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# Through the Eyes of Children: First Nations Children's Perceptions of Health

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A thesis submitted in partial fulfillment of the requirements for the Master of Science degree in Health and Rehabilitation Sciences

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THROUGH THE EYES OF CHILDREN: FIRST NATIONS CHILDREN'S  
PERCEPTIONS OF HEALTH

(Thesis format: Monograph)

by

Kyla Annui Ursa English

Graduate Program in Health and Rehabilitation Sciences

A thesis submitted in partial fulfillment  
of the requirements for the degree of  
Masters of Science

The School of Graduate and Postdoctoral Studies  
The University of Western Ontario  
London, Ontario, Canada

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## **Abstract**

Few studies addressing Indigenous children's health have incorporated the voices of children or integrated an occupational science perspective. In partnership with the Southwest Ontario Aboriginal Health Access Centre, this community-based study used artwork and sharing circles to understand First Nations children's perceptions of health during a week-long culture camp. The objectives were: (1) to understand how First Nations children view their health, and (2) to explore how children connect health and culture. Findings demonstrated that children's perceptions (n=20, aged 10 to 12) focused on physical aspects of health, such as diet and fitness. Children attended much less to spiritual, mental, and emotional aspects, or to links between cultural occupations and health. Given that children's perspectives emphasized relationships, space, and learning through doing, the findings point to the importance of involving community members, enacting experiential learning, and incorporating cultural traditions in programs aimed at promoting the health of First Nations children.

## **Keywords**

First Nations children, Indigenous health, community-based participatory research, occupation, sharing circles, arts-based methods, culture camp

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## **Chapter 1**

### **1 Introduction**

“Aboriginal children’s well-being is vital to the health and success of our future nations” (Greenwood & de Leeuw, 2012, p. 381). Nevertheless, research has shown that Indigenous children, on average, have poorer health compared to other children in Canada (Gracey & King, 2009; Greenwood & de Leeuw, 2012). In recognition, various communities, Indigenous organizations, and health professionals have sought to design effective ways to promote Indigenous children’s health. However, our understanding of how First Nations children perceive their health is limited. A review of the literature has shown that while much research has been done with parents and caregivers, few studies addressing First Nations children’s health have incorporated the voices of children (Isaak & Marchessault, 2008). Given that one third of the First Nations population is under the age of 14 (Assembly of First Nations (AFN), 2008), there is an urgent need to address this gap in our understanding.

The research outlined in this thesis forms one part of a larger on-going community-based participatory research (CBPR) project with the Southwest Ontario Aboriginal Health Access Centre (SOAHAC). Together with Dr. Chantelle Richmond and other academic partners at Western University, SOAHAC is in the process of creating and enacting health-promoting programs for First Nations children, with a key aim to facilitate the transfer of Indigenous Knowledge (IK) between Elders and youth. This research was based on an assumption shared by the team members that in order to create appropriate and effective health programs for First Nations children, an understanding of how they view health must first take place (Graham & Stamler, 2010).

Overall, the objectives of this research were two-fold: (1) to enhance understanding of how First Nations children think about their health, with a focus on occupations connected to health; and (2) to explore how these children connect health and culture. The overall aim was to generate knowledge that can inform the development of future health programs for First Nations children.

### **1.1 Situating Myself in the Research**

I am a non-Indigenous Master's student in the field of Occupational Science within the Health and Rehabilitation Sciences program at Western University. In June 2012, I completed my undergraduate degree at the University of Waterloo (UW) in Applied Health Sciences. In my final year at UW I developed a sincere interest in health promotion, largely through volunteering for a tobacco awareness campaign called Leave the Pack Behind. This organization gave me the opportunity to work with students in the community and to provide them with the resources needed to make informed decisions about their health. In addition to health promotion, I am interested in working with children. During my last year at UW, and throughout my Master's program at Western, I have been a supply worker at a number of daycares, both in Waterloo and London. Working in these settings has heightened my interest in infant and child health, and how various biological, social, and environmental factors can play a role in child development.

By the time I graduated from UW, I was ready to further my knowledge in relation to health promotion within a different context. Knowing that I wanted to switch universities, I approached the Dean of Health Sciences at UW to ask for advice on finding a supervisor in Southwestern Ontario. Following her suggestion, I contacted Dr.

Richmond at Western University (Department of Geography) and set up a meeting with her and Dr. Rudman (Field of Occupational Science, Faculty of Health Sciences), whom she had worked with previously. At this meeting I learned about Dr. Richmond's research, which centers around the social and environmental determinants of Indigenous people's health. Although, at the time, I knew little about this field, I quickly became interested in the research that she and Dr. Rudman pursue. A few short months later, in September 2012, I found myself back at Western University, ready to begin my Master's degree with Drs. Richmond and Rudman as my co-supervisors.

**1.1.1 My critical constructivist perspective.** Despite my undergraduate training, which largely focused on quantitative methodologies and postpositivist ways of thinking, my perspective on the world is more in line with a critical constructivist view. In thinking about Indigenous children's health, I aim to be critical through examining the social determinants of health, or "... the conditions in which people are born, grow, live, work and age" (World Health Organization (WHO), 2014). In Canada today, determinants such as colonialism and racism continue to marginalize Indigenous people and create health inequities that are disproportionally experienced by Indigenous children (Loppie-Reading & Wien, 2009). Throughout this thesis I aim to be critical in being attuned to how these and other factors, including Indigenous children's social and physical environments, play a role in how they think about themselves, other people, and ideas such as health.

As a constructivist, I also believe that our perceptions of reality, including the ways that we think about health, are influenced by our individual values, and the values of those around us. Within this research study, we therefore assumed that the children's perceptions were co-constructed through socio-cultural processes, including the

interactions that occurred within the context of the research. The children's values, as well as the values of the researchers and the Research Assistants (RAs), influenced what was found (Ponterotto, 2005). A greater discussion on my epistemological view, and the ways in which it aligns with the principles of CBPR and IK, is provided in Chapter 3 of this thesis.

