
main objectives;

1) to understand how Anishinabe youth define health & well-being
2) to explore youth perceptions of social relationships
3) to examine how social relationships influence health; and,
4) to understand how Anishinabe culture shapes health.

Based on what is known about contemporary patterns of health in the First Nation’s youth
technology – in particular the strong emphasis from the social environment - I hypothesize that
as processes of environmental dispossession continue to affect the ways Indigenous
Knowledge is shared at the community level –social and cultural ties will weaken, thereby
resulting in poor youth health (Cajete, 1994; Battiste et al., 2000; Simpson, 2004).

2 Anishinabe refers to First Nations people who are Ojibway in ancestry.
My research adds to the health geography literature both theoretically and methodologically as it utilizes an Indigenous Knowledge framework and a community-based participatory method as a way of understanding how social relationships and culture shape Anishinabe youth health. In order to examine these links and the above objectives, this research draws from a case study of Pic River First Nation. As a means of setting the community context, a brief profile is next outlined.

1.3 Community Profile

The Ojibways of the Pic River First Nation, or Begetekong, is located along the Northern shores of Lake Superior approximately 300 kilometres East of Thunder Bay and 400 kilometres Northwest of Sault Ste Marie (Figure 1.1; Figure 1.2). The mouth of the Pic River was historically used as a trading post due to its convenient location as a half-way point along the Northern shore, and northward access to James Bay by travelling along the Pic River (Figure 1.3). In 1914, the community became a treaty reserve (PRFN, 2010). Today, the on-reserve population of males and females is 508; the off-reserve population is 493, thereby totalling 1001 band members (INAC, 2010).

The community holds multiple values and beliefs in reference to their community members, including youth and band employees. These values underpin the delivery of programs and funding of initiatives such as major investments in post-secondary education, home care for Elders and a holistic health care centre. In terms of youth, the community sees “the potential of our youth as future leaders and developers of our community” (PRFN, 2010). Two of their beliefs consist of “higher education to promote the growth and capacity of the individual, community and Nation” and “the healing and recovery of one’s
The community is very progressive and actively involved in their economic development and land claim settlements. Economic development in areas such as forest fire fighting, tourism, hydro development projects, and more recently the opening of the Pic River Development Corp, are all foundations for creating a strong, self-sustaining and self-determining community. The community holds much optimism for their future, as evidenced through their development projects, educational priorities, and support programs (e.g. Biidaaban Healing Lodge). This determination and optimism stems from experiences endured in the past, including addictions, violence, and contamination events from nearby industrial development, and the desire to realize self-determination (PRFN, 2010).

As briefly mentioned, the Ojibways of the Pic River First Nation are no strangers to the effects of environmental contamination. In the 1980s, one of three upstream gold mines released toxic cyanide into the Black River, the main tributary of the Pic River, from which the community derives its drinking water. The contamination forced the community to depend on bottled water for several years. Fear for reliving the nightmare occurred in early December 2009, when a chemical spill occurred in Marathon, Ontario - a town neighbouring Pic River First Nation. In that spill, 12,000 litres of pulp mill effluent was leaked onto Pic River First Nation’s traditional territory (Chiefs of Ontario, 2009). These incidents highlight just two of many environmental justice issues that First Nation people face, and the fact that processes of environmental dispossession are not historic, but a common and pressing social justice issue in contemporary society.
Figure 1.1 Location of Pic River First Nation with respect to Canada (PRFN, 2010).

Figure 1.2 Location of Pic River First Nation with respect to Thunder Bay and Sault Ste. Marie (Google Maps, 2010).
1.4 Chapter Outline

This thesis is made up of five chapters. Chapter 2 provides a literature review of work relevant to this thesis. In this chapter, the concept of Indigenous Knowledge is explored and defined as they key framework guiding this thesis. Next, the health and social consequences of losing Indigenous Knowledge are examined. The Indigenous Knowledge section concludes with review of the literature. This literature demonstrates the importance of Indigenous Knowledge as a lens for understanding and undertaking Aboriginal research. The following section explores the Indigenous youth health literature, particularly the methods and results and then the importance of Indigenous Knowledge for youth. Indigenous geography is another area reviewed in this chapter, concerned with the work of researchers in this field. The fourth section of this chapter is concerned with the field of Indigenous health geography, which informs this thesis. Fifth, social relationships literature is examined, followed by a review of the implications of social relationship on health.

The research methods are discussed in Chapter 3 of this thesis. Through the case-study of Pic River First Nation, this thesis explored Anishinabe youth perceptions of health, social relationships and the ways they interact. Data was collected through the use of in-depth interviews with the youth from the Pic River First Nation. The interviews occurred in August 2010 and were digitally recorded and transcribed. NVivo 9 software was used for the analysis and an example of the analysis process is provided.

Chapter 4 provides detailed results of the in-depth interviews with 19 youth. The findings are structured around the research objectives (youth definitions of health; youth
perceptions of social relationships; youth perceptions of social relationships and health; and culture and health). These objectives are further broken down into the main findings.

Lastly, Chapter 5 ties the thesis together with a summary of the key findings and a discussion of those findings, including the role of Indigenous Knowledge in the research. A conceptual framework is also provided illustrating the influence of environmental dispossession on Indigenous Knowledge, social relationships and youth health. Also included in this chapter is a discussion of the theoretical and methodological research contributions, policy implications, limitations of the research and finally, a thesis conclusion.
2. LITERATURE REVIEW

This chapter provides a review of the literatures within which this thesis is theoretically and methodologically situated. The chapter begins with an examination of the Indigenous Knowledge literature, including a discussion of the health and social implications of losing that knowledge. Following these topics, an overview of the Indigenous Knowledge research is outlined. The next section explores the Indigenous youth health literature, followed by the importance of Indigenous Knowledge for youth. Literature in the field of Indigenous Geography and Indigenous Health Geographies is examined. Lastly, this chapter concludes with an examination of the literature on social relationships, and their implications for health.

2.1 Indigenous Knowledge

2.1.1 What is Indigenous Knowledge?

Though this thesis is one about health and social relationships in the Anishinabe context, in fact it is centrally concerned with the ways Indigenous Knowledge and processes of environmental dispossession works to create the conditions for these outcomes. Indigenous scholars such as Battiste & Henderson (2000) have commented on the difficulty scholars have when defining the term “Indigenous Knowledge”. They have identified problems associated with the creation of a definition including; the assumption that all Indigenous Knowledge across people is uniform; the assumption that knowledge can be separated from communities or people; and that it is not the same as the Eurocentric
The concept of culture (Battiste et al., 2000). The need to provide a definition is purely Eurocentric and while many may hesitate to apply a definition because of this reason, there are ways to describe Indigenous Knowledge. Battiste et al., (2000) identified one way for describing Indigenous Knowledge:

“knowledge is the expression of the vibrant relationships between the people, their ecosystems; and the other living beings and spirits that share their lands. These multilayered relationships are the basis for maintaining social, economic, and diplomatic relationships – through sharing – with other peoples. All aspects of this knowledge are interrelated and cannot be separated from the traditional territories of the people concerned” (Battiste et al., 2000; p42).

Indigenous Knowledge can also be described as “the dynamic way in which the residents of an area have come to understand themselves in relationship to their natural environment and how they organize that folk knowledge of flora and fauna, cultural beliefs, and history to and beliefs to enhance their lives” (Semali & Kincheloe, 1999). It is learned through oral traditions passed through generations of stories. Due to the long-term accumulation of knowledge expertise usually comes with age (Getty, 2009). As previously stated, this term was developed in academia in order to fit a Eurocentric definition. There is difficulty in the adoption of one specific definition as this assumes there is one Indigenous Knowledge. Eurocentric thinkers find it difficult to accept Indigenous Knowledge as a different way of knowing about the world or “knowledge system”. Due to the differences in Indigenous Knowledge globally, it is misleading to apply one definition. As a result, this thesis does not attempt to apply one standard definition, but rather recognize that there are multiple understandings of Indigenous Knowledge, each dependent on the particular local environment.
Indigenous Knowledge is expressed through language, stories and the way Indigenous peoples live their lives. The loss of local languages and ways of living decreases the ties to the local culture and knowledge (Battiste et al., 2000). Language is the direct link to Indigenous Knowledge and provides the most accurate way of understanding that knowledge (Battiste et al., 2000). This is in part due to the inability to translate some knowledge. Severances to language or the environment can have devastating consequences to Indigenous Knowledge. Simpson explains that “our knowledge comes from the land, and the destruction of the environment is a colonial manifestation and a direct attack on Indigenous Knowledge and Indigenous nationhood” (Simpson, 2004; p377). Additionally, the only way Indigenous Peoples will be able to recover their Indigenous Knowledge is through regaining control over their traditional lands (Simpson, 2004). This is because “Indigenous Knowledge must be lived, and so we must think very carefully about how we are preparing our children to live their cultural knowledge in the coming generations” (Simpson, 2004; p381).

While Indigenous peoples worldwide vary in regards to their individual worldviews and experiences, there are philosophical components that cross-cut each community. Some of these similarities include concepts such as: holistic thinking, interrelatedness, no hierarchical structures, collective thinking, and respect for all things (Getty, 2009). Holistic thinking implies that all parts come together to form a whole. This is especially important for Indigenous health, as this thesis will further discuss shortly. Interrelatedness means that everything throughout the world is connected in some way and one cannot change one component without altering another (Wilson, 2008). The absence of hierarchical structures is important in that Indigenous peoples view humans as equal and therefore not above or better than any other living species. This includes vegetation and rocks as everything has its
place with the world. Indigenous peoples also think in a collective rather than individual manner placing importance on family and communities before themselves. Finally, Indigenous peoples have respect for all things and therefore reciprocity is important for demonstrating this respect. Reciprocity is shown by providing an offering in return for taking something (i.e. laying down tobacco in return for hunting animals) or asking a favour of someone (i.e. asking an elder for advice or for their time) (Getty, 2009).

Wilson (2008) views Indigenous reality not as an object, but rather as a series of relationships that create reality for different peoples. To First Nations peoples land “represents the interconnected physical, symbolic, spiritual, and social aspects of First Nations cultures” (Wilson, 2003). This is important for health as a person can only achieve mino-bimaadiziwin\(^3\) (the good life) by balancing the four tenets of the medicine wheel (physical, mental, emotional and spiritual). A balance of these tenets is a reflection of good health (Malloch, 1989).

One example of an Indigenous concept of health is the notion of balance or holism. It is important to note that biomedical concepts of health differ in that health is considered to be the absence of disease (Ivanitz, 2000). For good health, an individual must seek to balance their physical, mental, emotional, and spiritual health (Malloch, 1989). Additionally, health is further described as “a healthy state in which one is free of pain or discomfort, is at peace with oneself as well as others, and is in harmony with all other elements of one’s environment” (Joe, 2001). Waldram et al., (2006) explain the basis of Aboriginal healing and the reasons Indigenous people understand it to be true:

\(^3\) Biimaadiziwin – Anishinabe saying for “the good life” (Gross, 2002).
“Aboriginal healing is based on tradition, which is to say that, as a medical system, it accepts that the medicines, techniques, and knowledge of the past were effective because they have been time-tested and, in many instances, shared with humans by the Creator” (Waldram et al., 2006; p249)

Exploring concepts of Indigenous health is not a new area of research. It has been explored by researchers in multiple fields of research, for example, community medicine; nursing, human ecology, and geography (Joe, 2001; Turton, 1997; Isaak, 2008; Wilson, 2003). Turton (1997) examined Indigenous concepts of health through ethnographic research and in-depth interviews with approximately 100 Ojibway people. In her study she found that knowledge about health stems from stories that are based on oral traditions passed through generations. Often, these stories are gained through spiritual ways and through elders, who in turn learned it from their elders (Turton, 1997).

Indigenous Knowledge also factors into ways of learning, some of which cross-cut all Indigenous communities and worldviews. A primary way of learning knowledge is through observations and interactions with the environment (Getty, 2009). Indigenous ways for educating are also similar and have five main components. These components are: interactions with other people; interactions with the environment (Traditional Ecological Knowledge (McGregor, 2004)); through stories and visions; customs based on stories; and individual maintenance of spiritual ecology and balance (Getty, 2009). These ways of learning become crucial when discussing the loss of Indigenous Knowledge.
2.1.2 How is Indigenous Knowledge Lost?

Since colonization, Indigenous Knowledge has been decreasing through processes such as environmental dispossession. This is particularly important in the youth context since these processes have hindered their uptake of knowledge. Environmental dispossession refers to the processes by which Indigenous people’s access to their traditional lands and resources are reduced or severed (Richmond et al., 2009).

Environmental dispossession occurs through direct and indirect processes. Direct forms of environmental dispossession involve physical processes that block use of land such as contamination events (e.g. mercury) which sever ties to traditional foods or resources required for sustaining daily activities. Indirect forms of dispossession occur as a result of policies intended to reduce or completely sever traditional links to the environment (e.g. residential schools). In the Canadian literature, processes of environmental dispossession have been linked in significant ways to the local social conditions of Aboriginal communities. For example, among Aamjiwnaang First Nation residents, the petrochemical industry has had considerably negative consequences for the physical, mental and social health of the community (Luginaah et al., 2010; Mackenzie et al., 2005).

Because of the special links between First Nation people and their physical environments (Richmond et al., 2005; Parlee et al., 2005; Wilson, 2003), environmental dispossession has had – and continues to have – disastrous implications for the health of affected communities (Richmond et al., 2009; Adelson, 2003). In Northern Ontario, resource development, such as pulp and paper, mining and the steel industry have exploited the traditional territories of First Nation communities, and have caused concern among community members that their health and cultural identity are at risk.
A major defining cause for the loss of Indigenous Knowledge is attributed to residential schools in Canada. Throughout the years of residential schools Aboriginal students were stripped of their culture and language and taught to be ashamed of who they were as Indigenous people. Instead, the students were taught to live Canadian lifestyles and practice their religions—dissolving their ties to their culture and families (Haig-Brown, 1988). Residential schools targeted children, a life stage fundamental for Indigenous ways of learning. This disrupted the transmission of Indigenous Knowledge and had social and health implications for Aboriginal communities.

### 2.2.3 Health and Social Consequences of Losing Indigenous Knowledge

The relationship between Indians and their environment was so deep that separation from their home territory by forced relocation in the last century constituted, literally, a loss of part of the soul of that whole generation. Indian people were joined with their land in such intensity that many of those who were forced to live on reservations suffered a form of soul death. The major consequence was the loss of a sense of home and the expression of profound homesickness with all its accompanying psychological and physical maladies. They withered like mountain flowers pulled from their mother soil. (Cajete, 1994)

The current health status of Indigenous communities tells us that something is wrong (Gracey et al., 2009). Aboriginal people across Canada are facing tremendous health problems, many of which can be explained by the poor conditions of the local environments, both social and physical; which have resulted from processes of environmental dispossession. Social and health consequences of losing Indigenous Knowledge include a loss of community and community values, and a loss of culture and
identity, each affecting the health of Aboriginal people. The first implication of losing Indigenous Knowledge is the loss of community and community values. Many ceremonies that reinforce a sense of community and associated community values were banned by governments and churches through the enactment of laws and residential schools (Cajete, 2010). This meant that the laws not only affected the transmission of Indigenous Knowledge, but the way that community members interacted with one another. This change in interaction has resulted in Aboriginal youth losing ties to Indigenous Knowledge. Indigenous Knowledge and sense of community are both required for the health of individuals as it gives people a sense of belonging and supports their sense of identity (Cajete, 2010; Baete Kenyon et al., 2011).

The second consequence of losing Indigenous Knowledge is a loss of culture and sense of identity. Culture is defined by Cajete, (1999; p86) as “in its most basic sense, culture is the way in which a group of people have come to relate to a place and its natural processes.” As previously discussed, Indigenous Knowledge is central to Indigenous culture and important for learning about history and the way to relate to the environment and to other people. The combination of community disintegration and loss of identity of youth has manifested in increasing national health disparities, including higher rates of youth diabetes, suicide, teen pregnancy, violence and high school dropouts (Young, 1994; Waldram et al., 2006; Chandler et al., 2004).

“Health, wholeness, and harmony of the individual, family, clan, and Tribal community were the ideal state of life, and therefore the ideal goal of life in community. To reach this ideal state, the tools of ritual, medicine, art, sport, and other formal and informal teaching were used in the context of Indigenous community” (Cajete, 1994; p180).
Indigenous youth that lose their ties to, and knowledge about, the environment are more likely to experience poor health since: “people who don’t have this strong identity to land are less than what they can be, leading them to drugs, alcohol, or domestic violence because they can’t find it within themselves” (Kingsley et al., 2009; p296). On the other hand, research by Baete Kenyon et al., (2011) is guided by the notion that a strong sense of youth identity is directly related to the extent in which they practice their culture. Youth must understand where they come from (both positive and negative stories) before they are able to move forward in developing a strong sense of identity (Wexler, 2009).

Work of researchers show that the loss of Indigenous Knowledge is linked to youth health disparities (Chandler et al., 2003; Chandler et al, 2004; Johnson et al., 1999). The work of Chandler & Hallet (2003) and Chandler & Lalonde (1998; 2004) identified the concept and measurement of “cultural continuities”; communities that were shown to have high levels of these continuities are shown to have fewer suicides than those who had low levels. Johnson & Tomren (1999) described their findings utilizing the terms “loose or tight” in measuring the social integration of communities. Loose social integration implied that communities emphasize individuality and tight integration emphasizes conformity. Communities that had tight social integration and were therefore more traditional than others saw fewer youth suicides. Additionally communities that have quickly undergone changes within social and economic conditions saw more youth suicides than others.

2.1.4 Indigenous Knowledge in the Literature

Indigenous Knowledge has been explored by many different disciplines in order to
understand various topics such as education, environmental change, cultural safety, resource management and empowerment (Ball, 2004; Ohmagari et al., 1997; Wohling, 2009; Simpson et al., 2009; Lauer et al., 2010; McGregor, 2004; Birch et al., 2009).

With regards to education, Ball (2004) utilized Indigenous Knowledge as a means of changing the way First Nation education is undertaken in Canada. Ohmagari & Berkes (1997) examined the link between Indigenous Knowledge and the loss and transmission of bush skills among James Bay Cree women. They found that some losses were a result of skills that were not required for survival.

The environment is another area wherein authors draw from the concept of Indigenous Knowledge in their research. Wohling (2009) provides a critical analysis of Indigenous Knowledge for resource management in Australia. Based on the literature, he questions whether Indigenous Knowledge is able to adapt to the scales and disturbances imposed by society on ecosystems. Research involving the Grassy Narrows and Wabauskang First Nation community members studied the impacts of environmental contamination on health and well-being of women and children by combining Elders’ Indigenous Knowledge and western science. Traditional foods were tested for contamination by the community and Simpson et al., (2009) explored the perceptions of the continuing impacts within the communities. Lauer & Aswani (2010) examined how resource management could be adapted by exploring how Indigenous Knowledge shapes the use of resources. McGregor (2004) examined the link between Indigenous Knowledge and Traditional Ecological Knowledge (TEK) through a review of literature.

In terms of Aboriginal healthcare, the number of hospitals being used by Aboriginal women for childbirth is increasing. As such, Birch et al. (2009) utilized literature on Indigenous Knowledge surrounding experience with western healthcare, childbirth beliefs;
and knowledge on health as a means to redesign cultural safety in the hospital for childbirth.

Work in the area of empowerment and decolonization has been done by researchers such as Simpson & Driben (2000); Simpson (2004); Wilson (2004). Simpson & Driben (2000) utilized Long Lake First Nation as a case for research that satisfies both academics and Aboriginal communities. Simpson (2004) used Indigenous Knowledge as an anticolonial strategy. She believes this must be done through protection of the land, revitalizing language and redesigning the face of education. Wilson (2004) argues that Indigenous Knowledge recovery is the key to empowerment through modes such as food and education. While there have been significant increased in the use of Indigenous Knowledge for understanding research areas, none of the above studies explored Indigenous Knowledge in the youth context.

2.2 Indigenous Youth Health

As previously mentioned, it is well documented in the literature that disparities in Aboriginal youth health can be linked to the quality of their local social environments (e.g. violence, suicide, addiction, diabetes). Much of this research has focused on describing these conditions from the perspective of the researcher. Literature that has examined these health conditions from the perspective of youth has been minimal (van der Woerd et al., 2005; Tiessen et al., 2009; Cargo et al., 2007; and Blum et al., 1992).

Furthermore, the body of literature that has examined Indigenous youth health have focused on the self-rated health conditions of youth, rather than their perceptions and definitions of health (van der Woerd et al., 2005; Tiessen et al., 2009; Cargo et al., 2007;
and Blum et al., 1992). While work in this field has been minimal, the method used most often in these studies has been the structured questionnaire. Blum et al., (1992) conducted an extensive youth survey of American Indians and Alaska Natives. In their work, they surveyed 13,454 youth between grades 7 and 12 in order to assess the risk behaviours and health concerns of the youth. Risk behaviours were compared to Caucasian youth and rates of risk behaviours were found to be higher in the Native population. The results recognized the need for culturally appropriate interventions.

A different study examined youth self-rated health in British Columbia (van der Woerd et al., 2005). The authors of this study, interested in improving the health of youth, are based out of a non-profit organization called the McCreary Centre Society. Similar to Blum et al. (1992) the survey was extensive and involved 4,800 youth residing in British Columbia. Questions included pertained to community involvement, physical health, emotional health, and smoking, among others. Results indicated positive trends (e.g. decrease in smoking and alcohol consumption) and that geography (i.e. the region in which the youth live and whether they are on or off reserve) matters when it comes to youth health.

Cargo et al., (2007) utilized a mixed-method approach to their research. Attempts were made to develop research that is culturally relevant (the inclusion of community members throughout research process and focus on cultural concepts of health i.e. the medicine wheel) Focus groups with youth were used for the development of the survey questions and structure. Self-rated health questionnaires were handed out to youth in high school. Health was measured through the use of Likert scales (very poor to excellent), enabling the researchers to undertake a statistical analysis of youth responses.
A study done by Issak et al., (2008), most closely resembles the work of this thesis. Their study explored perceptions of health in both the adult and youth context. Interviews occurred with adults, whereas focus groups were used with youth as a way to understand their perceptions of health. Issak et al. found that concepts of health identified by youth were the same as those that represented the medicine wheel. The interview guide utilized similar base questions as those in this research including: “what does being healthy mean to you?” and “how does your health compare to past generations’ health?”

As a means of contributing to this small body of literature on First Nations youth health, my work drew from a qualitative method that enabled youth the opportunity to discuss what health and well-being meant to them instead of applying preconceived notions of health and measuring their self-rated health, like previous studies have done. While similar in ways to Isaak et al., (2008), my research differs with respect to the concerted effort made to understand youth perceptions of social relationships. As demonstrated above, youth perceptions of self, family and community health conditions have not been well explored in this literature. Youth perceptions are important in order to redirect research and policies that will improve other health conditions.

2.2.1 Indigenous Knowledge and Aboriginal Youth

As evidenced by Aboriginal youth health conditions, something must be done to improve the situation. Not only is this a local issue in communities across Canada, but continuation of current inequalities will manifest into a greater national problem. The reason for focusing on Aboriginal youth is two-fold; the first reason is that the youth are the future of the population. Knowledge must be passed on to this generation as those
who hold knowledge – Elders - are passing on and taking that knowledge with them. Secondly, the rapid rate of growth of the Aboriginal youth population means that money will need to be funneled into this population both if the situation continues or worsens, for example through social assistance or healthcare. If Canada continues on the current approach without addressing the massive inequalities in Aboriginal youth health, the costs for health and social care spending will be substantial (Jamieson, 2008; Townsend & Wernick, 2008; Steffler, 2008). Additionally – strategies for youth empowerment has produced “multiple empowerment and health outcomes: strengthened self and collective efficacy, group bonding, sustainable youth groups, participation in social actions, and policy changes, leading to improved mental health and school performance” (Wallerstein & Duran, 2006; p318).

2.3 Indigenous Geographies

This work adds to the broader geography literature by examining the unique physical and social environments of a Northern Ontario First Nation community. More specifically, through the case-study of Pic River First Nation it also adds to the Indigenous and health geography literature by exploring how these local environments and processes of environmental dispossession shape the health of Anishinabe youth.

Geography is described as “the study of the earth as the home of humans, a perspective on the world that includes anything occurring on the surface of the earth that has a spatial or locational aspect” (Rundstrom et al., 2000; p86). Based on this concept, I believe this research is geographic as it is locational and focuses on a particular First Nation community (Pic River First Nation) along the northern shores of Lake Superior. Not only
does this research focus on a particular place, it also emphasizes the spatial and social interactions within that place. Additionally, while this community may be categorized as one of many First Nation communities across Canada – regional and spatial variations amongst these communities means that each community is unique in its own way and cannot be generalized to be the same as the others. While the language spoken in this community may be the same as in other Anishinabe communities, the dialects vary as a result of regional variation. It is important to understand this regional variation in order to preserve the local knowledge and traditions of the Ojibways of the Pic River First Nation. These community variations are shaped by physical landscapes, resources, the local people, historical events and processes.

In North America, various topics within the Indigenous Geography field have been covered by researchers such as Louis (2007), Smith (2008), Panelli & Tipa, Rundstrom and Herman. Louis (2007) utilizes her expertise in cartographic methods to explore Indigenous cartographies. Additionally, she provides a review of Indigenous methodologies and emphasizes the main goal of this method is “to ensure that research on Indigenous issues is accomplished in a more sympathetic, respectful, and ethically correct fashion from an Indigenous perspective” (Louis, 2007; p133). Smith (2008) examines Indigenous uses of GIS (mapping land use, and wild rice); for example by aiding the Bois Forte Reservation so that they may utilize GIS for land planning and claims. In this example traditional knowledge is preserved by recording place names and information in the local languages by community elders which are then presented spatially as maps. Panelli & Tipa (2009) provide a review of food geographies as a means for understanding how food, environment, society and culture impact health and well-being for Indigenous people. Rundstrom et al. (2000) provide a review of Indigenous Geography research in the United States and
Canada. Areas of geographical research discussed by Rundstrom et al. include: resources, sovereignty, dispossession, land restoration, sacred land, economic development and planning, gambling and tourism; postcolonialism and maps and GIS. In terms of resources, research has been done on topics such as community water allocation; flooding responses; plant and wildlife control; and land management. Sovereignty research has looked at land claim issues and land-use decision making and; dispossession through cases of reserve land utilized for other purposes, such as internment camps during World War II. Land restoration includes cases such as the regaining of Grand Canyon National Park land by the Havasupai. Sacred land research has occurred for documentation of the land for land-claim purposes. Economic development research has occurred in areas of tourism, land use and gambling; while planning research has focused on health care access and frameworks for establishing relations between communities and government. Gambling and tourism research has centred around gambling facilities and arts and crafts. Postcolonial research generally describes the impact European worldviews have had on Indigenous people, through their lands, minds and bodies. Lastly, as discussed by Rundstrom et al., (2000); research has occurred in areas of mapping & GIS; for example Inuit in Nunavut redesigned Canada’s map to have their own names and entitled it the Nunavut Atlas. This approach has been done by other communities and has been termed “mapping back”. Herman (2008) provides a review for the importance of Indigenous Geographies including the history and defining moments. He also explores one of his projects – Pacific Worlds – an internet project towards cultural preservation and education.
2.4 Indigenous Health Geography

While many topics have been covered in the Indigenous Geography literature, much work remains in the use of geographic perspectives for understanding health and wellness of Indigenous peoples. While there have been few researchers in Canada that have studied Indigenous Health Geographies, the work done has been influential in guiding the theoretical and methodological foundations of this research. Specifically, the importance of place (i.e. local social and physical environments) in shaping the health of individuals and communities. The results of this thesis will add to the growing base of Indigenous health geography. Researchers within this field of research include: Wilson (2003; 2008; 2010), Richmond (2007; 2008; 2009), Rosenberg (2010), Thouez (1989; 1990), Place & Hanlon (2009), McGregor (2004; 2006; 2009), Newbold (1999), Walker (2008) & Peters (2005), Castleden & Garvin (2009), Masuda (2010), and Luginaah (2010).

Health geographers that have worked with quantitative methodology include: Wilson & Rosenberg (2010); Richmond, Ross & Egeland (2007); Richmond (2009); Crighton & Wilson (2010); and Thouez (1989; 1990). Researchers have used the Aboriginal Peoples’ Survey (APS) for statistical analysis in order to examine the health and healthcare of Aboriginal elders, for the study of asthma within the Aboriginal population, and as a way to understand social support in the Canadian Arctic (Wilson et al., 2010; Crighton et al., 2010; Richmond et al., 2007; Richmond, 2009). Other research has utilized questionnaires to explore health care use and diabetes among the Cree and Inuit (Thouez, 1989; 1990).

Qualitative methodology within the health geography literature has been used by multiple researchers including: Luginaah (2010); Wilson (2003); Castleden & Hanlon
Interviews appear to be the qualitative method of choice. Interviews have been used to explore therapeutic landscapes, palliative care, perceptions of risk (e.g. mining), access to social support, aquatic risk in the Canadian Arctic (Luginaah, 2010; Wilson, 2003; Castleden et al., 2010; Place et al., 2009; Richmond et al., 2008; 2009; Giles et al., 2010). Other methods have included photovoice and a focus on community-based participatory research (Castleden et al., 2009).

With respect to areas of specialities within health geography, research within the urban geography field has involved urban populations and demographic characteristics of Aboriginal people across Canada, Aboriginal housing in Canada, Indigenous rights and determination, and the determinants of health (Peters, 2005; Walker, 2008; Wilson et al., 2010).

Work concerned with social and physical environments (i.e. the importance of place for shaping health) have been studied through environmental justice (Masuda, 2010; Luginaah, 2010; McGregor, 2009), Indigenous Knowledge (McGregor, 2004), traditional ecological knowledge (McGregor, 2004), resource management (McGregor, 2006), community-based research (Giles et al., 2010; Castleden et al., 2009), social determinants of health (Richmond, 2007; 2009; Wilson et al., 2002), and photovoice (Castleden et al., 2009).

Aboriginal health research has been an area of increasing focus in the discipline of health geography. There is much work left to be done, especially with respect to Aboriginal youth health. The youth population is quickly growing and there is a need for improved health and social conditions.
2.5 Social Relationships

2.5.1 Social Relationships

Social relationships or social networks are “the nature and extent of linkages between individuals” (House et al., 1988; Kirmayer et al., 2009). They are maintained through reciprocity, which is the assumption that if someone does something for you, you will do something for them in return (Plickert et al., 2007). The sources of social relationships are many and varied, and they have been identified and extensively examined through studies. In the most general sense, these sources include marriage, close friends and relatives, church membership, and informal and formal group associations (Berkman et al., 1979), and research on these relationships indicate that, independent of health behaviours such as diet or smoking, the greater the number of social ties one has, the better their health (e.g. they live longer and with less complications). Within the Aboriginal context, there seems to be a greater dependence on informal (e.g. family, friends) rather than formal networks (e.g. hospitals) of support (Newbold, 1999).

People with fewer relationships are more likely to suffer morbidity and early mortality as they are more likely to suffer psychologically or physically (e.g. depression, cardiovascular problems) (House et al. 1988; Berkman, 1995). In the Aboriginal context, the unique community structures, and their geographic remoteness means that social relationships are important for overall health and well being. This area of research is one that has been well documented by researchers in the adult context, but not within the youth
context. Furthermore, it has not been explored through the perspective of Aboriginal youth (Richmond, 2007).

### 2.5.2 Social Relationships and Health

Social relationships have been identified to have both positive and negative implications for health (House et al., 1988). Umberson et al., (2010) identified three mechanisms by which social relationships are able to influence the health of individuals (e.g. behavioural, psychosocial, and physiological). Behaviourally, relationships can improve health through the encouragement of exercise and nutritional habits. Psychosocially, good relationships provide social support and physiologically they can improve the functioning of body systems (e.g. the immune, endocrine, and cardiovascular systems) by reducing stress. Alternatively, these are areas also hindered by poor social relationships as these relationships may negatively impact behavioural, psychosocial, and physiological aspects of individual health.

Examples of the negative implications of social relationships for health include pressures to smoke, social isolation, stress, and other influences on health behaviours such as alcohol consumption (Berkman, 1995). Social pressures to smoke have been identified to come from families and historical influences in Australian Aboriginal communities (Johnston et al., 2008; Wood et al., 2008). These pressures can have negative implications for the health of pregnant women and their babies in situations where women continue to smoke during pregnancy. In these communities, smoking may be perceived to relieve stress among pregnant mothers, but with little consideration for the health effects on the growing fetus. It is important to note that significant changes in the cultural and social aspects of a
person’s life have also been found to negatively impact health (Berkman et al., 1979), for example, mental health issues such as depression. This has implications for the Aboriginal health context as cultural and social conditions have changed immensely in a short period of time.

Social isolation can also negatively influence health through its affect on one’s mental health (Berkman, 1995; Kawachi et al., 2001). Individuals with few or no social relationships may suffer from psychological problems such as depression or stress. This stress may lead to physiological problems, for example, increased blood pressure which in turn damages the body’s blood vessels and heart. Over time, these damages can lead to heart attack or stroke (Berkman, 1995). Furthermore, social relationships can affect health through embeddedness within a social network, and the influence of one’s social ties on health behaviours. For example, friends or family may promote or encourage behaviours that are harmful to the body or mind, for example through an exercise buddy, or in the case of alcohol consumption (Berkman, 1995). Research has found differences in the health of men and women (House et al., 1988; Berkman et al., 1979). Positive implications for health are associated with married couples that maintain satisfying relationships (Berkman et al., 1979). Other positive implications include the influence of a spouse on one’s health behaviours, for example in seeing a doctor, and through the socially supportive ties they provide (Richmond, 2007; 2009; Wilkinson et al., 2003; Raphael, 2004; House et al., 1985; 1988).