**1.1.2 Assumptions of occupational science.** This study is located within the field of occupational science, and was thus informed by key assumptions from this field. Given this disciplinary location, a key focus of this thesis is on the occupations that First Nations children associate with health and/or their culture. In this study, occupation is defined broadly, as encompassing "... all the ways in which we occupy ourselves individually and as societies" (Townsend, 1997, p. 19). All of the activities that the children associated with health and/or their culture, including brushing one's teeth or dancing in ceremonies, are considered in this thesis to be occupations.

A key assumption of occupational science is that engagement in occupation is associated with health and well-being (Yerxa, Clark, Jackson, Pierce, & Zemke, 1990). This connection is multifaceted and has been approached as a topic of research by a number of scientists within the field. Yerxa (1998), for example, has explained that "health may be influenced by discovering or developing new capacities, changing the environment, nurturing ambition, improving performance, and modifying mood" (p. 414). More recently, Christiansen and Matuska (2008) have connected occupation to health through the idea of lifestyle balance. According to these researchers, the daily occupations chosen by individuals can either lead to a balanced or imbalanced lifestyle, which can consequently affect a person's health status. Other authors have focused on the

inter-connections between occupation, identity and health, such as Christiansen (1999) who proposed, “occupations are key not just to being a person, but to being a *particular* person, and thus creating and maintaining an identity” (p. 547). Moreover, in relevance to the topic of this thesis, some occupational scientists have explored the idea that engagement in cultural occupations, defined broadly as occupations that “... maintain family and cultural connections... and keep customs alive” (Boerema, Russell, & Aguilar, 2010, p. 82), can strengthen one’s cultural identity and lead to greater overall health (Boerema et al., 2010; Kumar, 2011). Moreover, participation in cultural occupations can lead to a collective sense of self, and a sense of belonging to one’s culture (Kumar 2011; Riley, 2008). Riley (2008) explored the links between collective occupations, identity and health through examining textile-making among members of a Welsh guild. According to Riley (2008), “through a collective sense of self and through belonging we come to know who we are and what our purpose is, where a sense of belongingness is a strong indicator of health and happiness” (p. 71).

The present study adds to the knowledge base within occupational science by exploring the occupations that First Nations children connect to health, and the ways in which they connect their culture with health. Throughout this thesis, I will examine the links between occupation, identity and health, and make recommendations for future health programs based on these important connections. The following section will outline the research activities used to explore children’s perceptions, and the camp in which these activities took place.



## **1.2 Situating the Research: Exploring Health Within the BLE**

The research outlined within this thesis took place during a week-long summer culture camp, called the Bimaadiziwin Learning Experience (BLE), in August 2013. Past research has shown that exposure to traditional occupations and IK, in the context of the modern world, can help First Nations children to develop their cultural identity and consequently improve their health (King, Smith, & Gracey, 2009; Royal Commission on Aboriginal Peoples (RCAP), 1996). At this camp, First Nations children (n=20) aged 10 to 12 years participated in various cultural and research activities, including drum making, a medicine walk, and sharing circles. The BLE occurred at SOAHAC's Garden Learning Centre (GLC), on the Chippewas of the Thames First Nation. At the time of this study, only a few of the participants lived on this reserve; other children came from Oneida Nation of the Thames, Kettle and Stony Point First Nation, Walpole Island First Nation, and the city of London, Ontario. The BLE was facilitated by SOAHAC staff, local First Nations youth, a number of community Elders, and researchers from Western University.

In order to achieve our research objectives, our team employed a strengths-based qualitative methodology that included a painting activity and sharing circles. On the first day of the BLE, children were asked to paint individual pictures depicting their perceptions of health. In addition to this visual data, children participated in audio-taped sharing circles, with four to six children per circle, to discuss their paintings and to answer various open-ended questions about health. In addition to these research activities, I maintained a detailed field journal throughout the BLE as an additional source of data, in which I wrote down my observations and personal reflections about the

research process. Following the BLE, a thematic analysis was performed on the data, which was then presented to SOAHAC for elaboration and clarification. Further details regarding the methodology and methods is provided in Chapter 3 of this thesis.

Information gained throughout this project will be used by SOAHAC to better understand the knowledge that First Nations children have about health, and to create more effective health programs for children in their community. It is anticipated that this study, as well as the broader community-based participatory project in which it is embedded, will have implications not only for this specific Indigenous community but also for providing a template for key elements of programs aimed to improve children's health in other Indigenous communities across Canada.

### **1.3 Key Concepts Throughout this Thesis**

This section will briefly outline a number of key concepts that are foundational to this study and re-appear at several points in this thesis. Most of these concepts are defined elsewhere throughout this thesis; an indication of where to find a longer explanation is provided beside these concepts. Please note that the concepts are listed in alphabetical order.

**Children:** Any person up to, and including, the age of 14 (AFN, 2008; RCAP, 1996; Statistics Canada, 2014).

**Community:** For the purposes of this thesis, community is defined as “any group of people who share ways of being together” (RCAP, 1996. p. 139).

**Culture:** “[The] systems of belief, values, customs, and traditions that are transmitted from generation to generation through teachings, ecological knowledge and

time-honoured land-based practices” (McIvor, Napoleon, & Dickie, 2009, p. 7). Please see Chapter 2.

**Cultural Identity:** “A complex of features that together shape how a person thinks about herself or himself as an Aboriginal person” (RCAP, 1996, p. 523). Please see Chapter 2.

**First Nations:** Indigenous people in Canada who are not Métis or Inuit. The term became widely used in the 1980s to replace ‘Indian band’; however, it is still not legally recognized in Canadian law (Ashcroft, Griffiths, & Tiffin, 2013).