At the most basic level, social support is defined as the resources of one’s ties (Cassel, 1976; House, 1981). Social support is an important determinant of health; research indicates that social support is not an equally accessible resource however, and in fact we know that the social resources shared through our social ties can both improve or hinder
health. Within the social epidemiological literature, there are four generally accepted types of support: positive interaction, emotional support, affection and intimacy and tangible support (Kaplan et al., 1977; House, 1981). These types of social support have been validated for use among Aboriginal adults, and the independent effect of these types of social support on the health of First Nation adults has been evidenced (Richmond et al., 2007). However, no Canadian research has examined the meaning of social support among First Nation youth. This is an important area to consider so that future programs and policies may be geared towards their needs.

In summary, this thesis is theoretically and methodologically unique in that it incorporates First Nations youth into the field of Aboriginal health research. Further, it is theoretically situated within the Indigenous Knowledge, health geography, Aboriginal health, and social relationship literature. The bridging of these fields is important for understanding the complexity of the social and cultural processes that shape the health of First Nations youth. A qualitative methodology further enhances the uniqueness of this research by seeking youth perceptions of health and social relationships through the method of interviews.
3. RESEARCH DESIGN, METHODS & ANALYSIS

This thesis utilized a community-based participatory research, framed by qualitative methods, to examine youth perceptions of health and social relationships. In-depth interviews were selected as the research method due to its flexibility and freedom for youth responses to interview questions. This chapter discusses the study design, methods, and analysis of the research. It is structured around five components, including: the research design, data collection, participants and recruitment, analysis, and plans for disseminating the results to the community of Pic River First Nation.

3.1 Research Design

“In all community approaches process – that is, methodology and method – is highly important. In many projects the process is far more important than the outcome. Processes are expected to be respectful, to enable people, to heal and to educate. They are expected to lead one small step further towards self-determination.” (Tuhiwai Smith, 1999; p128)

In 2007, the Canadian Institutes of Health Research (CIHR) developed the Guidelines for Health Research involving Aboriginal People in co-operation with the CIHR Institute of Aboriginal Peoples’ Health as a way to protect Aboriginal people and their knowledge, and to ensure that Aboriginal health research is undertaken in an ethically sound and culturally respectful manner. The Guidelines helps researchers and communities to design and undertake health research that is mutually beneficial for both. The Guidelines contains 15 articles that guide Aboriginal health research in a way that ensures respect and research partnerships that are not exploitive of Aboriginal people. Some of these articles
involve the understanding and respect of Aboriginal worldviews; that researchers must obtain consent from community leaders; researchers must give communities the option of participatory-research; discuss the benefits of research to the community, and also ensure the community understanding and discussion of ownership, control, access and possession (OCAP) of research and knowledge. My research adhered to these Guidelines and utilized the participatory research methodology.

As mentioned, one of the methodological approaches that I have utilized in this research is Community-Based Participatory Research (CBPR). This was the best approach for this research since CBPR is a decolonizing method. A decolonizing method allows communities to take back research, or “research back” since research was historically done on Indigenous people through an imperial lens (Smith, 1999). Essentially, CBPR gives voices to the community and research participants by including their opinions into the decision-making process. For example, throughout this research process community collaborators were involved in multiple stages of the research, to be further discussed in subsequent section (3.3 Participants and Recruitment). CBPR integrates education and social action as a means of improving health (Wallerstein et al., 2006). There are four primary principles of CBPR, these include: “a) genuine partnership means co-learning (academic and community partners learning from each other), b) research efforts include capacity building (in addition to conducting the research, there is a commitment to training community members in research), c) findings and knowledge should benefit all partners, and d) CBPR involves long-term commitments to effectively reduce disparities” (Wallerstein et al., 2006; p312; Israel, 2003).

One of the key values of the CBPR approach is that it “can support the development of research questions that reflect health issues of real concern to community members”
(Minkler, 2005, pii5). This value is reflected in my research, as the interview guide and questions were developed through discussions with youth and elders. The questions reflect important community issues, for example, health and social conditions. Further importance of this methodology is the implication it holds for youth. “Youth interventions, for example, have produced multiple empowerment and health outcomes: strengthened self and collective efficacy, group bonding, sustainable youth groups, participation in social actions, and policy changes, leading to improved mental health and school performance” (Wallerstein at al., 2006; p318). By focusing on youth in this research, their involvement may ultimately encourage them to take an interest in their health, and that of their community.

My Masters project received ethical approval from the Non-Medical Ethics Research Board of The University of Western Ontario (Appendix A). As discussed, one component of the CIHR Guidelines involves the option of participatory-research. For example, one well known CBPR method is the photovoice method. Originally, this method was planned as a central data collection method for this research. The use of Photovoice methods with the youth would have allowed them to participate in very meaningful ways in the research. Through the use of this method, youth would have centrally directed the research questions and answers through their photos. However, after distributing seventeen disposable cameras to the youth, none were returned. A month into the research, it became clear that improvisation would be necessary and the in-depth interview subsequently became the main source of data collection. While the use of the Photovoice method would have enabled an interesting visual and highly participatory component to the study, there were several possible reasons why it did not work in this circumstance, such as the difficulty capturing desired images using a disposable camera, among others.
The research undertaken in this thesis is just one part of a larger multi-year, community-based project with three Anishinabe communities along the northern shore of Lake Superior. The larger project was developed with the communities of Red Rock Indian Band, the Ojibways of the Pic River First Nation and Batchewana First Nation by Professor Chantelle Richmond and other co-investigators from Lakehead University and The University of Western Ontario. Prior to the start of my Master’s project, this larger project had already been developing, and had secured funding and significant community support. This assisted me on many levels including the ability to tap into pre-existing trusting relationships, access to financial, material and social resources needed to travel to the North to conduct the research, participant recruitment, and greater ease with circulating project advertisements.

Gaining community trust as an outsider can be difficult to achieve (Smith, 1999). As previously mentioned, past research with Aboriginal communities was not always done with good intentions, thereby creating a disconnect between researchers and communities (Smith, 1999). As a researcher and non-band member of Pic River First Nation, I am considered an outsider to the community. The influence of the on-going project thereby had a directly influence the trust I received, in particular as a result of the role of my supervisor (Dr. Chantelle Richmond) and a local Research Assistant hired into the larger grant to act as a co-interviewer (Michelle Richmond-Saravia, a graduate student at Lakehead University). Both are band members of the Ojibways of Pic River First Nation and are very familiar with the local people and land. Their connections allowed me to be introduced to community members. While I am an outsider to the community, I am an insider culturally due to my status as a First Nation woman. Having grown up in a First Nations community, my community holds similar traditions and has experienced similar
effects of environmental dispossession (e.g. loss of knowledge). Additionally, being a youth as well, made me an insider to the youth and connected me to the participants as I am similar in age and familiar with the generation. However, my status as a graduate student may have been intimidating to some youth. As documented in the literature, my position as both an Indigenous person and a researcher may have predisposed me to power imbalance (Smith, 1999). Nonetheless, I believe that I did receive trust from the youth and community as a result of my community connections to my supervisor and the Research Assistant, and community collaborators. This was essential in the interview process, so interview data would be meaningful and true.

3.2 Data Collection

Indigenous Knowledge can be incorporated into all stages of research. Within the field of health geography, Indigenous Knowledge can be used when developing research questions, or even before then, through considering ways of approaching potential Aboriginal research participants or communities. In the research methods process, this knowledge can be used for choosing the most appropriate method in which to gather information. Loppie (2007) suggests story-telling and group discussions to be culturally appropriate methods as they are traditional ways of learning knowledge. Herman (2008) believes the importance of an “Indigenous Geography” is the ability to connect different areas and values (i.e. cultures, politics, social geography, and the environment) within geography and to integrate them holistically. Herman also believes that “Native Science” or knowledge is imperative should the western world wish to fully understand the connections between humans and the environment (Herman, 2008).
The opposite of Indigenous Knowledge is medical geography. Medical geography has traditionally followed a positivist, and very linear way of thinking, educating and undertaking research. This includes learning knowledge based on formal education, objective knowledge, based on models and theories, and also explanations that stem from hypotheses, theories and laws (Wilson, 2003; McGregor, 2004; Crowshoe, 2005; Kearns et al., 2010). Health geography has expanded medical geography’s concept of good health to include well-being instead of only focusing on the presence or absence of disease (Kearns et al., 2010). Qualitative methods have not traditionally been used in medical geography as quantitative methods suffice for describing rates of and spatial patterns of disease. Health geography differs in this respect as the questions it seeks to answer demands the inclusion of qualitative and mixed methods for understanding health and well-being (Kearns et al., 2010). These methods are essential for understanding how Indigenous Knowledge works in the everyday lives of youth and for insight as to why the social and health conditions of the communities are the way that they currently are, and for developing strategies to preserve Indigenous Knowledge.

### 3.2.1 Interviews

In the field of health geography, the most popular choice of qualitative method is the interview (Eyles, 2008; McDowell, 2010). Interviews are conversations between an interviewer and individual in order to gather information from individuals pertaining to certain topics and questions (Harrell, & Bradley, 2009). Within the context of qualitative research, interviews are primarily used for research purposes in order to understand topics as understood by the individual and gain depth of understanding with respect to that topic.
McDowell, 2010). Valentine (2005) describes interviews as taking a “conversational, fluid form, each interview varying according to the interests, experiences and views of the interviewees”. They are useful for the collection of data pertaining to two main areas; one is to obtain background information from a participant; and the other is to gather opinions, perceptions and attitudes from the participants. Some interviews only look at one of the two, whereas some include both (Harrell et al., 2009). As Indigenous Knowledge is based on oral traditions, the interview is more culturally appropriate in comparison to quantitative methods such as surveys. In this research, interviews were usually one-on-one with a few exceptions. An exception was made for one set of participants who preferred a combined interview.

3.2.2 Types of Interviews

There are three types of interviews that may be utilized by researchers including, structured, semi-structured, and unstructured interviews (Gill et al., 2008; Cloke et al., 2004). Structured interviews are “verbally administered questionnaires” that are based on a set of questions administered by the interviewer (Gill et al., 2008; Valentine, 2004). This type of interview allows for little derivation from the outline as follow up questions to responses are not included. Unstructured interviews are the opposite of structured interviews in that there is little structure and organization to the interview. Interviews begin with an initial question and additional questions are derived as follow up to interviewee responses. Semi-structured interviews incorporate aspects from both structured and unstructured interviews. Here, interviews consist of a set of guideline questions but leaves room for improvisation of question order, if necessary. This flexibility is important so that
the interviewer is not required to interrupt the flow of conversation (Gill et al., 2008).

Depending on the depth of knowledge and understanding sought by researchers a particular type may be most appropriate. Structured interviews do not enable much room for depth of understanding due to the stringent guidelines. Unstructured interviews allow for much depth but due to little organization, conversation may deviate from areas important to the researcher. Semi-structured interviews on the other hand, enable the best of both worlds through use of guideline questions while still maintaining the opportunity for the interviewee to expand on topics of importance. Additionally, each type of interview is associated with a level of interviewer power; structured interviews grant the interviewer with the most power and unstructured with the least (Harrell & Bradley, 2009). Semi-structured interviews are best suited for power balance as it allows the interviewer to guide the conversation but still allow the interviewee to speak about important concepts. Based on the above – semi-structured interviews seemed appropriate for this research.

3.3 Participants and Recruitment

This research was undertaken with youth from the Ojibways of the Pic River First Nation, and it forms part of a larger community-based project involving two other communities (Red Rock Indian Band, Batchewana Nation of Ojibways). My Master builds on research initiated the summer of 2009, wherein perceptions of health and education were explored in the communities of Red Rock and Pic River. Dr. Chantelle Richmond and I led focus groups with the youth (health and education) and elders (changing environments and health). These focus groups allowed the communities to identify research areas including; local health and improving social health conditions (e.g., addictions, abuse, and family
problems) and involvement of local youth. Elders addressed concerns over the weakened Indigenous Knowledge over time. Also of concern was the disconnect between elders and youth and the need to find a way to reconnect the two generations. The elders pointed to environmental change as cause for disconnect and loss of knowledge. An example of environmental change discussed by the elders was the building of the TransCanada highway and the close proximity of the highway to Pic River.

This research was community-based in approach and involved the community in multiple research steps including: identification of research areas, development of interview questions, participant recruitment and meetings. My co-interviewer is a band member of the Ojibways of Pic River First Nation and her assistance was beneficial to me throughout the entire research process. Her knowledge of the community, both geographically and socially was essential in many steps of the research for example, gaining trust of community members and participant recruitment. She was also essential for transportation (from Thunder Bay to Marathon and Marathon to Pic River) as I was not able to drive.

Interview development occurred in the spring of 2010, and was honed while sitting around a fire with a community collaborator and elders in July 2010. The original template was designed for the Photovoice project but since themes were the same, we applied the questions to the interviews. The questions focused on four themes including: health, social relationships & culture, land & environment, and learning & education. For the purpose of my thesis, I was primarily interested in sections of the interview that examined health and social relationships & culture.

An introductory meeting for research information was held on July 7th at the Pic River Community Centre. At this meeting community collaborators and researchers were available to discuss the components of the Photovoice study and invited all interested youth
to return the following night (July 8th) for the Photovoice workshop. The workshop
introduced youth to the Photovoice method and research expectations. Seventeen youth
(between the ages of 14-30) were given cameras and asked to take photos that convey their
understandings of topics such as: what does health mean to you as an Anishinabe youth;
and what is the importance of social relationships to you? Following photo-taking the youth
were asked to participate in interviews based on the photos taken. As previously stated –
cameras were not returned and therefore we focused solely on interviews.

Interviews were co-conducted in August 2010 (by myself and co-interviewer, Michelle) and involved the participation of 21 Anishinabe youth. The interviews were
scheduled during the work hours of youth allowing them to be compensated by their
employers. Interviews were recorded, with the permission of youth. Participation in this
study was voluntary and included an honorarium in the form of a gift certificate.
Community collaborators were very helpful and important throughout the participant
recruitment process as they scheduled interviews for the week of our (myself and co-
interviewer) return to Pic River.

3.4 Interview Analysis

This research utilized an inductive approach in the interview analysis. There are
three primary purposes for the use of an inductive approach (Thomas, 2003). The first
purpose is to condense the data, so that it summarizes the main ideas. The second is to
determine links between the main ideas and research objectives. The third purpose is in the
creation of models or theories based on findings (Thomas, 2003). The analysis of this
research is structured around the main purposes outlined. The following section details the
As mentioned, the first purpose of the inductive approach is to condense the data. In the context of this research, this was done through coding. There are multiple ways to code interview transcripts including the use of computer software programs or using pen-and-paper. I chose to utilize computer software, specifically NVivo 9, as a way of organizing my codes. The coding method I decided to use in the analysis of the interviews was open-coding; the assigning of codes or ideas to text as they emerge beside the line or sentence (Crang, 2005).

An excerpt from one interview is included below; it is followed by the process of analysis in which I undertook.

**Interviewer:** What does the land mean to you as an Anishinabe youth?

**Youth:** I think it means everything, its life! We get everything from here rather it be locally, whether it be hunting, whether it be blueberry picking, whether it be staring, as Anishinabe youth this is home! It’s important and again like I said it wasn’t until the last two years of it that I started realizing how important it was. How important – you don’t stop and realize that our drinking water is important, you don’t stop and realize that recycling is important, you don’t stop and realize how much garbage you put out. Any of that stuff, what kind of food you get, until you’re told that you can – blueberry picking, you can’t do because they spray insecticides, you know, but that was one of my favourite pass times, going out with my Granny and stuff like that, but you know what? Couldn’t do it the last couple of years because of that and now you go out and you find little patches here and there, that just kind of concerns me for the future, you know what’s it going to be like 20 years from now?

The process of analysis occurred through the following series of steps: reading of text, open coding, and identification of main themes through the frequency of codes. The first step for the analysis of results was reading each of the transcripts. This allowed me to take in my initial perceptions of themes that I believed emerged from the interviews. After reading all of the transcripts, I began the process of coding.
I began assigning codes as free nodes in NVivo 9. Once I began to see distinct categories (e.g. Environment & Land, or Health Perceptions), I merged free nodes into tree nodes. These tree nodes were followed by subcategories (child nodes) when themes emerged within tree node categories (e.g. Definitions of Good Health within the category of Health Perceptions). Using the example above, I coded the entire response within the category of Environment & Land. It was further coded as “Land = Life”.

How important – you don’t stop and realize that our drinking water is important, you don’t stop and realize that recycling is important, you don’t stop and realize how much garbage you put out. Any of that stuff, what kind of food you get, until you’re told that you can – blueberry picking, you can’t do because they spray insecticides, you know, but that was one of my favourite pass times, going out with my Granny and stuff like that, but you know what? Couldn’t do it the last couple of years because of that and now you go out and you find little patches here and there, that just kind of concerns me for the future, you know what’s it going to be like 20 years from now?

This second half of the response was coded as Environmental Change, and later merged within the category of Indigenous Knowledge.