**Indigenous:** In Canada, the term ‘Aboriginal’ refers to the original peoples of Canada, including First Nations, Inuit, and Métis people (Ashcroft, Griffiths, & Tiffin, 2013). However, it has come to my attention that many Aboriginal people, including those involved in this project, prefer the term ‘Indigenous’. I will therefore use the word Indigenous rather than Aboriginal within this thesis, except when direct quotes contain the word Aboriginal.

**Indigenous Knowledge (IK):** The knowledge held by First Nations, Inuit, and Métis people that allows them to live in balance with the natural environment (e.g., with the plants and animals of their local ecosystem) and the social environment (e.g., with their family members, friends, and greater community) (Little Bear, 2000; Richmond, 2014). Please see Chapter 3.

**Occupation:** “The various everyday activities people do as individuals, in families and within communities to occupy time and bring meaning and purpose to life” (World Federation of Occupational Therapists, 2011, para. 2). Please see Chapter 2.

## **1.4 Structure of this Thesis**

The second chapter in this thesis begins with an overview of First Nations children's health in Canada, followed by a discussion of the social determinants of health. A review of the literature on First Nations children's health is then provided, as is literature pertaining to the connections between health, occupation and culture. In addition, relevant research from the field of occupational science is explored, with an emphasis on research linking engagement in cultural occupations to an enhanced sense of cultural identity. Chapter 3 outlines the CBPR methodology that was employed within this study, as well as the various methods that were used to collect and analyze the data. Throughout Chapter 3, I aim to be transparent in describing how the research decisions were made, and the various challenges and successes that our research team experienced. Chapter 4 explores the results from the data analysis, with examples of the children's paintings and descriptive quotes integrated throughout. Finally, in Chapter 5, I interpret and discuss the findings, and provide recommendations for subsequent research and suggestions for health promotion programs aimed at First Nations children. I conclude Chapter 5 by discussing the strengths and limitations of the present study, followed by some final reflections on my own research experience.

## **Chapter 2**

### **2 Literature Review**

This chapter provides a background for this study through reviewing literature regarding Indigenous children's health in Canada. I begin by summarizing what is known regarding the prevalence and growth of this young population, and the various health issues that Indigenous children face. Given the evidence of the influence of social, political, and historical conditions on the health of Indigenous children, I then focus on the social determinants of health, and provide the broad definition of health that informed the present study. Throughout the rest of this chapter I highlight the diversity of research that has been done on Indigenous children's health in Canada, both within and outside the field of occupational science. In particular, given the foci of this study, research addressing the important connections between health, culture, and identity is explored, followed by a discussion on the importance of involving families, Elders, and other community members in health promotion programs for First Nations children. It is important to note that the majority of information within this chapter will pertain to a broad Indigenous population rather than solely First Nations people, as most studies and reports that were relevant to this thesis did not differentiate between First Nations, Métis, and Inuit children. Nevertheless, whenever possible, I will highlight research done specifically with First Nations children. Throughout this chapter and specifically at the end, I will summarize relevant gaps in research, and explain how the present study, including the camp in which the study occurred, was designed to address these gaps.

## **2.1 Indigenous Children in Canada**

**2.1.1 Prevalence and growth of Indigenous children.** In Canada, over half of the Indigenous population is under the age of 25, and approximately one third are under the age of 14 (Assembly of First Nations (AFN), 2008; First Nations Centre (FNC), 2005). Canada's Indigenous population is therefore considered young, and has almost double the percentage of children as compared to the general population (Royal Commission on Aboriginal Peoples (RCAP), 1996; Kral, Idlout, Minore, Dyck, & Kirmayer, 2011). Moreover, due to higher fertility rates among Indigenous teenagers and a shorter life expectancy as compared to the non-Indigenous population, the proportion of youth within the Indigenous population is expected to rise (AFN, 2008; United Nations Children's Fund (UNICEF), 2009). Unfortunately, as will be discussed in the following section, Indigenous children are also more likely to experience a variety of health conditions, such as type two diabetes and obesity (FNC, 2005). Given the high proportion of Indigenous children in Canada, and the health issues that these children face, it is a crucial focus of our research.

**2.1.2 The health of Indigenous children in Canada.** While notable differences between and within Indigenous groups exist, for example in the customs and traditions that each community pursues, certain similarities are present as well, such as the health issues that their children face (Gracey & King, 2009). In Canada and throughout the developed world, Indigenous children fare far worse on most indicators of physical, mental and emotional health as compared to non-Indigenous children. Over one third of First Nation children are obese, for example, and are two to three times more likely to be obese than non-Indigenous children (FNC, 2005; Smith, Findlay, & Crompton, 2010).

Participating in regular physical activity can help prevent obesity as well as reduce stress and increase self-esteem (FNIGC, 2012); however, according to calculations of energy expenditure, over 43% of First Nation youth are considered inactive (FNIGC, 2012).

Due in part to the high rates of obesity among Indigenous people, the prevalence of type II diabetes among First Nations children is also on the rise (Isaak & Marchessault, 2008). First Nations people are four to five times more likely than the general Canadian population to develop type II diabetes, and the age of onset is decreasing as well, affecting younger populations (Kirmayer, Simpson & Cargo, 2003; UNICEF, 2009). Moreover, according to a 2009 report on Indigenous children's health, "research conducted in northern First Nations communities in British Columbia and Ontario concluded that diabetes has reached epidemic proportions among children and youth" (UNICEF, 2009, p. 13).

In addition to the high rates of obesity and diabetes, Indigenous children are more likely than non-Indigenous children to suffer from dental caries (AFN, 2008), to report ear infections (UNICEF, 2009), and to have a disability (AFN, 2008). Injury rates are much higher among Indigenous children and youth, and suicide rates are three to six times greater than in the general Canadian population (Kirmayer et al., 2003). As Indigenous children reach adulthood, their average life expectancy is eight years less than the broader Canadian average (Bennett, Blackstock, & De La Ronde, 2005).