The second step in the inductive approach was to determine links between the main ideas and research objectives. This was done after I finished assigning codes. Here, I identified the main codes within nodes and identified key themes that related to my research objectives. With these key themes I created tables to illustrate the total number of times each theme was mentioned and number of individuals that mentioned each theme (see Table 4.1 in Chapter 4).

After completing the tables, I was able to begin the third step: the creation of models or theories based on findings. Organizing the findings of the research through tables allowed me to visualize the key findings. The key findings of this research are outlined in
the next chapter, and then a discussion of the results and a conceptual framework are provided in Chapter 5.

3.5 Plans for Dissemination

In Spring 2011, I plan to return to Pic River to disseminate the results of this thesis by holding a community feast. The dissemination of results to the community is an important component of the CIHR Guidelines. It allows the community the opportunity to actively engage with researchers, listen to the results, and ask any questions. Furthermore, this presentation will allow the community the opportunity to discuss next steps for research and local policy.
4. RESULTS

This chapter outlines the results of the Anishinabe youth interviews conducted by both myself and co-interviewer, M. Richmond in August 2010. Interviews centred around four main objectives including: 1) understanding how Anishinabe youth define health & well-being; 2) exploring youth perceptions of social relationships; 3) examining how social relationships influence health; and, 4) understanding how culture shapes health. The results chapter is sectioned according to the above objectives. Those objectives are further divided into the main themes identified.

To protect the identity of the youth, interview quotes utilized pseudonyms chosen by the youth instead of their real names. Additionally, due to the small group size, ages and sex of participants were not included with quotes for further protection of youth identity.

4.1 Youth Definitions of Health

Anishinabe youth were asked to define health in terms of individual, family and community levels. For each level, youth defined health (both good and poor) in terms of their own perceptions and knowledge. As youth broadened their scope of health definitions (i.e. starting with the individual level out to community level), their concepts of health also changed. Interestingly, the individual level identified the person to be responsible for their own health, whereas when conversation changed to community health, the community as a whole was deemed responsible for overall health (e.g. community involvement in activities, participation in workshops).
4.1.1 Individual Health

Individual health was described in terms of the four quadrants that make up Aboriginal health and well-being (physical, spiritual, mental and emotional health). As such, these quadrants were used as a way to break down and illustrate youth definitions of health for individual health. As previously stated, individual health definitions often referred to factors (e.g. active lifestyle, food choices) that put the health of a single person into their own hands. These definitions therefore, made the outcome of one’s health (e.g. good or poor health) the individual’s own responsibility.

4.1.1.1 Good Health

Table 4.1
Youth Definitions of Good Health

<table>
<thead>
<tr>
<th>Descriptors of Good Health</th>
<th># of Mentions</th>
<th># of Respondents Mentioning (n=19) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Health</strong></td>
<td>86</td>
<td>18 (95)</td>
</tr>
<tr>
<td>Putting Good Things Into Body</td>
<td>24</td>
<td>13 (68)</td>
</tr>
<tr>
<td>Active Lifestyle</td>
<td>19</td>
<td>11 (58)</td>
</tr>
<tr>
<td>Healthy Figure</td>
<td>8</td>
<td>8 (42)</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>15</td>
<td>7 (37)</td>
</tr>
<tr>
<td>Confidence</td>
<td>2</td>
<td>2 (11)</td>
</tr>
<tr>
<td>Non-Judgmental</td>
<td>4</td>
<td>3 (16)</td>
</tr>
<tr>
<td><strong>Spiritual Health</strong></td>
<td>19</td>
<td>7 (37)</td>
</tr>
<tr>
<td>Beliefs</td>
<td>2</td>
<td>2 (11)</td>
</tr>
<tr>
<td>Taking Care of Your Spirit</td>
<td>2</td>
<td>2 (11)</td>
</tr>
<tr>
<td>Participation in Cultural Activities</td>
<td>3</td>
<td>3 (16)</td>
</tr>
<tr>
<td><strong>Emotional Health</strong></td>
<td>18</td>
<td>7 (37)</td>
</tr>
<tr>
<td>Positive Emotions</td>
<td>5</td>
<td>5 (26)</td>
</tr>
<tr>
<td>Abstaining from Negativity</td>
<td>2</td>
<td>2 (11)</td>
</tr>
<tr>
<td>Expressing Feelings</td>
<td>2</td>
<td>2 (11)</td>
</tr>
<tr>
<td><strong>Balance</strong></td>
<td>11</td>
<td>5 (26)</td>
</tr>
</tbody>
</table>
Youth definitions of health tended to weigh more heavily on the physical component of the four quadrants when describing individual health (86 mentions, by 18 youth). In terms of physical health, youth perceived good health to be factors of maintaining a healthy figure, exercise, and what people choose to put into their body (e.g. healthy food).

A person that maintained a healthy body weight and figure appeared to give the impression of good health (8 respondents). Lydia spoke of this using an example of a person that is physically fit as a result of working out:

*I think good health to me is being healthy, like physically, being fit and working out, eating healthy, eating right.* (Lydia)

Jaelyn further indicated that a component of good health is a person that is not overweight and whose physical appearance would be small figured or slim.

*Interviewer: What does good health mean to you?*
*Jaelyn: Exercising, eating right, not being overweight.*
*Interviewer: If you had an image that you considered to have good health or to be healthy, what would they look like or how would they act?*
*Jaelyn: Probably, I don’t know, be small figured.* (Jaelyn)

Thirteen youth discussed health in terms of what people choose to put into their bodies (e.g. food, drugs and alcohol). Nutritionally, a person that eats a diet of primarily healthy food was viewed as a type of person that would have good health:

*... Eating properly like your fruit, your vegetables – basically being healthy is just – I don’t know – basically living, but it’s taking all the abuse of substances out there out of it.* (Walking Turtle)

*Healthy eating, staying fit – really just health – lifestyle and just keeping yourself intact.* (Whistling Dixie)
In terms of drugs and alcohol, Walking Turtle described a healthy person as one that does not put these items into their body and therefore drug and alcohol free:

*Drug and alcohol free. That's the main thing of being healthy.* (Walking Turtle)

Dancing with Wolves further explained the bodily harm that is induced through the ingestion of drugs and alcohol:

*Dances with Wolves: Someone who is active, not into drugs and smoking and alcohol maybe.*
*Interviewer: And why do you think that would make someone have good health if they don’t smoke and do alcohol.*
*Dances with Wolves: You’re ruining your body doing that stuff. Your body runs better without that stuff.* (Dances with Wolves)

When mentioned by youth, an active lifestyle was considered important for good health (11 respondents). This was often paired with eating healthy foods, therefore demonstrating that the combination of activity and nutrition are both considered important for good health. Little Blue Bird and Victoria both spoke of the importance of maintaining daily exercise and a healthy diet:

*Being physically active, staying in your most shape – walking every day, or eating healthy – just trying to be – keeping your body healthy, not eating junk food, and all that.* (Little Blue Bird)

*Good health means staying active, eating a healthy diet, feeling good about yourself, and – I don't know – just being healthy, being confident that you're doing well for your body.* (Victoria)
**Spiritual**

The spiritual component of health was spoken by seven youth. Good spiritual health centred on beliefs, taking care of their spirit, and through participation in spiritual and cultural activities. Beliefs were identified as important for fulfilling spiritual health in that they give people a sense of meaning and of a higher power:

> I wouldn’t say you have to specifically believe in a certain type of culture or belief, or anything like that because I know I even have that struggle where I don’t know what I want to do. But I still have the belief that there is something, like a higher power. And that’s probably one of my biggest struggles in life. Overall health is just finding that balance. *(White Light)*

Little Blue Bird explained that in order for someone to be spiritually healthy, they must also take care of their spirit, whether or not the person has native beliefs:

> Believing in your culture. Maybe you could – maybe you have a native one and that way having a healthy spirit, and just keeping yourself healthy. *(Little BlueBird)*

Participation in spiritual and cultural activities (e.g. ceremonies) was identified by three of the youth as a way of maintaining that spiritual health. Little Blue Bird spoke of participation in sweat lodges and of the health benefits:

> Well, for me, I attend sweat lodges. When I come out of there, I feel like a new person. I feel everything that I went in there – I just released it all, and when I got out of it, I felt like this new person. I was just a ball of energy and had nothing on me, like no weight. I just felt like a feather. It just felt so great. So, attending like ceremonies that make me feel good, and I know people – other like that just attend ceremonies like that and even like doctoring ceremonies. *(Little Blue Bird)*

Lydia discussed the importance of participating in spiritual and cultural activities for good spiritual health, but recognized that few people in the community (including herself) actually partake in those events:
“Spiritual, I think, is people who participate in any spiritual activities or cultural activities that happen. You don’t see a lot of that around here... but I think getting back to it is, I don’t know how you would put – spiritual help, spiritually healthy is someone who partakes in a lot of it and gets in involved with it and doesn’t contradict what they say, like me. I’m at a point where, personally, I don’t think I’m spiritually healthy. I’m spiritually curious, but I’m at the point where I think spirituality comes where I have to make a choice between do I want to be young and want to go out with my friends and do all that stuff, but I made a choice that once I’m done with that, that’s when I’ll take that next step. So, that’s what spiritual healthy means to me anyways, personally.” (Lydia)

**Emotional**

Components of emotional health were discussed by seven youth. Youth identified good emotional health in terms of positive emotions, abstaining from negativity, and the ability to express feelings. Emotionally healthy people were described as having positive emotions, for example in the case of someone who is happy and/or outgoing:

*Someone that’s healthy, that umm they go for walks, and they go for jogs, you know and they’re healthy emotionally, like they’re happy, someone that’s umm I would picture someone that’s really an outgoing person and umm you know cuz it’s not just the weight healthy, it’s everything else.* (Denali)

In Jane’s opinion, emotional health also included abstaining from negativity or pushing beyond unavoidable moments with positivity:

*I think for me emotionally, I’ve learned not to get involved in anything that’s negative. I know you can never totally avoid it, but to always try and be positive and to try and live a positive life. We don’t talk bad about people. We don’t think bad things about people and just try and go along our business. If you don’t like something somebody’s doing, then you turn the other way.* (Jane)

For Lydia, good emotional health involved the ability to separate oneself from negative relationships.
Emotionally healthy, again has to – I think it kind of teeters with mentally healthy. People who are seemingly happy, well off, who enjoy life and then there is people who are sarcastic and mean and just kind of bring that negative energy, negative vibe to them. Emotionally healthy people who establish good relationships with other people, that’s another one I think is emotionally – if you’re emotionally healthy you’re able to do that and not so standoffish to other people and I think it really has a lot to do with the confidence level, too because when you get older you start to build that so, you can have those relationships with other people where other times you are like, “Nah, I don’t need them, I don’t even want to bother with them anymore”. (Lydia)

Mental

Good mental health was described by seven Anishinabe youth as noticeable by the outer appearance of a person, their confidence, and the ability to balance life activities. The outer appearance of a person with good mental health was described as someone that appears to be happy, rather than depressed:

I think somebody who, I don’t know, probably looks happy. You know what I mean? You see a lot of people especially around here, you see a lot of people that are sad and depressed or are just miserable and you can see it and you can feel it by the way they come across to people, I think that’s what mentally healthy is... (Lydia)

Patrick explained that a component of good mental health was having confidence and in particular, not being hard on yourself:

Interviewer: What does good health mean to you?
Respondent: To me, mentally fit and physically.
Interviewer: Okay, so when you think of good health, what kind of pops in your mind? Do you get a picture of something that means good health?
Respondent: Not down on yourself, sort of. Something – somebody like that. Always wanting to do stuff. (Patrick)

Additionally, a person with good mental health would be non-judgmental and able to balance their studies with social life:
They’d possess like good goals around school. They’d pay attention in school, but after their work was done, they’d hang out with friends. And they’d be outgoing type, like friendly... They wouldn’t judge a book by like its cover and stuff. (Tia)

**Balance**

Some youth felt that good health and well-being occurred when a balance of the four quadrants (e.g. physical, spiritual, emotional and mental) was achieved. White Light illustrated the importance of not focusing on only one component of health, (e.g. physical health) and therefore remembering to care for the others as well (e.g. spiritual health):

> I would say that just taking care of your overall health, because I’ve learned in the past couple of years that physical health is a big importance, but you also have to take care of your spiritual health as well in order for it to all be balanced out, because you have to have that balance. (White Light)

Similarly, Jane recognized the importance of balancing the four quadrants by eating healthy foods, caring for yourself as whole:

> Good health to me means having – I guess just feeling good about yourself in all different areas. Like with food and nutrition, taking care of your body physically, and taking care of yourself mentally and spiritually. And just making sure you’re looked after as a whole. (Jane)

While balance is important, May Mary indicated difficulties people may encounter (e.g. struggling with one quadrant) with trying to achieve that balance:

> It doesn’t just mean physical health to me. Good health means everything spiritually, emotionally, physically and everything. And it’s really hard to define a healthy person, especially around here because there could be a person who is not over weight, who does eat, but yet they still have this problem with drinking or something. Or you could have this sober person who does eat and who does exercise, but yet they have still the mental health problems to work on or whatever because of the life they had before, because of their choices. So good health, to me, means having the balance between everything, between all those aspects in life kind of thing. (May Mary)
4.1.1.2 Poor Health

Table 4.2
Youth Definitions of Poor Health

<table>
<thead>
<tr>
<th>Descriptors of Poor Health</th>
<th># of Mentions (%)</th>
<th># of Respondents Mentioning (n=19) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>113</td>
<td>18 (95)</td>
</tr>
<tr>
<td>Not Caring for Body</td>
<td>32</td>
<td>17 (89)</td>
</tr>
<tr>
<td>Addictions</td>
<td>35</td>
<td>14 (74)</td>
</tr>
<tr>
<td>Chronic Health Problems</td>
<td>12</td>
<td>8 (42)</td>
</tr>
<tr>
<td>Mental Health</td>
<td>21</td>
<td>13 (68)</td>
</tr>
<tr>
<td>Social Exclusion</td>
<td>7</td>
<td>5 (26)</td>
</tr>
<tr>
<td>Stress</td>
<td>4</td>
<td>4 (21)</td>
</tr>
<tr>
<td>Spiritual Health</td>
<td>6</td>
<td>3 (16)</td>
</tr>
<tr>
<td>Lacking Spiritual Connection</td>
<td>4</td>
<td>3 (16)</td>
</tr>
<tr>
<td>No Participation in Cultural Activities</td>
<td>1</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Beliefs</td>
<td>1</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Emotional Health</td>
<td>3</td>
<td>3 (16)</td>
</tr>
<tr>
<td>Negative Emotions</td>
<td>2</td>
<td>2 (11)</td>
</tr>
<tr>
<td>Not Emotionally Stable</td>
<td>1</td>
<td>1 (5)</td>
</tr>
</tbody>
</table>

**Physical**

Similarly to good health, youth poor health definitions primarily focused on the physical components of health (18 respondents). This resulted in an overrepresentation of the physical quadrant (113 mentions compared to 21 mentions of mental health). Poor physical health was described by youth through examples of not caring for the body, addictions, and chronic health problems.

The first theme, not caring for the body, was described by 17 youth through examples of obesity, inactivity and poor nutrition. In the following community example, obesity is illustrated to be a result of sedentary lifestyles and poor nutrition. Poor community nutrition, for example has been facilitated through easy access to junk food at the local convenience store:
What do I think are poor health? Look around in my community and see like the obesity, and people are overweight, and they’re going to Cecil’s and just buying like – they just eat in unhealthy ways, or they just sit there. (Little Blue Bird)

Inactivity (i.e. staying indoors on a computer all day) combined with over eating and poor food choices were additional ways that a person may not care for their body as illustrated by Lydia:

*Probably doing a lot of non-physical stuff so, you sit down at your computer all day or I don’t know, just not expanding yourself. Just kind of over eating, I’ve seen a lot of that! Comfort eating. A lot of stuff to do with food.* (Lydia)

Poor nutrition was an additional way a person may not take care of their body. Walking Turtle spoke of poor nutrition and of the abuse the body endures when it is combined with inadequate sleep and improper hygiene:

*Poor health – not taking care of yourself. Like, not bathing, not getting the sleep you need, not eating properly, I guess. I guess that would be it not like – I don’t know – abusing your body.* (Walking Turtle)

Another main factor of poor physical health was addiction. This was discussed by 14 of the youth and had 35 mentions overall. Drug and alcohol addictions were examples of the different types of addictions illustrated by the youth:

*Someone that is really down and emotionally they’re unhealthy and do things like drinking all the time and do drugs.* (Denali)

Respondent: Well, they didn't take care of themselves...
Interviewer: So how might they not take care of themselves?
Respondent: Drinking, doing drugs, not getting along with their family, getting along with others – yeah, that would be poorly done. (Whistling Dixie)
Lydia spoke of people introduced to prescription drugs as a result of body pains that over time became addictions:

...Bad habits, drugs, you know, a lot of people are in here have physical pain and then they have to deal with it by taking prescription drugs and then what happens, it becomes an addiction. (Lydia)

Chronic health problems were another area of poor health recognized by eight of the youth. The health problems identified included diabetes, cancer, and disease. White Light spoke of the high diabetes rate as a result of community members’ inability to access nutritional foods or the knowledge to properly exercise:

Not having the ability to have access to stuff that we need. Because I know on this, even for healthy eating and whatnot, my sister's a diabetic educator, and she just opened my eyes to the obesity rate, and the rate of diabetes on this reserve is abnormally high compared to other places. And that's due to the fact that we don't have – a lot of people on the reserve don't have the means to be able to eat, or the knowledge that they need to do their exercises and whatnot. (White Light)

Victoria explained that there are some illnesses that occur by chance and not as a result of personal choices. She also indicated that other illnesses may be a result of circumstances endured in early life:

There's chances that you can have poor health not by choice. I mean, there's all kinds of diseases and stuff that are out there now that you can that are airborne, and that's poor health too, right? But I mean, you find out now in today's society that a lot of cancers and a lot of diseases that have been around for quite some time are caused by people who don't take care of themselves properly when they were younger. (Victoria)

Just in general, it would probably be, you know the high rate of it would be obesity levels in Pic River and that to me symbolizes poor health. High rates of cancer, what else do we have? Diabetes you know... (Lydia).
**Spiritual**

Poor spiritual health was expressed by six youth as lacking a spiritual connection, lacking participation in spiritual and avoidance of cultural activities, and a belief system. The spiritual connection to a particular set of cultural beliefs or institution was not viewed as mandatory, but rather was the individual’s choice:

*Someone who doesn’t have any type of spiritual connection. It doesn’t have to be your Native tradition or through the church. Any type of whatever you want to believe in. (Jane)*

Another indicator of poor spiritual health was someone that does not participate in spiritual and/or cultural activities. Interestingly, one youth did not consider participation in these activities to be very common amongst Pic River band members:

*Spiritual, I think, is people who participate in any spiritual activities or cultural activities that happen. You don’t see a lot of that around here. (Lydia)*

A lack of beliefs and/or of a higher power was another description of poor spiritual health. Essentially this was described as someone that does not have spirituality in their life at all:

*No spirituality or whatever. No one to believe in is poor health. (Mary)*

**Emotional**

Emotional health was only discussed by three youth. Indicators of poor emotional health were considered to be people that are unhappy and sad, and those not emotionally
stable. Negative emotions such as sadness and low self-esteem, disinterest in participating in activities were discussed as poor health. Denali illustrated disinterest in activity participation through sitting around and watching TV:

*Respondent: Just someone that ah, doesn’t necessarily do anything. Just sits around. Kind of sad and stuff and does things that like just does things that a normal person. I don’t know.*

*Interviewer: Can you expand on what kinds of things?*

*Respondent: Well like they really don’t do anything. Someone that sits around and watches TV all day. Umm someone that is really down and emotionally they’re unhealthy and do things like drinking all the time and do drugs.*

*Interviewer: Might they behave a different way than someone that’s healthy or has good health?*

*Respondent: I think so. For sure. I mean someone that’s healthy from someone that’s unhealthy there is just a total different change umm in so many different ways, especially personality wise.*

*Interviewer: So what would their personality be?*

*Respondent: Well, I mean like depending on their self-esteem you know if they’re really unhealthy I mean they’re not going to be as jumpy, happy as someone that is. (Denali)*

People that were not emotionally stable or unable to express themselves were considered to be another aspect of poor emotional health. Jane described these people as being emotionally closed off:

*Somedone who is not emotionally stable. They can’t express their feelings or they’re really closed off. (Jane)*

**Mental**

In terms of mental health, social exclusion, and stress were factors involved in poor health. Social exclusion and people lacking the confidence to be social were examples of poor mental health:

*Respondent: Someone who doesn’t go out and be social with people and get out and do stuff. People like that.*
Interviewer: Okay.
Respondent: Who don’t have the, I forget that word.
Interviewer: Confidence?
Respondent: Yeah, confidence to go out and talk to people and get active and stuff. (Phyllis)

No education and in particular people who may have dropped out of school were discussed by Whistling Dixie as examples of those that would be more likely to experience poor mental health:

*Maybe if they’ve never gone too far in school, and they’re mental health isn’t that great.* (Whistling Dixie)

Additionally, stress from an individual’s surroundings was something considered to impact the health of individuals:

*I mean, stress is another thing that causes poor health, so if you’re – how would you say that? If things around you are causing you stress, then yeah, it can cause poor health.* (Victoria)

### 4.1.2 Family Health

Perceptions of family health differed across all of the youth. Some of the youth perceived their overall family’s health to be good (7 youth), while others (15 youth) were concerned with the health and well-being of their family. Even though youth may have perceived their overall family health to be good, that did not exclude all from the possibility of family health concerns.

#### 4.1.2.1 Good Family Health

Seven youth considered their family to have good health. Of the seven some views of good family health included good communication, active lifestyle, and eating healthy.
food. Youth that perceived the health of their family to be good discussed the importance of communication through the expression of feelings and reinforcement of love for one another:

*I think they’re really good because my family, sure we get into little disagreements, but it’s not like something big like actually fighting. We just kind of talk about it. Like we love each other. We tell each other we love each other, and we think about each other’s feelings. Say if we say something mean to each other, then we’ll apologize right away. We’ll realize that we’re wrong. And we eat healthy and our behaviour is good and personality is good, too. So I think my family has good health.* (Tia)

Walking Turtle perceived the health of her family to be a result of self control, maintaining an active lifestyle, and eating nutritiously:

*I can say we’re healthy. We don’t – it’s not that we don’t – we do. Like, we smoke. We have the occasional drinks and all that stuff, but we don’t go crazy about it. I can say we’re a pretty healthy family. We all stay active, go for our walks every once in a while. We eat properly, three meals a day.* (Walking Turtle)

4.1.2.2 Family Health Concerns

<table>
<thead>
<tr>
<th>Descriptors of Family Health</th>
<th># of Mentions (%)</th>
<th># of Respondents Mentioning (n=19) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Health Concerns</td>
<td>24</td>
<td>15 (79)</td>
</tr>
<tr>
<td>Inactivity</td>
<td>6</td>
<td>3 (16)</td>
</tr>
<tr>
<td>Chronic Health Problems</td>
<td>3</td>
<td>3 (16)</td>
</tr>
<tr>
<td>Obesity</td>
<td>4</td>
<td>3 (16)</td>
</tr>
<tr>
<td>Imbalance</td>
<td>1</td>
<td>1 (5)</td>
</tr>
</tbody>
</table>

As mentioned briefly, some youth considered the health of their family to be good overall, but still had some health concerns. Family health concerns were discussed by 15
youth. These concerns included but were not limited to: inactivity, imbalance and obesity.

Inactivity was perceived to be a family health concern for Jaelyn, due to the health effects that may stem from prolonged inactivity.

*Interviewer:* So when you think about your family’s health, what’s the first thing that comes to your mind?
*Respondent:* Not very healthy.
*Interviewer:* And why? Why do you think so?
*Respondent:* I don’t know. Because they’re all older and they don’t exercise. *(Jaelyn)*

Family obesity was also of concern for youth as weight gain that is not managed or controlled generally precedes many additional health problems such as diabetes, heart attacks and in the worst cases, death.

*Interviewer:* And when you think about your family’s health, what does that look like? Or what’s the first thing that comes to your mind?
*Respondent:* My family doesn’t really have – they’re not all in shape most of them.
*Interviewer:* So does that mean they’re over weight or just not –
*Respondent:* Most of them are overweight. *(Delilah)*

Family obesity was of great concern to Victoria. Her hope was that family members would start caring for their bodies so that the cycle would not continued by the younger generation:

*I’m almost saddened at my family’s health because a lot of my family is obese, so – are obese – sorry, a lot of my family are obese, and you can tell that there’s very poor health. I mean, it’s not as bad, but it can be worse, so I really think that some of them should start looking after themselves a little bit more carefully, and the younger generation is starting to see into that, but some of the kids in my family are still a little bit not taking care of themselves. *(Victoria)*

One youth, Little Blue Bird was particularly concerned with the family imbalance and the
inability to express feelings:

Well, they're slowly trying to improve themselves big time. It's big – they just feel just – I don't know what – they just seemed unhealthy. They just don't look happy. They have their own issues to deal with, but I don't really know how they feel because my family don't talk about how they feel. That's like they'll, "Oh, hey - How are you feeling?" Or they don't explain what's wrong with them, but we ended up – they had a shitty life, too growing up, too. So, they have their own issues to deal with. Like, I don’t know. My family is unbalanced and unhealthy. (Little Blue Bird)

4.1.3 Community Health

Table 4.4
Youth Perceptions of Community Health

<table>
<thead>
<tr>
<th>Descriptors of Community Health</th>
<th># of Mentions (%)</th>
<th># of Respondents Mentioning (n=19) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Concerns</strong></td>
<td>48</td>
<td>18 (95)</td>
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<tr>
<td>Chronic Health</td>
<td>7</td>
<td>5 (26)</td>
</tr>
<tr>
<td>Obesity</td>
<td>13</td>
<td>10 (53)</td>
</tr>
<tr>
<td>Addiction</td>
<td>8</td>
<td>7 (37)</td>
</tr>
<tr>
<td><strong>Changing Health</strong></td>
<td>31</td>
<td>11 (58)</td>
</tr>
<tr>
<td>Physical Health</td>
<td>20</td>
<td>10 (53)</td>
</tr>
<tr>
<td>Mental and Spiritual Health</td>
<td>3</td>
<td>3 (16)</td>
</tr>
<tr>
<td><strong>Overcoming Health Issues</strong></td>
<td>10</td>
<td>8 (42)</td>
</tr>
<tr>
<td>Community Activity</td>
<td>3</td>
<td>3 (16)</td>
</tr>
<tr>
<td>Prevention Workshops</td>
<td>7</td>
<td>5 (26)</td>
</tr>
</tbody>
</table>

4.1.3.1 Concerns about health

Youth concerns about community health were much less individualistic in nature than were their definitions of individual health. These community health concerns were
much broader and social than were the individual health concerns discussed earlier. For example, the main concerns identified by youth were chronic health problems, obesity, and addictions. When the youth discussed present health concerns, their focus was on the physical quadrant of health, rather than the other three, as evident by the main concerns listed.

The main chronic health problems of concern to youth included: high rates of diabetes, disease and cancers:

*I have big concerns about my community’s health. Just from – yeah. We do have the high rate of diabetes, and especially lately with kidney disease, or other types of organ failure. And it does go back to their eating habits. They’re eating a lot more processed foods, and with a lot of preservatives. And if they would just curb their eating, or change their eating habits then they would cut down on the obesity and their health would start to improve. But a lot of them are just – they’re only doing what they know what to do. Like what they grew up doing. (White Light)*

*There’s more cancer out there. I don’t know if there’s a month that’ll go by that you don’t hear that somebody, either they’ve been diagnosed with a tumor or some form of cancer. And then of course there’s liver cirrhosis because of the amount of drinking that a lot of the older generation participates in. I’d imagine that once my generation gets older, they’ll be facing the same problems from alcohol abuse. (White Light)*

Rates of obesity, as a result of inactivity were perceived to be a community health concern.

Tia was deeply concerned with the sedentary lifestyles of community members and suggested the community speed up the process of building community walking paths:

*Interviewer: So what worries you most about your community’s health? Respondent: Oh my God, probably like they don’t seem all that active. And sure everybody is kind to each other, but I don’t know. The community, they should have like – sure they’re making the path, like there’s a walking path that they’re trying to make, but it doesn’t seem to be getting anywhere. And it’s not happening fast enough. It would be good if they put community benches around so if the older people or
overweight people want to go for a walk, then they could take occasional breaks and stuff so they don’t have to keep going and going. (Tia)

Environmental health (e.g. mine) was identified by one youth to be directly linked to community health and particularly, to the health of future generations:

*I don’t see – my community’s health, it’s like why are we going to put in this mine that could potentially harm us and our future generations? It’s like why don’t parents understand the importance of feeding your kids healthy foods or whatever around here? It’s everything about the community’s health, I think. Obesity is a big problem. And it’s like why are we going to put in a mine. The earth ain’t going to get better no matter which way we look at it. This world’s not going to get a better place. Even if everyone did stop looting, we’re probably still screwed. So is money really worth it enough for the community’s health that we need a mine or whatever? Or should we just be trying to work with what we got and not take any more away from it kind of thing.* (May Mary)

4.1.3.2 Changing Health

While youth focused solely on the physical quadrant of health in present community health concerns, that was not the case when they discussed changing community health. Through they mentioned other quadrants (i.e. mental and spiritual), the mentions were still disproportional to the physical quadrant. The physical quadrant dominated with 20 mentions, compared to 3 mentions for the others. As such, the primary theme identified in changing health was the physical aspect of health, while spiritual and mental was another.

In terms of changing physical health, youth generally perceived physical health to have been better in the past than in present day. Their interpretations of the change over time related to outdoor activities and diet of community members. Denali spoke of the higher activity levels in the past and changing food choices:
Well like to be honest it seems like they did more you know, they were always out all the time. Unlike us, we have the choice to stay in, we don’t have someone that’s going to beat us. You know, physically hurt us if we don’t go outside. I don’t know it seems like they were out more and they were more in with the land and eating healthier compared to what we are now – but I think the difference is that we have help by other people now. You know, telling us what’s good to eat and stuff like that. (Denali)

Even though youth were much more aware of the fact that physical health was changing throughout the community, a couple youth spoke of worsening mental and spiritual health. This change in mental health was perceived to result from relatives’ attendance at residential schools. Whistling Dixie illustrated that the relatives that attended residential schools were not treated equally and the abuse they suffered had detrimental effects on their mental well-being:

Interviewer: So how do you think your generation's health differs from your grandparent's generation – when they were younger?
Respondent: Residential school... They were in residential school; we're in high school. You get treated equally.
Interviewer: Do you think high school is the same thing as residential school?
Respondent: No, no, no – oh, no. No, we get treated equally at high school.
Interviewer: Oh, okay.
Respondent: Yeah, I'm sure them, it's a lot different – quite opposite.
Interviewer: So how do you think that affected their health, then?
Respondent: How did it affect – hmm?
Interviewer: Would you say that they had worse health – because of that than you do?
Respondent: Yeah, yeah, yeah, they did.
Interviewer: And how – why –
Respondent: They were bullied.
Interviewer: And so why would that negative – like affect their health, do you think?
Respondent: Well, ... – it'd affect their health because it changed their ways pretty much, like they gone from totally respectful and traditional type of people that now thinking – thinking they're – they got their heads shaved and their haircut, so now subtracted out of their lives (Whistling Dixie)
4.1.3.3 Overcoming Health Issues

The third theme of community health was the notion of overcoming the concerns previously mentioned (chronic health, obesity, and addiction). Eight of the youth offered suggestions for overcoming community health issues including: community activities, and health prevention/educational workshops. Walking Turtle suggested community activities as a way to combat community inactivity and obesity. In this case, the entire community involvement and support is required so that those in need of an intervention are not singled out:

*Getting more active, making it more of a community thing, not just a – like a singled out thing. Make it a community thing. Not saying that you can't go for a walk if it's – like the whole Get Up and Get Active thing that's going on right now. I think that's cool, but I think it should be a thing where the community does a walk around the big block every year – every week, or every two weeks. Where it's not always singling out the people who need to lose weight, but it's people who don't really need to lose weight, but just go up and do it anyways.* *(Walking Turtle)*

The other suggestion for overcoming the community health concerns included the implementation of health prevention/educational workshops. Tia recommended that youth should be targeted for diabetes prevention workshops and presentations in order to bring awareness of the issue as many youth do not feel they are at risk:

*Respondent: And if they were to put presentations on, I think that would benefit a lot.*
*Interviewer: Yeah. Maybe letting people know that they are still at risk [of diabetes] even though they're young.*
*Respondent: Like I’m sure they know it, but they don’t know what they should do because we don’t have a lot of diabetes education. So how are we supposed to fix something that we don’t know about or even, to be honest, teenagers don’t really worry about illnesses because we always think we’re invincible to them like we’re too young to get them. But I*
don’t know, I think some of us should probably start realizing that we’re not all that invincible, and we could get it. (Tia)

4.2 Youth Perceptions of Social Relationships

Table 4.5
Youth Perceptions of Social Relationships

<table>
<thead>
<tr>
<th>Descriptors of Social Relationships</th>
<th># of Mentions (%)</th>
<th># of Respondents Mentioning (n=19) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>People in the Community</td>
<td>17</td>
<td>15 (79)</td>
</tr>
<tr>
<td>Relationships in the Past</td>
<td>16</td>
<td>14 (74)</td>
</tr>
<tr>
<td>Benefits of Social Relationships</td>
<td>127</td>
<td>18 (95)</td>
</tr>
<tr>
<td>Social Support</td>
<td>70</td>
<td>18 (95)</td>
</tr>
<tr>
<td>Having Someone To Talk To</td>
<td>10</td>
<td>7 (37)</td>
</tr>
</tbody>
</table>

Sixteen of the nineteen youth did not speak about bad relationships or were simply not willing and/or comfortable discussing the topic. The other three youth however, spoke briefly about them (e.g. jealousy as a component of bad relationships). In comparison to bad relationships, all of the youth were willing to discuss good relationships, including relationships that concerned family, friends, and/or community members. As a result of the youth focus on good relationships, the youth perceptions of social relationships were ultimately, perceptions of good social relationships. In terms of this topic, three main themes stood out in the interviews. These themes included: benefits of social relationships, people in the community, and relationships in the past.