While it is important to understand the health disparities that Indigenous children face, a growing body of work has moved beyond just identifying these disparities, to critically examining the underlying social and structural causes of their existence. The

following section will examine some of these underlying causes, also known as the social determinants of health.

**2.1.3 Social determinants of Indigenous children's health.** The health disparities between Indigenous and non-Indigenous children have existed for decades, and no single elucidation can explain why they exist. Increasingly, it has been argued that in order to understand the underlying causes of these disparities, it is important to consider the social determinants of health, defined as “the conditions in which people are born, grow, live, work, and age – conditions that together provide the freedom people need to live lives they value” (Commission on Social Determinants of Health, 2008, p. 26). Several researchers and organizations have created lists or developed models to illustrate the complexity of the social determinants within an Indigenous context (e.g., AFN, 2008; UNICEF, 2009). Within this thesis, I draw upon Loppie-Reading and Wien (2009), whose framework provides a means to categorize such determinants in relation to three broad categories, including proximal, intermediate, and distal determinants of health. These determinants have combined to create an environment where Indigenous children struggle to live a healthy, balanced lifestyle (Gracey & King, 2009).

Proximal determinants “...include conditions that have a direct impact on physical, emotional, mental, or spiritual health” (Loppie-Reading & Wien, 2009, p. 5), and “... include employment, income, and education” (Greenwood & de Leeuw, 2012, p. 5). In general, Indigenous people have lower employment rates, lower incomes, and fewer years of education as compared to the general Canadian population (FNIGC, 2012). These factors contribute to a greater percentage of Indigenous children living in poverty. As they enter high school, First Nations youth are more likely to drop out early,



continuing the trend of lower employment levels and below-average incomes (FNIGC, 2012; Statistics Canada, 2011).

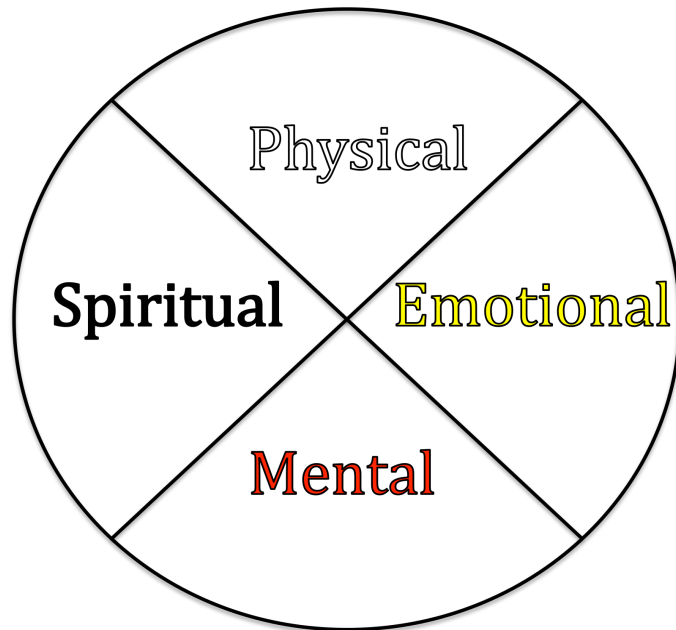
Intermediate determinants are described as “the origin of... proximal determinants” (Loppie-Reading & Wien, 2009, p. 15) and include cultural continuity and health care systems. Studies have shown that communities with higher levels of cultural continuity, including control over local programs and services, report greater levels of community wellness and fewer numbers of suicides (Chandler & Lalonde, 1998; Hallett, Chandler, & Lalonde, 2007). A further discussion of cultural continuity is provided later in this chapter.

Finally, the distal determinants of Indigenous children’s health “...have the most profound influence on the health of populations because they represent political, economic, and social contexts that construct both intermediate and proximal determinants” (Loppie-Reading & Wien, 2009, p. 20). Colonialism, racism, and self-determination are examples of distal determinants of health (Greenwood & de Leeuw, 2012; Loppie-Reading & Wien, 2009). For centuries, distal determinants have had an effect on the social, cultural, economic, and political lives of First Nations, Métis, and Inuit children (Gracey & King, 2009; Larkin et al., 2007). Many of the substandard health conditions that Indigenous children face today are a direct result of these distal determinants of health (Loppie-Reading & Wien, 2009). Moreover, while distal determinants are “...the most difficult to change” (Greenwood & de Leeuw, 2012, p. 5), it has also been argued that “...if transformed, distal determinants may yield the greatest health impacts, and, thus, long-term change to Aboriginal child health inequities” (Greenwood & de Leeuw, 2012, p. 5).

While proximal, intermediate, and distal determinants of health allow us to understand the underlying causes of health inequities, it is important to consider how health is defined. It is clear from the statistics presented above that many reports on Indigenous children's health highlight physical illness and disease, with relatively little attention paid to the mental, emotional, and spiritual aspects of health. In the following section I will introduce the First Nations medicine wheel to reinforce the importance of employing a holistic definition of health when conducting research with First Nations children.

**2.1.4 Defining health using the medicine wheel.** Within First Nation communities, the notion of health is often represented by the medicine wheel, which symbolizes “balance, interdependence, and wholistic health” (Cargo, Peterson, Lévesque, & Macauley, 2007, p. 88). While the medicine wheel originates from the Plains Cree tradition, it has become a universally understood and accepted cultural conceptualization of “living well” among Indigenous peoples across Turtle Island, or North America. The medicine wheel is divided into four quadrants that represent many concepts, including the four directions (North, South, East, and West), the four stages of life (childhood, adolescence, parenthood, and later life), and the four aspects of health (physical, mental, emotional, and spiritual) (Wilson, 2003). Each aspect in the medicine wheel is dependent upon the others, meaning one must live in balance in order to be healthy (Wilson, 2003). Health is therefore more than just a physical state, but a combination of physical, mental, emotional, and spiritual well-being (Cargo et al., 2007; Wilson, 2003). Moreover, “balance extends beyond the individual realm, such that good health and healing also require that an individual live in harmony with others, their community, and the spirit

worlds” (Wilson, 2003, p. 87). The medicine wheel is used in different ways by different First Nation communities, and is used by programs and health centres, such as the Southwest Ontario Aboriginal Health Access Centre (SOAHAC), as a tool to promote balance and overall well-being. An example of the medicine wheel, showing the four aspects of health, is provided in Figure 1 below.