4.2.1 Benefits of Social Relationships

Benefits of social relationships were most often discussed (127 mentions) by the youth. Additionally, almost all of the youth spoke of the benefits (18/19 youth). The youth
identified these benefits to include social support (e.g. family and/or community support), and having someone to talk to.

Social support was the most discussed benefit of social relationships, as identified by 18 of the youth. In terms of family social support, Lydia spoke of cultural differences in the support systems of Anishinabe families (e.g. closeness) when compared to non-Anishinabe families (e.g. disconnect of generations):

*I think one of the best things about being native or Anishinabe had to have been your family, your community, the support you get. I don’t think that if I grew up with – well, I can’t really say. I’ve talked with friends who are non natives and they’ve talked about it, their family, growing up, stuff like that. My conversations with them or my contributions to the conversation were different because family was so important. I couldn’t stand being away from my family you know, family events, family this, we do this together, we do this together, we do this together, were it was so different and there was such a big difference in age, ages, their parents were probably turning 50, 60. Where my grandparents were probably turning 50, 60 and you know it was hard for them to understand that concept.*  

(Lydia)

Community support was integral across all levels of education. The constant support and acknowledgement of successes, by community members, reinforced the importance of education and provided motivation for continued success:

*It’s the family, not even family support, community support. I remember growing up and always having people helping you out, always pushing you. That was one of the things I learned in public school and why education was a big part of my life is because of community. When they acknowledge the fact that you do good, as bad as that might seem in physiology it was actually a good thing for me because I knew that my community was proud of – you get awards for this, you get awards that and the same thing with my family, it just made me want to push harder and harder, but you always knew that if anything ever went wrong in your life, you always have here to come back to. You would never ever, even here, today; I don’t think anybody in this community would go hungry ever! Because it always there, there’s always somebody there to help and I think you can’t get that anywhere else.*  

(Lydia)
Others sources of support for youth included financial support for education and support from friends. One youth in particular was grateful for the financial support received from the band for funding education:

Respondent: I’m proud to be Anishinabe and everything that we have and we’re so grateful. I’m going to school this year and it’s all being covered by funding, which I’m so thankful for. I couldn’t imagine having to go through the whole OSAP or student loan and not knowing if you’re gonna make it each month. I’m really thankful and grateful to be Anishinabe definitely.

Interviewer: So the support you’re getting educationally is definitely something you really appreciate?
Respondent: Yeah, so thankful for that. There’s not – there’s no words that I can use to describe how thankful I am for that. (Storm)

Having someone to talk to was considered to be an important component of social relationships (mentioned by 7 of the 19 youth). Storm spoke of the importance of relationships in order to learn about the past (i.e. from elders) and also for communication with people (i.e. about feelings).

Well, to learn about things that were in the past, or just have someone to talk to. It’s good to just let it out and just let someone know how you’re feeling and it’s good to have people there to help you. Especially when you’re struggling, it’s definitely a good thing. I think that it’s really important to have friends and talk to people and just go for a walk and talk about anything. It could be whatever you want just to talk to someone. It’s a good thing. (Storm)

Walking Turtle spoke of differences in the importance of relationships across types of relationships (i.e. family, friends and co-workers). Families were viewed as having unconditional love and support, while as a result of being more open with friends; friends knew more personal details about their lives. Co-workers or colleagues on the other hand
offered more tangible support concerning the work and/or school environment.

_I would say I wouldn't be where I am without my friends. I think a lot of people would say that. Yeah, your family is one thing, but your friends are another. Even having your coworkers – it's like – it's not calling you like two-faced or anything, but it's giving you those different environments and switching it up so you're not doing the same thing over, and over, and over again. You have your family. They'll always be your family. You have your friends. Like, my best friend knows more – probably more about me than my family does because you just open it up to them a lot more. My coworkers probably only know so much about me, but yet, there's certain things I can communicate them that I can't communicate with anybody else. Like, I can have a conversation about – for example, when I went to college, my best friend wasn't in the same program as me. I have another friends that I met where I can talk to them about what our program was going on, but my best friend didn't know what we were talking about._ (Walking Turtle)

4.2.2 People in the Community

People in the community, another theme of social relationships, were perceived by youth as central to the strength of the community. This was due to the kindness and compassion shown by community members, and in particular, in times of need. Jane spoke of this community closeness through an example of the death of a community member. While all community members may not get along, they still come together in times of grieving in order to support one another:

_I think overall despite the gossip and a lot of stuff, when something happens, we are still a pretty tight knit community. I think there are certain times when our community does know how to put everything aside. Like if there’s a death in the community, we have a funeral and we have the wake and everything. And nearly everyone attends and everyone shares in the grieving and stuff like that. They may still leave and they gossip and everything is all still there, but in the end, when you need a lot of people, they’re there._ (Jane)
Tia described another situation in which the people of the community come together, illness of community members. In these situations, community members offer support to the person and/or family in need:

*I think it’s just like the support that everybody has, and everybody is so kind to each other. If one person is sick, then everybody is praying for that person. And everybody is supporting the family however they need. And I think that this community has a lot of respect for each other. Especially when they need it.* (Tia)

### 4.2.3 Relationships in the Past

Relationships in the past (i.e. youth parents and grandparents generation) was another theme of social relationships. Some youth speculated on past relationships since that information was not always known by the youth. Often youth did not know as a result of grandparents and family members not discussing past relationships. Phyllis drew from the knowledge of grandparents attending residential schools combined with movies and documentaries that explored life in residential schools as a way of understanding what past relationships were like:

*Interviewer: Have you ever heard stories from your grandparents?*
*Respondent: Not really, but on movies, you could see where they just shove them off and don’t listen to them and whatever.*
*Interviewer: You mean residential schools?*
*Respondent: Yeah. Stuff like that and just like okay, well, you can’t learn that, so you have to learn this. Or we don’t do that, so go somewhere else, and they don’t even help them and show them where else there’s an idea of where they can get that or whatever.*
*Interviewer: Yeah. And have you heard of your grandparents going to residential school?*
*Respondent: Yeah. My grandparents went to residential school.*
*Interviewer: So do you think their idea of relationships is really different than yours?*
Another youth, Whistling Dixie, had heard stories from relatives and community members about family neglect that resulted due to alcoholism:

*Respondent: Well, my grandparents, they weren't like — they didn't have much attention from their parents because of the alcohol and stuff like that. Yeah, that's the relationship attention-wise, and their fun and their needs getting in the way of their relationship with each other, yeah.*

*Interviewer: So do you think they had bad relationships, then, when they were younger?*

*Respondent: Uh-huh, as for today, yeah, it's the other way around pretty much.*

Similar to Phyllis, Storm had not been told stories specifically about past relationships, but instead drew from other stories told by grandparents about life in the past. Storm concluded that close relationships in the past (e.g. spending time with parents) influenced relationships today:

*Interviewer: Have you ever heard stories from your grandparents about how people related way back when?*

*Respondent: Not really. They don't really — well, I guess my grandpa would tell me about his mom and how they would go blueberry picking. And that bond seemed to be really good and strong. I guess then too they had really good relationships with a lot of people, so yeah.*

*Interviewer: The closeness.*

*Respondent: Yeah, which I think actually influenced their relationship with me. They know how important it is to be close to someone that you love. I think that’s why they’re always there for me no matter what.*

(Storm)
4.3 Social Relationships and Health

Table 4.6
Perceptions of Social Relationships and Health

<table>
<thead>
<tr>
<th>Social Relationships and Health</th>
<th># of Mentions (%)</th>
<th># of Respondents Mentioning (n=19) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Behaviours</td>
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<td>3 (16)</td>
</tr>
<tr>
<td>Communication and Stress</td>
<td>5</td>
<td>4 (21)</td>
</tr>
<tr>
<td>Four Quadrants of Health</td>
<td>9</td>
<td>7 (37)</td>
</tr>
</tbody>
</table>

Youth had various perceptions of how social relationships influenced health. This included good relationships and their influence on healthy behaviours, communication and stress, and the four quadrants of health (i.e. physical, mental, emotional and spiritual).

Healthy behaviours (e.g. youth participation in ceremonies) were influenced by good relationships. With the support and encouragement of relatives, Little Blue Bird was able to overcome addiction and turn to spirituality as a way of healing:

Yeah, well I hit rock bottom – been two years. I went through the whole depression. I was my lowest – the lowest, lowest I could – ever be in your life. I did it. I turned to the drugs and the alcohol. I was drinking every day and doing the drugs. Then, I hit the lowest and like my uncle and my auntie came to my bedside and they told me, "You need to change." They was like, "Your first step," and they guided me through my whole spiritual way. Now, it's been like – well, I still work on it, but it is like the hardest thing in my life. I screwed up my school. I fell behind. I lost friends a little bit, but me returning to the whole spiritual way is like – I'm more – I love myself more. I'm more healthful. I'm so awake. I always – I'm so friendly now. It's like the best thing in my life having those two people who came in my room and told me. Now, I do attend ceremonies. I do go there. I'm like – I feel so high in my life. I love it. (Little Blue Bird)

Youth also perceived social relationships and in particular, good relationships as essential for the communication and expression of feelings. Walking Turtle discussed the importance of releasing built up emotions through conversation or crying:

They're important because it's not good to hold anything in. It's not good at all. I can say that honestly. Having a best friend – you might have a
feud with your sister and you can’t go tell your mom because you don’t want her to know. So, you go tell your best friend. You get that out, rather than hold it in. Holding everything in just builds up anger, depression, stuff like that. You need to — in order to be healthy, you have to let that stuff out. You need to cry. You have your mom and dad to go cry to; if not, your best friend; if not, your other friend. Like, so having all those relationships do help. (Walking Turtle)

Storm explained that expressing your emotions and feelings to a friend also allowed that friend to support you, especially in times of need.

Well, to learn about things that were in the past, or just have someone to talk to. It’s good to just let it out and just let someone know how you’re feeling and it’s good to have people there to help you. Especially when you’re struggling, it’s definitely a good thing. I think that it’s really important to have friends and talk to people and just go for a walk and talk about anything. It could be whatever you want just to talk to someone. It’s a good thing. (Storm)

Social relationships were also understood to help multiple quadrants of health (e.g. emotional and physical). This was illustrated by respondents as they spoke about the motivation and encouragement they receive as a result of their relationships:

It helps your emotional health. Your physical health as well because if I didn’t have a strong relationship with my sister she wouldn’t have been encouraging me to do what I’m doing now. And she is so immersed in her new lifestyle, it’s just bleeding within our whole family. She just changed the lifestyle of our whole family within — it was hard, but she did it. (White Light)
4.4 Culture and Health

Table 4.7
Culture and Health

<table>
<thead>
<tr>
<th>Descriptors of Culture and Health</th>
<th># of Mentions</th>
<th># of Respondents Mentioning (n=19) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditions and Ceremonies</td>
<td>15</td>
<td>9 (47)</td>
</tr>
<tr>
<td>Importance of Community for Health</td>
<td>19</td>
<td>8 (42)</td>
</tr>
<tr>
<td>Changing Culture</td>
<td>22</td>
<td>9 (47)</td>
</tr>
</tbody>
</table>

Interviews revealed that there were links between culture and health. These links were illustrated through themes such as traditions & ceremonies, community importance for health, and changing culture.

4.4.1 Traditions & Ceremonies

Traditions and ceremonies were identified as important for health by nine youth. Ceremonies were described to promote and encourage good health (i.e. sobriety) since a key factor in attending these events is the abstinence from drugs and alcohol.

_Interviewer:_ Is there anything else that someone with good health might –
_Respondent:_ Ceremony.

_Interviewer:_ Attending a ceremony you mean?
_Interviewer:_ Yeah. So what is it about attending ceremony that might make someone have good health?
_Respondent:_ They’re not scared to participate in it. You got to be sober to go to that stuff. (*Dances with Wolves*)

Walking Turtle described traditions such as hunting as a method of engaging youth and children in an active lifestyle and also to teach lessons about healthy foods:

_Interviewer:_ So, do you think there are other things that you can learn out there [land]?
_Respondent:_ Yeah, you can learn a lot about independence, respect. Basically, like I know a lot of people don’t know how to cook, and that’s one thing that you learn out there. You learn a lot from your elders and your – not necessarily elders, but adults. You can take a lot of lessons...
and out there, they can learn how to respect. That's one big thing because how to respect living off of that, rather than being here where you have the convenience of a store. You have the convenience. Like, even just – like, I said. It's a community effort. They gotta do simple things like that to change this whole situation around because right there and then, they can fix the thing of obesity – teaching the kids how to respect the land. Go out hunting. Get more active rather than going and running to the store. (Walking Turtle)

4.4.2 Community Importance

Community members were considered important for developing and maintaining a sense of community amongst band members. In particular, community involvement was necessary to reinforce community values and traditions. Walking Turtle spoke of the need for community members to take responsibility and get involved with teaching the children and youth about their culture:

*Interviewer:* So, why do you think that maybe they're not taking responsibility to teach it [teachings]?  
*Respondent:* Lack of involvement, lack of trying to think – basically it's basically involvement. The community needs to get more involved. They say there's a problem, we all have to deal with it. It's not just one majority of – like, yeah. They said, "Oh, the youth are so bad on this reserve." Well, what makes the youth so bad on this reserve? It's not just the youth. Who did they teach it – who did they learn it from?  
*Interviewer:* Yeah.  
*Respondent:* Exactly. Like, who are they showing it to? Who is gonna be following in their footsteps? It's not just the youth. "Oh, the youth are bored in this reserve." Well, why are the youth bored in this reserve? Like, they don't think it's them to blame. It's not – I'm not saying it's a certain amount of people to blame. It's the community to blame because it's everybody. Like I said, it takes a community to raise a child. It takes a community to keep it going – not just band, chief, and council. Chief and council are people that sit here to like govern the reserve, keep it in order, and stuff like that, but chief and council snap their fingers, we all don't do something. So, it's gotta be the community's involvement. (Walking Turtle)

Even some band members that may not be perceived to have good health due to their
addictions were still involving their families in community events, demonstrating the importance of community involvement.

There are people in the community who are heavy into alcohol and that, but some of those people – I know that they get criticized because they are into alcohol and drugs. But there’s a couple of them who are the only ones that I ever see out with their kids. They are the only ones that’ll go to community events with their kids. So even those people who are so far lost in addictions or whatever, they make the community strong because they show people that if I could do this with my kids, you should be able to do it with your kids as well. (White Light)

4.4.3 Changing Culture

Changing culture was discussed by nine of the youth. Culture appears to be changing as a result of themes identified by youth such as: losing knowledge, changing gender roles, and the loss knowledge keepers (i.e. elders). The loss of knowledge, particularly in concern with spirituality was viewed as detrimental to culture. One youth believes this loss of knowledge was directly related to the health problems seen in the current generation of adults and youth:

If you look at the way things were in the past and what research has shown that Anishinabe people used to be really healthy people, and we used to be really active and spiritual and all of these things. And I think overall, they just had a really great well being. And now, there’s been so much like our kids are diabetic and overweight. And I don’t think it’s just the junk food. I think it’s a lot of that our spirituality and everything is kind of dying out, and we’re getting attacked by all these diseases. Like alcoholism and all these things. And I think if we start to build up our own traditions and a lot of that kind of stuff, we can get stronger and overall having more healthy living. (Jane)

Changing gender roles have been changing the dynamics of the community. Traditions that were once dominated by males (e.g. hunting, fishing and fire keeping) are now being taken up by females. This switch in roles results from disinterest in males and interest in females
in the participation of those activities. Lydia spoke of a group of women interested in learning to hunt themselves and therefore went to get their gun licenses:

*I think there’s a lot of change going on lately. A lot of change! You see a lot more of the girls doing a lot of stuff. I was actually recently asked to go and get my gun license, our firing license because the girls and these are girls probably between the ages of 20 and 30 who want to go hunting, but just the girls, you know, I think – and you see all these girls that, who you honestly never ever see fish, are fishing almost every night now. I see a big shift in it; I think it’s very important.* (Lydia)

White Light described the changing gender roles of men and women when it came to watching over the fire. Due to the disinterest in men to occupy the role women have come forward to assume them.

*Interviewer: So do you think that the culture is changing over time then – the Anishinabe culture?
Respondent: I would say yes only because when I was a summer student, and we were trying to put the powwow together, and they just could not get anybody to watch the fire. And it’s supposed to be a male that watches the fire. But just slowly over time now you’ll see like the female students out there watching the fire.
Interviewer: Only because the males don’t want to do it?
Respondent: The males, yeah, they don’t want to do it.
Interviewer: And why do you think they don’t want to do it?
Respondent: I don’t know. I think that they just have – they’d rather stay home and play video-games than to be out there helping with the fire.* (White Light)

This change in roles may impact community health by allocating even more responsibility to the women in the community.

Another factor influencing a change in culture is the loss of knowledge keepers (i.e. elders). As discussed by youth, the elders hold vital information and teachings that are important for health (e.g. medicines). Jane explains that once the elders pass on, so will their teachings:
Jane: A lot of our elders, we don’t have that much elders left in our community that would be great teachers for us. And in the past couple of years, we’ve had elders pass away. And they’re teachings weren’t properly passed on. And pretty soon, you just start to realize that pretty soon there’s not going to be anyone – because even people maybe in their ‘50s, early ‘50s, even they don’t really know as much as our elders do. And you know, who are we going to go to even if we wanted to? There’s nobody.

Interviewer: So would you say that would impact your community’s health?

Jane: I think it would, yeah, because there’s a lot of teachings that come from them even just like say for instance different medicinal medicines that are out in the bush that nobody is going to know about once elders are gone. And we just take for granted that so and so knows where to get this if I need it. And even my grandmother is in a wheelchair now, and she’s sick with cancer. And she knows different things on medicines and how to make them, but we don’t know anything. So she has to go to another elder to get them to make medicine for her because we can’t do it. And she can’t do it for herself because she’s sick. (Jane)
5. DISCUSSION AND CONCLUSION

The final chapter of this thesis is organized around five main components. The first outlines a summary of the key findings and discussion of the research, based on the research objectives. Key findings of this research include the implications of environmental dispossession on Indigenous Knowledge, and also the role of Indigenous Knowledge for youth health and social relationships. The second component provides a detailed discussion of the theoretical and methodological research contributions as well as policy implications. Third, this chapter discusses the limitations of this research, for example, an underrepresentation of male participants, and availability of researchers and participants. Next, suggestions for the direction of future research are provided, for example, in areas of research methods, health geography, and integration of youth and elders. This chapter ends with a conclusion of the research.

5.1 Summary of Key Findings and Discussion

Recall that Aboriginal health researchers have not adequately explored how local social environments influence health using an Indigenous Knowledge framework, nor has the role of environmental dispossession been examined as it affects the quality of local social environments. Additionally only a small base of literature has aimed to qualitatively understand the unique social dimensions that determine First Nations youth health (Young, 2003, Isaak, 2008). As such, drawing from an Indigenous Knowledge framework, the objectives of this research were to: 1) understand how Anishinabe youth define health & well-being; 2) explore youth perceptions of social relationships; 3) examine how social
relationships influence health; and, 4) understand how culture shapes health. A summary of the key findings and discussion of these objectives are the focus of the following section.

5.1.1 Youth Perceptions of Health and Well-Being

People often hold different perspectives and meanings associated with health, making it difficult to apply one standard definition to the term. Through time, these different perspectives of health have led to multiple concepts of health and well-being (Rootman et al., 2007). As such, the first objective of this thesis was to understand Anishinabe youth’s perceptions of health and well-being. This was an important first step so that I could identify and relate their understandings of health to the other objectives. Through use of in-depth interviews, the youth discussed both good and poor concepts of health. It was interesting to see that youth perceptions of health differed across the individual, family and community levels. The most significant difference was the changing responsibilities of the individual for health, for example, the perception that individual health results from one’s decisions versus the belief that the health of community members is influenced by social processes.

Anishinabe youth perceive that their health has changed through time as a result of various processes of environmental dispossession. The loss of Indigenous Knowledge combined with increased Western influences, such as television and the internet, in the lives of Anishinabe youth has affected their health. Youth recognized these influences to negatively affect their health through social isolation. Increased internet and television usage has led to sedentary lifestyles and increased time spent indoors. This has also led to less face-to-face social interactions. On the individual level, health was most often
discussed in terms of the physical component. However, some of the youth spoke of health as a balance of physical, mental, emotional, and spiritual health. This concept of balance for health was linked to the Anishinabe concept of health, represented by the medicine wheel. Figure 5.1 illustrates the youth’s understanding of good individual health in the form of the medicine wheel. The youth’s perceptions of health in this community were similar to those found in a Northern Manitoba community (Isaak et al., 2008). In Manitoba, youth spoke of, and emphasized, the physical aspects of health, yet they were still able to reflect on the other components of the medicine wheel.

As mentioned, youth definitions of health weighed more heavily on the physical component, when compared to the other components (mental, emotional, and spiritual). The main physical components identified by youth were factors that placed responsibility of good or poor health on the individual, for example in the case of nutrition, drugs/alcohol, exercise, rather than larger social or structural processes. Even when youth addressed poor physical health (Figure 5.2), their responses were still associated with a level of individual control. For example, chronic health problems such as diabetes were deemed controllable through nutrition and exercise. Overall, the youth’s definitions for health were similar to the biomedical concept of health, with the exception of the few youth that identified the Indigenous concept of balance as an indicator of good health. The biomedical concept of health defines health in terms of an individual that is free from disease (Hepworth, 1997). Conceptualized by scientists, the original purpose was to study disease (Engel, 1977). In essence, this definition only considers physical components of health and excludes other factors (e.g. social) in the role of health.
Figure 5.1 Youth perceptions of good individual health based on the medicine wheel

- Spiritual
  - Beliefs
  - Taking Care of Spirit
  - Participation in Spiritual/Cultural Activities

- Emotional
  - Positive Emotions
  - Abstaining from Negativity
  - Expressing Feelings

- Physical
  - Putting Good Things into Body
  - Active Lifestyle
  - Healthy Figure

- Mental
  - Confidence
  - Non-judgmental
Figure 5.2 Youth perceptions of poor individual health based on the medicine wheel

Good family health was perceived by youth to result from communication, an active lifestyle, and eating healthy foods. In the family context, these perceptions placed responsibility on the individual for controlling the outcome of family health. The family health concerns held by youth, on the other hand, included inactivity, chronic health problems (e.g. diabetes, disease, cancer), obesity, and overall imbalance (i.e. of four quadrants). Here, responsibility starts to shift from the individual and into the greater social
As briefly mentioned, youth tended to place more emphasis on social rather than individualistic processes when they discussed overall community health concerns. On this level, youth identified concerns such as chronic health problems, obesity, and addictions. Here, the responsibility seemed to shift from individual to social concerns about health and well-being, for example those processes that affect the community overall. Community involvement was articulated to play a role in the overall health of the community members, for example through participation in walking programs. By involving the entire community in the walking program, those in need of weight loss are not singled out. Instead, the focus is on support and achieving/maintaining health for all band members. Addictions to drugs and/or alcohol were also considered to stem from social processes, for example, peer pressure (Richmond et al., 2008).

Processes of environmental dispossession were evident in the changing community health context. When youth discussed the changing health of the community over the years, perceptions of health seemed to shift from predominantly physical components to include other components that define the balance of health. For example, youth spoke of declining physical, mental, and spiritual health across the generations and they identified residential schools and changing lifestyles as factors key to this decline. Another significant concern to the youth was the introduction of a local mine. Youth perceived this mine would negatively affect the health of the community and that of future generations as it focused attention on generating economic development rather than the protection of environmental resources and health.

Overcoming community health issues was another theme evident in the youth interviews. Here, youth suggested that the community should implement more community
activities, and increase educational workshops. Community involvement was considered important for promoting active lifestyles, rather than singling out overweight and/or unhealthy individuals. Educational workshops were also viewed as important for all community members, so that they may hold accurate information on health issues, for example, symptoms of diabetes and information for those at risk.

5.1.2 Youth Perceptions of Social Relationships

The second objective of the research was to explore youth perceptions of social relationships. Three main themes emerged from the interviews including: people in the community; relationships in the past; and benefits of social relationships. The first theme, people in the community, was identified as central for community strength. Youth perceived people in the community as close. Youth described a situation wherein people in the community will come together in times of need, in spite of whether or not they get along with each other. These times of need were described as deaths and/or illnesses in the community. Youth generated their perceptions of the way relationships were in the past (i.e. the grandparents of youth) through their own speculation or the combination of stories with outside sources. Outside sources often came from movies or documentaries, for example, documentaries about residential schools.

Findings indicated that the primary benefit of social relationships was social support. This finding was similar to the social relationship literature (Berkman, 1995; House, 1988). Youth spoke of three main sources of support: family, community, and financial. The importance of social support has been well documented in research with the
general population (Berkman, 2000) and in the Aboriginal adult context (Richmond 2007; 2009). When youth spoke of their support networks, they primarily identified informal sources of networks (family, community, and friends). This was supportive of work that linked the Aboriginal context with more informal networks of support (Newbold, 1999). In terms of family support, youth identified a cultural importance of family support.

5.1.3 Social Relationships and Health

Healthy behaviours, communication and stress, and the four quadrants of health, were all identified by youth as ways social relationships influence health. Relationships influenced healthy behaviours by providing the necessary support and encouragement required for overcoming addiction. Likewise to perceptions of social relationships, much work has documented the importance of social relationships in the health of individuals (House et al., 1988). The results of this research supported past research, but provided youth examples of how social relationships affect health in their lives. Good relationships were found to be essential for communication and expressing oneself for stress and emotional relief. As previously mentioned, the literature that has examined the importance of social relationships for health is vast. The literature has identified the role that community plays in shaping health, and the results of this research indicate the same. The area in which this research diverges from the literature is with respect to Indigenous Knowledge. This role of Indigenous Knowledge is further elaborated in section 5.1.5.
5.1.4 Anishinabe Culture and Health

The findings of this thesis demonstrated that youth believe their culture is being lost and/or weakened over time. The preservation of knowledge is important and critical to youth as elders are passing on and taking that knowledge with them. Three main themes emerged from the objective of understanding how culture shapes health. These themes included: traditions and ceremonies; importance of community for health; and changing culture.

Traditions and ceremonies were identified by youth as important for health. Ceremonies have influenced good health through the enforcement of sobriety. Those that wish to attend the ceremonies are only permitted to do so if they are free from the influence of drugs and/or alcohol. Traditions such as hunting were discussed by youth as a way of promoting youth to participate in the collection of their food. Providing the opportunity for the youth to actively engage in this process encourages an active lifestyle and teaches youth about healthy foods.

Community involvement was seen another key theme that emerged from this research. This was mentioned as a key component for maintaining traditions and enforcing community values and knowledge. This finding supports Cajete’s (2010) discussions on the importance of community in maintaining values and traditions. Addictions, for example, were not considered a reason for isolating oneself from community events. In fact, some community members with addictions set examples for other members in the importance of community participation and involvement.

The last theme, changing culture, centered on loss of knowledge, changing gender
roles, and the loss of knowledge keepers (i.e. elders). The change in culture is believed to
directly impact current health status of community members through the loss of spirituality.
One youth spoke of the fact that community members were healthy in the past when
spirituality (e.g. ceremonies and traditions) played an important role in lifestyle. A concept
that cross-cut many of the youth’s interviews was the loss of language. This loss of
language has been identified by Battiste et al., (2000) as directly linked to a loss of
Indigenous Knowledge. Youth were very aware of the loss of language in their community
and spoke of the importance of the language for culture. Language, and in particular,
Ojibway, was considered important for prayers and therefore the spiritual connection to the
creator.

The changing gender role in the community was an interesting aspect of cultural
change. Youth spoke of the increased sighting of females in traditional male roles. Roles
such as hunting, fishing and fire keeping have been increasingly occupied by females.
Youth noted this change to stem from male disinterest in participation and in the desire for
females to learn these traditions. For example, participants provided examples of female
interest in moose hunting and fishing. While it is interesting that females are attempting to
maintain traditions within the community, this participation may have implications for
health. In particular, females may start to become overwhelmed with the various roles they
assume within the community.

5.1.5 The Role of Indigenous Knowledge in Health and Social Relationships

Although youth were not asked directly about Indigenous Knowledge, it was a
concept that significantly underpinned each of the findings. When questioned about health,
Anishinabe teachings such as balance were often brought to conversation. The loss of the traditional Anishinabe lifestyle was also discussed by youth as a way that overall health in the community has been negatively affected. For example, youth identified changing diets, decreased activity levels and a decrease in the gathering of medicines as factors that have contributed to the loss of a traditional lifestyle. The literature has documented a loss of Indigenous Knowledge that has occurred over generations and across communities (Ohmagari, 1997; Plinkerton, 1994). This loss of knowledge was also identified by the Pic River youth. The youth were particularly concerned about the loss of the Anishinabe language as it is the language of their people and holds many stories and importance for ceremonies and traditions. Oral tradition is also maintained through language, which is central to the transmission of Indigenous Knowledge (Smith, 1999).

Youth perceived social relationships in Pic River to be influenced by Indigenous Knowledge. Youth spoke about people and of their support and respect in times of need, as integral to the strength of the community. While some processes may tear people apart, times of need showcase the knowledge community members have of teachings such as respect and love. In terms of social relationships and health, Indigenous Knowledge emerged through the use of ceremony and spirituality as healing and overcoming addictions.

Indigenous Knowledge also appeared to figure strongly in the relationship between health and culture. For example, it is interesting to see that even with the loss of knowledge and changing lifestyles of the community, youth spoke about strong connections to the land, they identified cultural teachings (i.e. respect for land/elders), and hold close ties to their community and land. This suggests that while some processes may be damaging (i.e. environmental dispossession) of Indigenous Knowledge, some are protective (i.e. social
relationships).

While youth are directly facing the effects of environmental dispossession and are in the process of losing their Anishinabe culture, for example language and traditions, it is important to note that not all hope is lost. Youth repeatedly expressed a desire to learn more about their culture, (e.g. the language, how to hunt, and how to identify medicines) and hold strong connections to the land. The strong connection to the land was particularly evident when youth were asked to identify their favourite place. Thirteen of the youth spoke of the natural environment as their favourite place, including: “by the water”, “the mouth of the Pic”, and Pukaskwa National Park. Furthermore, the built environment was identified by youth as their least favourite place. Places identified by youth included the church, garbage dump, cemetery, and playground. This information is critical as it demonstrates the connection youth hold to the land. This information may also play a larger role in the community land claims. Indigenous scholar Leanne Simpson (2004) writes that regaining control over traditional lands is important for recovering Indigenous Knowledge. Having control over their traditional lands would allow the community to use the land in ways that foster and promote Indigenous Knowledge. For example, the land could be used for hunting, and for preserving the natural environment so that it may be available for the use of future generations. The Ojibways of the Pic River First Nation have been engaged in the land claim process and are determined to regain their traditional territory (Figure 5.3). Their repossession of the land would be a step forward towards the recovery of their Indigenous Knowledge.
Figure 5.3 The traditional territory of the Ojibways of Pic River First Nation
Ways of learning Indigenous Knowledge are not occurring in the traditional ways for youth. These traditional ways include learning through observations, interactions with the environment, and through stories. While cultural teachings such as love and respect are recognized by youth in their everyday lives, they also recognized their lack of overall knowledge. Youth were unable to recall many stories, in particular those in reference to their history. Youth spoke of the lack of opportunity to learn local knowledge and expressed great interest for the opportunity to learn. They indicated that the current education system is a barrier for Indigenous Knowledge. This included the structure of indoor classes, disconnecting the youth from the natural environment. Youth also identified disappointment in the Indigenous material taught in courses. They viewed this course material as inadequate and spoke of the need to change the current curriculum. Youth would like schools to offer more cultural components, for example language, and expressed the importance of incorporating the components early in life. For example, youth stressed the importance of elementary school.

5.1.6 Research Framework

As previously stated in the introduction chapter, my hypothesis was that as processes of environmental dispossession continue to affect the ways Indigenous Knowledge is shared at the community level, social and cultural ties will weaken, thereby resulting in poor youth health. The results of this thesis are summarized in a conceptual framework for understanding health and social relationships in the Anishinabe youth context (Figure 5.4). This framework demonstrates the influence of environmental
dispossession on the health and social relationships of youth. This framework suggests that experiences of environmental dispossession directly influences the amount of knowledge an individual can hold. That amount of knowledge influences the relationships of individuals through the way they socially interact with each other, the quality of their social relationships, and the social and moral values of the community. In turn, these relationships influence the quality of youth health. Relationships can also play a role in the amount of Indigenous Knowledge an individual has, should those relationships foster community values that support learning Indigenous Knowledge and offer encouragement and social support. Alternatively, relationships can also hinder the uptake of Indigenous Knowledge if the support is not in place. Essentially, this framework demonstrates that although environmental dispossession is at play in these processes, good community relationships may reverse the loss of knowledge through support and facilitation of learning.
Figure 5.4 Conceptual framework for the influence of environmental dispossession on Anishinabe youth health.
5.2 Research Contributions

This work makes important theoretical, methodological and policy contributions. It makes theoretical contributions to the literatures on Indigenous Knowledge and Health Geography. The methodological contributions are through its use of qualitative and community-based participatory research. Lastly, this research has the potential to inform policy at the local and national levels.

5.2.1 Theoretical Contributions

Theoretically, the results of this thesis have contributed to: 1) improved understanding of the relationship between social relationships and health within the Aboriginal youth context and; 2) a hypothesis detailing how Indigenous Knowledge shapes their health and social relationships. Since this work was exploratory, the results have implications for research with Indigenous youth and for the potential to guide future research. Researchers and/or communities may use the results of this work as a baseline for future work. In addition, my research has contributed to work in areas of Indigenous Knowledge and health geography.