*Figure 1.* The First Nations medicine wheel. Adapted from teachings I received at SOAHAC.

In summary, most of the research addressing Indigenous children’s health has focused on the health disparities that these children face. These disparities, however, cannot be understood as separate from the contexts in which they occur. Research focusing on Indigenous children’s health must therefore address the social determinants of health and consider the broader social, cultural, historical, and political contexts that shape the health of today’s children. In addition, research needs to address how First Nations people experience and perceive health, rather than impose Westernized

conceptions that are incongruent with Indigenous ways of knowing. The present study was developed based on teachings from the medicine wheel, as the medicine wheel was viewed as important by SOAHAC, and as a tool to achieve and maintain health. The following section will explore research that has been done with Indigenous children in Canada, and the relevant gaps that the present study addresses. In particular, the section will address the relative neglect of children's perspectives in the research process, despite a growing understanding that "Aboriginal children and young people need to be actively engaged in conversations about child and youth health" (Blackstock, Bruyere, & Moreau, 2006, p. 7).

## **2.2 Research on Indigenous Children's Health in Canada: The Relative Neglect of Children's Perspectives**

In Canada, research on Indigenous children's health has largely been quantitative and has relied on data collection with parents and other caregivers in order to understand children's health issues and behaviours (Pigford, Willows, Holt, Newton, & Ball, 2012). Children's perceptions of health and well-being have rarely been explored (Isaak & Marchessault, 2008; Kalnins, McQueen, Backett, Curtice, & Currie, 1992); the health behaviours of children have thus been "documented separately from an understanding of their meaning" (Shucksmith & Hendry, 1998, p. vi), or from the caregiver's understanding rather than the child's (Isaak & Marchessault, 2008). While caregivers' perceptions are important to understand, they may differ significantly from those held by the child (Kalnins et al., 1992). Including children in research leads to "... a deeper understanding of youth's health issues and behaviours" (Woodgate & Leach, 2010, p.

1173), and is “an essential first step to provide effective programming for Aboriginal Peoples” (Graham & Stamler, 2010, p. 7).

In order to understand the extent of qualitative research that has been done with Indigenous children and youth in Canada, I conducted a review of the literature in November 2012, using three online databases: Web of Knowledge, Scopus, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Given the topic of this thesis, I initially intended to focus my literature review on studies with First Nations children. However, due to a lack of relevant literature, and in order to gain a better understanding of all research with Indigenous children in Canada, I decided to extend my search to include Métis and Inuit participants as well. A total of 18 relevant studies were retrieved from this review, all examining health and/or well-being and all involving a qualitative component with Indigenous children under the age of 18. In February 2014 I repeated this search to uncover any new publications, and found an additional 13 articles which were relevant to this review.

Of the 31 studies found, the majority of studies involved children or youth over the age of 12 years. Given the age range of children in the present study (10-12 years), it is important to note that only three studies have focused on the meaning of health among Indigenous children aged 12 years and younger (Pigford et al., 2012; Skinner, Hanning, & Tsuji, 2006; Dyckfehderau, Holt, Ball, Alexander First Nation, & Willows, 2013).

Pigford et al. (2012) looked at First Nations children’s perceptions of food, health, and activity on a First Nations reserve in Alberta. In this study, children (n=15) aged 8 to 10 years participated in focus groups, accompanied by drawing and pile-sorting activities. Results of the study showed that children preferred food and activities from both Western

and traditional cultures, and that their perceptions were highly influenced by “traditional Cree values and the values of the larger society” (Pigford et al., 2012, p. 990). Children discussed cultural activities and foods that they liked, and considered many of these to be healthy (Pigford et al., 2012). The children also discussed the importance of family, indicating that the majority of their activities and their food-related experiences involved siblings, cousins, parents, and/or grandparents (Pigford et al., 2012). While parents and Elders were cited as important sources of cultural knowledge, other sources, such as school teachers and the media, were identified as contributing to children’s nontraditional knowledge. Finally, foods and activities related to nature, such as growing seeds and eating seeds from the ground, were identified as healthy by the children (Pigford et al., 2012).

Another similar study was conducted by Skinner et al. (2006) in northern Ontario, with Indigenous children (n=30) under the age of 12. While the first phase of this study included only adults over the age of 20, the second phase involved focus groups with Indigenous children in grades six to eight (aged 11-14 years). Within these focus groups, children were asked various questions about healthy foods and physical activities, as well as the barriers and supports to accessing these foods and participating in exercise. Unfortunately, at least for the purposes of this review, the results mainly focused on the adult participants, and very few quotations were provided from the children. I found it challenging to separate the children’s results from the adults’, as both sets of results were grouped under the same themes and within the same concept map. The authors attributed the lack of children’s quotations to the fact that “their responses tended to be short, one word answers” (Skinner et al., 2006, p. 157), concluding broadly that the children’s

replies “confirmed some of the barriers identified during discussions with the adults participants” (Skinner et al., 2006, p. 157). While perhaps not on purpose, this study exemplified the common approach in children’s research of valuing adult and caregivers’ opinions while overlooking those of the child.

The third study involving Indigenous children aged 12 years and under was conducted by Dyckfehderau et al. (2013) in conjunction with Alexander First Nation in Alberta. In this study, First Nations children (n=7) aged 11 to 12 years were interviewed about the “external, behaviour-shaping factors that influence [their] lifestyle behaviours” (Dyckfehderau et al., 2013, p. 1). The interviews comprised of three sections, including: (1) a photo review of pictures from their community; (2) a mapping exercise, where children looked at a map and identified places associated with health, and; (3) an ‘ideal-world’ discussion, where children were asked to describe changes that they would like to see in their community. Results of the study showed that children enjoyed playing outside, on the trails and pathways around their community. In their ideal world, however, the children said that they would appreciate a greater number of paved trails, a new park, and a leisure centre with a pool, a gym, and a skating rink. The children identified a number of locations where they eat, and suggested that the local convenience store should start selling healthier foods. This study allowed researchers and community members to see Alexander First Nation through the eyes of its children, and to create changes in the community that would serve the children’s interests and help them lead healthier lives.

A number of other studies have included Indigenous children aged 12 years and over. However, the majority of these studies included participants of a large age range,

and often did not concentrate on the perceptions of the younger participants, or failed to separate their voices from those of the older youth. Kral et al. (2011), for example, explored Inuit meanings of health and happiness by conducting interviews with participants (n=50) aged 14 to 94 years. Prominent themes within the findings were that consumption of traditional foods, as well as strong kinship and community ties, were important determinants of health and happiness (Kral et al., 2011). While Kral et al. (2011) included a wide variety of quotes from different age groups, the majority of these quotes were from participants aged 20 years and over, with only a few quotes included from the youth.

Isaak and Marchessault (2008) conducted interviews with first Nations adults (n=10) and focus groups with First Nations youth (n=29) aged 12 to 19 years, in order to understand what health meant to them. While older youth discussed health in terms of the medicine wheel and had knowledge about the four aspects of health (physical, mental, emotional, and spiritual), younger youth rarely mentioned the medicine wheel, and spoke mostly about factors influencing physical health, such as eating well and exercising (Isaak & Marchessault, 2008). While the younger youth discussed some traditional practices, such as hunting and participating in sweats, they did not hold much knowledge of these practices, and attributed the health benefits primarily to the physical effort involved (Isaak & Marchessault, 2008).

A study by Stewart, Riecken, Scott, Tanaka, and Riecken (2008) also explored the meanings of health and well-being among urban Indigenous youth over the age of 12 years. In this study, youth created educational videos about various aspects of health, such as drug and alcohol use or drinking and driving, and were later interviewed about



their research experience (Stewart et al., 2008). While the article did not specify the number of youth involved in the creation of videos, it did state that 35 interviews were conducted with the youth, their teachers, and the university researchers. Four inter-related themes emerged from these interviews: community, culture, confidence, and control. Community and culture were important components of the entire research process as youth worked within their communities and cultural contexts to understand health and create their videos. Confidence was gained by the youth in this project by being empowered in the video-making process and gaining valuable knowledge and skills. Finally, the youth were in control of the project, and made their own decisions about what to research, who to approach for help, and what to reveal in their videos. Some of the youth even talked about changing their own health behaviours, and feeling more in control of their health, after researching these important issues within their community (Stewart et al., 2008).

One final study, which is particularly relevant to the topic of this thesis, was conducted by Cargo et al. (2007). The purpose of this study was to create a measure of perceived holistic health, and to use this measure in assessing the health of local First Nations youth. Nine participants aged 13 to 17 years helped to create this tool by providing definitions of each aspect of health – physical, mental, emotional, and spiritual – and suggesting that holistic health represents a balance between these aspects. After applying the final measure to local youth in grades seven to 11, findings suggested that “youth living in balance tended to be more physically active and watch less television than those youth experiencing disharmony” (Cargo et al., 2007, p. 100).

Overall, while a few studies have explored Indigenous children's perceptions of health, the majority of these studies have involved individuals over the age of 12 years, and/or have highlighted adults' opinions over those of the children. The first three studies that involved children aged 12 years and younger found that family members and community connections, including access to cultural programs and opportunities to learn from Elders, play a significant role in how children view health. As well, Indigenous children associated being healthy with being outdoors. The final four studies which involved youth aged 12 years and over uncovered similar findings, and found that health is associated with maintaining relationships and feeling connected to one's community. While Indigenous children in all of these studies connected cultural activities to health, and a few had knowledge about the medicine wheel and/or other cultural symbols, their perceptions of health generally centered around physical well-being.

This review has highlighted an important gap in research, specifically, that little is known about Indigenous children's understandings of health. Indigenous children have been defined as one of the most marginalized groups in Canada (National Collaborating Centre for Aboriginal Health, 2012; UNICEF, 2009); by excluding these children from participating in research, and preventing their voices from being heard, we are only marginalizing them further. Moreover, as Greenwood and de Leeuw (2012) have explained, Indigenous children today are the leaders of tomorrow. By participating in research and helping to develop programs that will benefit their communities, Indigenous children will have opportunities to gain skills and build the capacity needed to work with their communities to achieve self-determination, a distal determinant of Indigenous people's health (Loppie-Reading & Wien, 2009).

The study described in this thesis aims to incorporate the voices of children by exploring the perceptions of First Nations children aged 10 to 12 years. The information gained from this study will be used by SOAHAC to create future health programs for children in and around London, Ontario; the voices of the children in this study will thus be used to affect change and to improve the health of others within their community.

## **2.3 Health, Occupation and Culture: Employing an Occupational Science**

### **Perspective**

As explained in Chapter 1, a unique feature of the present study is that it was located within the field of Occupational Science at Western University. Occupational science is a relatively new field that began to take form in the mid-1970s in Southern California (Yerxa, Clark, Jackson, Pierce, & Zemke, 1990). From the beginning, this basic science has had a dual aim of (a) supporting occupational therapy practice, and (b) building a knowledge base about the concept of occupation “without the prior constraint of practical application” (Yerxa et al., 1990, p. 4). The intent of the present study was not to support occupational therapy, but rather to help SOAHAC carry out research in their local community, and to enhance our understanding of if and how children connected their occupations to health. More specifically, the objectives of this study included examining the occupations that First Nations children associate with health, and the connections they make between occupation, health, and culture.