5.2.1.1 Indigenous Knowledge

Indigenous Knowledge has played an increasing role in Aboriginal research (Chandler et al., 2004; Durie, 2004). More importantly, it has been increasingly accepted and used within Aboriginal health research, in understanding the health conditions of communities (Healey et al., 2008). Within the youth context, the results of this research demonstrate that youth perceive
Indigenous Knowledge to be important for health, and that youth believe it should be preserved. As previously mentioned much research has been done with Indigenous adults, but little with youth. This research therefore contributes to the growing body of youth literature. Within this literature, this thesis is the first of its kind to draw from an Indigenous Knowledge framework as a way of understanding how perceptions of health and social relationships are shaped in the youth context. The incorporation of Indigenous Knowledge in research has changed the way Aboriginal health research has been done by redirecting the research to benefit Aboriginal people and communities (Loppie, 2007; Dickason, 2000). In the context of my research, Indigenous Knowledge is found to be protective of First Nations health therefore demonstrating the importance for the preservation of this knowledge.

5.2.1.2 Health Geography

This work contributed to the growing discipline of health geography through the focus on youth within the context of First Nation’s health research. To date, the field of health geography had not explored Aboriginal youth health in terms of their perceptions of health and social relationships. This research chose not to quantify youth perceptions, as much of the current literature has done, but instead focused on a qualitative methodology. By speaking and listening to the voices of youth, this work has added to health geography, as it sought understanding of the importance of place for health through the unique perspective Anishinabe youth hold around their social and physical environments.

This research also added to the health geography literature that examines social determinants of health (Wilson et al., 2002; Richmond, 2007; 2009). While social determinants of health were not directly measured in my research, social support was a key finding of the
research. Understanding these social determinants from a youth perspective is important in the Aboriginal context as youth comprise half of the Aboriginal population and still quickly growing. Only when their perceptions are understood, will solutions that are developed with a focus on preventative and protective health, be able to succeed.

5.2.2 Methodological Contributions

Methodologically, my work adds to the growing base of community-based research and decolonizing methods with Aboriginal communities (Salsberg et al., 2009; Dickason, 2000; Loppie, 2007; Krieg et al., 2008). This research has added to qualitative methodology by utilizing interviews within the context of First Nations youth health. The interview method allowed research to seek understanding of youth perspectives rather than a focus on description. Qualitative research strives to understand meaning in individual life experiences and the processes that shape those experiences (Dwyer et al., 2001). As opposed to quantitative research, qualitative research views the world as dynamic and continually changing, rather than objective and existing as one reality (Dwyer et al., 2001). As such, the interview method was important in gathering the unique perspective of Pic River youth. By working alongside Pic River First Nation on issues of local relevance, this community-based research serves as mutually beneficial to both community and research needs. The base of health research that builds on the needs and interests of First Nation communities is small, and it is an approach that requires considerably more attention (Wilson et al., 2008).
5.2.3 Policy Implications

Government policies, and other forms of environmental dispossession, have been affecting the lives of Canadian Aboriginal people since the onset of colonization. Historically, policies such as the Indian Act of 1876 were enacted with the intent of assimilation and without prior consultation with Aboriginal people (Maaka et al., 2005). The trend of enacting these policies without consultation and/or approval of Aboriginal people has continued until present day and little consideration has been given to the effects of such policies. Recall that an objective of community-based participatory research is to produce results that are relevant to community needs. By working with the Ojibways of the Pic River First Nation, this thesis sought to examine local youth’s perceptions of health and social relationships, so that they may use this information to inform local policies in ways that is beneficial to their needs.

This research has articulated youth perceptions of health and social relationships in the context of local conditions. Specifically, these results may be used to influence policy at the local level (Pic River First Nation), by allocating resources and programs specific to youth. Youth spoke of the desire to learn the language and traditions, therefore indicating an area in which the community should focus. As previously mentioned, the youth health literature has documented the importance of cultural continuities for health (Chandler et al., 1998; 2004; Hallet et al., 2007). Knowing this, the community should focus on activities and programs that strengthen their cultural continuities. For example, one of these continuities is language (Hallet et al., 2007). Language could be strengthened by offering language camps, night courses, or by offering more courses in school. Perhaps schools could offer the option of taking courses in the Ojibway language. Another indicator of cultural continuity is through the existence of cultural
facilities, for example, sweat lodges. Here, the community could focus on this indicator by creating a medicine garden and introducing programs that teach band members how to identify the medicines, and learn their primary uses. Results of this research may also be used within the greater Anishinabe nation to influence decisions and directions for future research, for example, by offering youth in other communities the opportunity to speak about their own perceptions and needs.

The results of this thesis drive home the point that good relationships foster good health. As such, one direction for policy within Anishinabe communities may be to implement or promote programs that bring community members together. For example, community programs could include sweat lodges, recreational activities, hunting camps, and language programs. Another suggested area is the development of programs that strengthen relationships. This could be done within age groups (e.g. children, youth, adults, and elders), and across support networks (e.g. family and community levels). A program that could bring multiple generations together is a hunting or cultural/language camp. In this program, community members could gather for a fixed period and focus on language and cultural activities.

In terms of health promotion, traditional and community activities should be the focus for Pic River. For traditional activities, youth were interested in learning various traditions (e.g. hunting, blueberry picking, identifying medicines, and fishing). Community activities could include cooking demonstrations, or motivational speakers.

5.3 Limitations of the Research

There were multiple, although no significant limitations in this research. These
limitations included an underrepresentation of male youth, availability of youth and interviewers, space for interviews, and advertisement. Participation in the interviews was voluntary and resulted in a 4:1 ratio of female to male participants. The research did not purposefully seek equal numbers of males and females, but rather focused on undertaking interviews with all available and interested youth. Youth availability for interviews was a limitation, as some youth worked more than one job and were not available to partake in one-on-one interviews throughout the week. Some youth, had other obligations such as family that did not allow time to participate in interviews. The availability of interviewers also limited the interview scheduling to one week. Since both Michelle and I do not reside in Marathon, travel and accommodation were both factors that played into our availability.

Interviews were conducted in the band office, youth centre, Pukaskwa National Park, and over the phone. These places were dependent on the availability of space, weather, and the time of day. The band office space was dependent on availability of offices. Conducting interviews at Pukaskwa was both a limitation and benefit. The limitation was the outdoor background noise for the recorded interviews, whereas the benefit was the opportunity to spend time outdoors, which allowed for a less formal interview setting.

The last limitation was advertisement. Although we had held an information session prior to the scheduled interviews, advertised on the television and through flyers – many youth were still unaware of the research. A suggestion for future research would be to mail information letters to all households.
5.4 Directions for Future Research

Research specifically focused on Pic River will proceed to the next phase of the larger community-based project with the other communities in the summer of 2011. This project will draw from a community-based approach that will engage youth from three Anishinabe communities on Northern Lake Superior (Nipigon First Nation, Pic River First Nation, and Batchewana First Nation) in ethnographic research that involves interviewing their community elders about key health and environmental issues.

Based on the results of this research, there are multiple directions for future research in the area of Aboriginal youth health. Some potential directions include, research methods, environmental dispossession, youth and elder integration, Indigenous Knowledge, health geography, and cultural continuities. Future research should be directed towards further understanding Aboriginal youth health through research methods, specifically those that engage the youth throughout the research process, for example, community-based participatory research. This method is valuable for creating research results that are meaningful and beneficial to youth and more of this type of work is required in collaboration with Anishinabe communities and across Canada. Environmental dispossession and its effects on youth health, is another area requiring further research. We know that youth have much to learn from their elders with respect to Indigenous Knowledge. As such there is much potential for research that integrates youth and their elders. Some of the possibilities include language programs, medicine walks, hunting skills, stories about the past, ceremonies, crafts, and ways to care for the land. Additionally, research could focus on what the elders perceive to be important for their youth to learn. Since work with Aboriginal youth is new to health geography, this is also an area of endless
possibilities. Finally, as previously discussed – researchers have described the importance of cultural continuities for the health of Aboriginal people. Future research in this area could examine communities that have implemented indicators of cultural continuities, for example, cultural facilities, and the impact on the health of those communities.

5.5 Conclusion

In summary, this research investigated Anishinabe youth’s perceptions of the relationship between health and social relationships at Pic River First Nation. The overall aim of this thesis was to better understand the role of Indigenous Knowledge in youth’s perceptions of health and social relationships. This research has demonstrated that processes of environmental dispossession are deteriorating Indigenous Knowledge in First Nation communities, thereby changing social relationships (i.e. the way people interact with one another) and the health of communities. This thesis examined these issues at Pic River First Nation because it is a community that has been shaped by unique environmental and social processes, such as water contamination and residential schools – those which pose threat to the maintenance of Indigenous Knowledge at Pic River.

This research was one step in the direction of empowering youth voices within the health and community-based research literature. By bridging youth perceptions of health and social relationships, this work has demonstrated the importance of relationships for health in the lives of youth. Community is vital for the preservation of Indigenous Knowledge and is also important for youth health. Much work remains in this area of research, policies and research should be directed towards youth.
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Appendix A: Ethics Approval

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Use of Human Subjects - Ethics Approval Notice

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<tr>
<th>Principal Investigator:</th>
<th>Dr. C.A.M. Richmond</th>
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<td>Review Number:</td>
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<td>Review Date:</td>
<td>June 10, 2010</td>
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<tr>
<td>Protocol Title:</td>
<td>Anishinabe narratives about health and environment: A participatory approach for preserving elder knowledge and promoting positive experiences for youth</td>
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<td>Department and Institution:</td>
<td>Geography, University of Western Ontario</td>
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<td>Sponsor:</td>
<td>CIHR-CANADIAN INSTITUTE OF HEALTH RESEARCH</td>
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<td>Ethics Approval Date:</td>
<td>June 15, 2010</td>
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<td>Expiry Date:</td>
<td>August 31, 2012</td>
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<td>Approved Local # of Participants:</td>
<td>36</td>
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<td>Review Level:</td>
<td>Expedited</td>
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Documents Reviewed and Approved: Revised study methods, number of study participants, co-investigators and study instruments. Interview Questions for Photovoice Project. Letter of Information and Consent (Elder Interview), Letter of Information and Consent (Youth Interview), Letter of Information and Consent (Youth Photovoice Project).

Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Non-Medical Research Involving Human Subjects (NMREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the applicable laws and regulations of Ontario has granted approval to the above referenced revision(s) or amendment(s) on the approval date noted above.

This approval shall remain valid until the expiry date noted above assuming timely and acceptable responses to the NMREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the study or consent form may be initiated without prior written approval from the NMREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g., change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the NMREB:

a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) all adverse and unexpected experiences or events that are both serious and unexpected;
c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes/adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information/consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the NMREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the NMREB.

Chair of NMREB: Dr. Jerry Peepreeke
FDA Ref. #: IRS 00000041

Ethics Officer to Contact for Further Information

| Dr. Grace Kelly (grace.kelly@uwo.ca) | Janice Sutherland (j.sutherland@uwo.ca) | Elizabeth Wambolt (e.wambolt@uwo.ca) | Denise Grafton (d.grafton@uwo.ca) |

This is an official document. Please retain the original in your files.

cc: CRE File
Appendix B: Interview Guide

Interview introduction

We would like to thank you for being a part of this research, which is about capturing youth voices of Pic River. Your opinions are important because they will help to bring awareness of what Pic River’s youth feel in regard to four main areas: Health & Well-Being, The Land, Culture and Social Networks, and Education and Learning. Over the next hour and a bit, I will ask you questions about each of these four areas.

Remember that this interview is confidential. This means that no one will be able to link you back to your interview. We also want you to know that there are no right or wrong answers, so please feel free to share what matters most to you – if its good, bad – or whatever – we just want to hear what you are thinking about. It is also important that you know you can choose NOT to answer questions if you do not want to.

Do you have any questions before we get started?

-- BEGIN RECORDING ---

1. Before we begin the main part of the interview, could you tell us your full name and date of birth?
2. Do you have any brothers or sisters?
3. What is it you like to do for fun?
4. If you could go anywhere in the world, where would you go, and why?

Section 1: Health & Well-Being

1. What does good health mean to you?
   - When you think of good health, what image pops into your mind. Why? What else?

2. What does poor health mean to you?
   - When you think of poor health, what image pops into your mind. Why? What else?

3. When you think about your family’s health, what’s the first thing that comes to mind?
   - Why do you think that is?
   - Do you have concerns about your family’s health? Which concerns, and why?

4. What worries you most about your community’s health?
   - How might this impact future generations?
   - How might this issue be overcome?

5. How does your generation’s health differ from that of your grandparents?
   - What do you believe are the reasons for these differences?
Section 2: Environment and Land

1. Can you describe for me your favourite place?
   ▪ Why is this place special to you?

2. Can you describe for me your least favourite place?
   ▪ Why do you not like this place?
   ▪ What might make this place more appealing to you?

3. What does the land mean to you as an Anishinabe youth?
   ▪ (Prompt: would you say that the land means something different to you than youth from Marathon?)

4. Is the land important in your learning as Anishinabe youth? How so? Why not?
   ▪ (Prompt: are there types of knowledge you might learn out on the land that you would not learn in a classroom?)

Section 3: Social Networks and Culture

1. What does it mean to you to be Anishinabe?

2. What makes you special as a Pic River youth? For example, what is it about this place that shapes who you are? (Prompt for land AND people)

3. Do you think that the Anishinabe culture is changing over time?
   ▪ If yes, what is changing?
   ▪ How might this change affect future generations?
   ▪ How can we work to maintain Anishinabe culture?

4. What is it that makes this community a strong one? Is this important to you? Why?

5. In moments where you need to be your very best, what is it that encourages you to be your best?

6. What is the importance of social relationships in your life? (Prompt: Your health? Your learning?)
   ▪ What do relationships mean to you?
   ▪ Is it possible for relationships to be both good and bad for you?
   ▪ How might relationships differ today than they did in the past?
     ▪ (prompt: Have you heard stories from your grandparents about what relationships were like in the past?)
Section 4: Education/Learning

1. Tell me about someone who is a role model to you.
    Why is this person a role model to you?
    How has this person influenced and supported your learning?

2. Tell me about someone that you have a lot of respect for.
    How has this person gained your respect?

3. What does it mean to you to have wisdom?
    How is wisdom gained?

4. When you think about learning, what does that mean to you?
    Is it possible for learning to happen OUTSIDE of the classroom? How so?

5. Can you tell me about what you know about Pic River’s Land Claim?
    Do you see this as an important issue for youth in Pic River to learn about?
    Why or why not?

6. Has your experience in this project caused you to think in different ways about your everyday life? If so, how?

END OF INTERVIEW

Thank you for your time. We really appreciate the great efforts you have put into this project and we hope you know how valuable we consider your input.

Is there anything that you would like to add?

Or are there any questions you would like to return to?

--STOP RECORDING--

We would like to get your mailing address so that we can send you a gift card for your participation today. [write on paper].

Also, would you like a copy of your interview?

If you could choose a name to represent you [to maintain confidentiality], what name would you choose?
Appendix C: Curriculum Vitae

KATIE BIG-CANO

EDUCATION

2009-2011
MA: Health Geography
The University of Western Ontario, London, ON
MA Supervisor: Dr. Chantelle A.M. Richmond
Thesis Title: Indigenous Knowledge, Social Relationships and Health: Community-Based Participatory Research with Anishinabe Youth at Pic River First Nation

2004-2009
BSc: Double Major in Biology and Geography
The University of Western Ontario, London, ON

2000-2004
Lakefield College School, Lakefield, ON

RESEARCH & WORK-RELATED EXPERIENCE

- Teaching Assistant – Department of Geography (September 2009-April 2011)
The University of Western Ontario – London, ON
  -Environmental Hazards and Human Health
  -People, Places and Landscapes
  -Geography of Canada

- Research Assistant – Interviewing Youth in Pic River (May 2010-August 2010)
The University of Western Ontario – London, ON

- Research Assistant -Indigenous Health Research Development Program (Summer 2009)
The University of Western Ontario – London, ON

- Research Assistant - The Exercise and Pregnancy Lab (June 2007 -April 2009)
The University of Western Ontario - London, ON
AWARDS

University of Toronto/McMaster University Indigenous Health Research Development Program Graduate Scholarship and Research Support, funded by the Canadian Institutes of Health Research-Institute of Aboriginal People’s Health (value $20,000) (2009-2010)

McMaster University Indigenous Health Research Development Program Graduate Scholarship, funded by the Canadian Institutes of Health Research -Institute of Aboriginal People’s Health (value $13,333) (2011)

PUBLICATIONS AND REPORTS


CONFERENCES AND INVITED LECTURES

- **Chippewas of Georgina Island Career Fair – Invited Speaker.** My Graduate School Experience. Sutton District High School – Sutton West, ON (Mar 2, 2010)

- **National Gathering of Graduate Students – Poster Presentation.** Indigenous Knowledge, Social Ties and Health: Community-Based Participatory Research with Anishinabe Youth at Pic River First Nation. The University of British Columbia – Vancouver, BC (June 2010)