A number of important concepts of relevance to this study have emerged from the field of occupational science within the past few decades. Throughout the following section I will explore these concepts. I will then examine a few discernible gaps in

occupational science research, and subsequently explain how the present study will address these gaps and contribute to the knowledge base in occupational science.

**2.3.1 Relevant contributions from the field of occupational science.** Simply put, the goal of occupational science is to study the concept of occupation, and how engagement in various occupations – or lack thereof – can enhance or inhibit one’s ability to achieve health (Yerxa et al., 1990). Occupations have been defined as “the various everyday activities people do as individuals, in families and within communities to occupy time and bring meaning and purpose to life” (World Federation of Occupational Therapists, 2011). To date, much of the research within occupational science has focused on the individual, investigating how individuals occupy time with meaningful and purposeful activities, and how such occupations are connected to an individual’s sense of health and well-being (Hocking, 2009). Nevertheless, scholars in the field have recently criticized this emphasis on studying individuals, arguing that “occupation rarely, if ever, is individual in nature” (Dickie, Cutchin, & Humphry, 2006, p. 23). Increasingly, scholars are attempting to conceptualize and study occupations as occurring within and through complex social, cultural, political, and historical contexts, and as inseparable from the environments in which they occur (Dickie et al., 2006). This shift is commensurate with a social determinants of health perspective, which sees health itself as shaped within and by various aspects of social, cultural, political, and historical contexts.

The pervasive use of an individualistic frame within occupational science has not lent itself well to the study of occupations within collectivist cultures, such as Indigenous cultures, which emphasize interdependence over independence, and the community over

the person (Phelan & Kinsella, 2009). Some scholars have therefore turned their focus from individual to collective occupations. Within the occupational science literature, collective occupations have been defined in two major ways: as occupations engaged in by more than one person (Fogelberg & Frauwirth, 2010), or as occupations that may be done alone, but contribute to a collective sense of self through shared meaning with others (Stephenson, Smith, Gibson, & Watson, 2013). Stephenson et al. (2013) explored the collective occupation of weaving among women in the Karen culture. Weaving can be done alone or in a group, but either way “can connect the women together and create a social context” (Stephenson et al., 2013, p. 19). Similar to weaving within the Karen culture, many occupations within Indigenous societies are collective in nature as well (Darnell, 2009).

According to Ramugondo and Kronenberg (2013), collective occupations are “... informed by a shared vision across all levels of an organization” (p. 8), and are defined by their “intention towards social cohesion or dysfunction, and/or advancement of or aversion to a common good” (p. 8). Social cohesion is a primary goal within many First Nation communities; as Little Bear (2000) states, “interrelationships between all entities are of paramount importance” (p. 77). Moreover, a common belief among Indigenous people is that all of Mother Nature – the trees, the rocks, and the water – is animate. According to Little Bear (2000), “If everything is animate, then everything has spirit and knowledge. If everything has spirit and knowledge, then all are like me. If all are like me, then all are my relations” (p. 78). When studying occupations within Indigenous communities, it is important to consider how all of life’s relationships – not only between people, but between people and their environments – shape the experience

of the ‘collective’. Unfortunately, I could not locate any studies within the field of occupational science that examined collective occupations from an Indigenous perspective.

**2.3.2 Occupational science research with Indigenous communities.** Very few studies within occupational science have explored the occupations of First Nations and/or other Indigenous populations. The majority of articles that make reference to Indigenous people have discussed the impacts of colonization on traditional occupations, such as hunting and gathering. Yalmambirra (2000), for example, discussed the impact of colonization on the traditional occupations of Indigenous people living in Australia, as well as the difference between traditional Wiradjuri time and Western time. Similarly, Thibeault (2002) examined traditional occupations of Inuit communities in Canada, and the various social, health, and occupational consequences of colonization. More recently, Darnell (2009) explored traditional subsistence occupations, such as hunting and fishing, among First Nations people in Canada, and concluded that, “for many Aboriginal peoples, to be occupied in a satisfying way is to be occupied in ways continuous with the past” (p. 4). Finally, Fiddler and Peerla (2009) addressed the impact of the mining industry in Northern Ontario on the traditional occupations of First Nations people living in the community of Kitchenuhmaykoosib Inninuug First Nation. According to Fiddler & Peerla (2009), “loss of traditional occupations [stemming from the mining industry] can threaten the sense of identity of individuals and the community, the ability to pass on traditional meanings and forms of occupations to future generations, and the culture of a group of people” (p. 10).

Of these four articles, Fiddler and Peerla (2009) appeared to be the only authors with a clearly stated connection to the community of which they wrote. The first author, Alvin Fiddler, was the Deputy Grand Chief of the Nishnawbe Aski Nation, and the second author, David Peerla, was described as an Advisor to this Nation. While the articles by Yalmambirra (2000), Darnell (2009), and Thibeault (2002) provided detailed information about issues of importance to occupational science, I found it difficult to decipher the positioning of these authors in relation to the Indigenous communities of which they wrote. Of most concern, what appeared to be missing in the occupational science literature concerning research in this area was the voice to whom this research matters most – the voice of the Indigenous communities. In order to gain an insightful, insider perspective on the connections between occupation and health, further research should involve First Nation, Inuit, and/or Métis people in all aspects of the research process. Through employing a community-based participatory research (CBPR) methodology, the present study aimed to not only incorporate, but emphasize, the voices of all those involved, including team members from SOAHAC, community Elders, and - perhaps most importantly – those of the children.

In reviewing the occupational science literature, only two studies were found that explored the health of First Nations children (Gerlach, 2008; Gerlach, Brown, & Suto, 2014). Gerlach (2008) explored child-rearing practices among Indigenous women in Canada, as well as Indigenous mothers' perspectives on healthy child development. Unlike the occupational science papers mentioned previously, Gerlach (2008) conducted qualitative interviews with key First Nation informants to get an emic perspective on raising a healthy child. Key findings revealed that the occupation of raising a child is

perceived as a “shared-responsibility within an interdependent family system” (Gerlach, 2008, p. 23), and that the legacy of residential schools continues to have an intergenerational impact on child-rearing practices, including a distrust of non-Indigenous health care providers. Within her study, Gerlach (2008) also identified strong connections between health, spirituality, and the natural environment. Importantly, Gerlach (2008) concluded that “further research in partnership with First Nations peoples... is required to broaden the discourse within occupational therapy on child rearing, family, and the meaning of health” (p. 24). Indeed, community-based studies with Indigenous communities are missing from the occupational science literature, as are studies that involve Indigenous children and youth. Despite emphasizing the need for partnerships with First Nation communities, it was unclear whether Gerlach (2008) herself employed a community-based methodology. While a community-advisory committee was developed to help create the interview questions, Gerlach (2008) did not discuss community participation in any other stages of the research process.

More recently, Gerlach et al. (2014) drew on critical perspectives to examine the concept of play among Indigenous children in Canada. Gerlach et al. (2014) proposed that play should be reframed as an occupational determinant of Indigenous children’s health. Throughout their article, Gerlach et al. (2014) argue that various historical, political, and socio-economic factors “...prevent [Indigenous] children from participating fully and freely in meaningful play as a health-promoting occupation of early childhood” (p. 7). This article will be revisited in Chapter 5 of this thesis.

Within occupational science, various researchers, including Gerlach (2008), have recognized the importance of acknowledging non-Western ways of knowing in order to



gain a better understanding of how occupations can impact health. Turner (2007), for example, identified the need to embrace tacit knowledge systems, which she described as knowledge that “...is often personal and hard to formalize and is therefore difficult to share. It is deeply rooted in action and experience and is linked to values [and] emotions” (p. 11). According to Turner (2007), Indigenous Knowledge (IK) is an example of a tacit knowledge system that has been used for centuries to maintain human health and the health of our ecosystem; by acknowledging and exploring IK, occupational scientists could advance their understanding of the connections between occupation and health (Turner, 2007). However, given the collective and embodied nature of IK and the oral tradition of passing it down, it can often be difficult to acquire such knowledge, especially from a researcher’s and/or a non-community member’s position (Turner, 2007). Unfortunately, Turner (2007) did not extend the conversation beyond these challenges, to discuss the relationships required to gain such tacit knowledge, and/or the idea of engaging in CBPR – research by, with, and for Indigenous communities.

In addition to Turner (2007), a few other researchers within the field of occupational science have explored some of the challenges of studying occupation within an Indigenous context. In occupational therapy and occupational science, occupations are often traditionally divided into three separate categories, including self-care, leisure, and productivity (Darnell, 2002; Townsend, 1997). Townsend (1997), for example, described occupations as “... all the active processes of looking after ourselves and others, enjoying life, and being socially and economically productive over the lifespan and in various contexts” (p. 19). While the divisions of self-care, leisure and productivity were thought to make sense for occupations within the Western world, researchers have recently

argued that the above categories are overly simplistic (Hammell, 2009), and may pose particular challenges for classifying occupations within other cultures that do not fit neatly into only one category (Darnell, 2002; Hammell, 2009). For example, while the occupation of hunting may seem leisurely to some, it is often also productive, providing food and material for one's family and community. In the present study, it was therefore important to take a non-categorical approach to occupation, and to refrain from classifying occupations in a pre-determined way. This inclusive approach allowed our research team to better understand occupation from the children's point of view, including the reasons for - and perceived outcomes of - engaging in such activities.

**2.3.3 Culture, occupation, and health.** Despite the lack of occupational science research with Indigenous people, a larger body of research has examined the links between culture, occupation, and health. Boerema, Russell, and Aguilar (2010), for example, explored the occupation of sewing among immigrant women in South Australia. According to their participants, sewing was a form of cultural expression; it allowed immigrant women to stay connected to their culture, which enhanced their identity and contributed to an overall sense of well-being (Boerema et al., 2010). Similarly, Kumar (2011) examined *bharatanatyam*, a South Indian classical dance, and the meaning of this occupation to South Indian immigrants in California. Kumar (2011) defines culture as “those activities that bring meaning to people's lives” (p. 36), and *bharatanatyam* is identified as a “cultural occupation” (Kumar, 2011, p. 36). Through participating in *bharatanatyam*, participants were able to learn about their culture, enhance their cultural identity, and achieve a greater sense of holistic health (Kumar, 2011). Furthermore, through engaging in this form of dance, participants were able to

keep their culture alive, and to “transform the abstract, antique India... into a lived India of the present” (Kumar, 2011, p. 38). While both of these studies explored unique occupations within specific cultural groups, both concluded with a similar insight: engaging in cultural occupations are important to one’s identity and health.

Unfortunately, however, neither of these studies, nor any other studies I could find, explicitly defined the term ‘cultural occupation’. Given that the present study examined occupations within a First Nations context, cultural occupations will therefore refer to the specific occupations associated with First Nations culture. The definition of culture that I use throughout this thesis, as well as a more detailed description of cultural occupations, is provided in the next section (2.4) of this chapter.

The present study aims to build on the occupational science literature by exploring the ways in which culture, identity, and health intersect from the perspective of First Nations children. Through engaging local communities in the research process, and acknowledging IK as a legitimate way of knowing, this study builds a case for pursuing this type of research in the occupational science field.

A number of studies within the health and social sciences have examined the connections between First Nations identity, culture, and health, and have important implications for occupational science. King, Smith, and Gracey (2009), for example, have demonstrated that for Indigenous children and youth, participation in cultural activities, which can be conceptualized as a type of occupation (Kumar, 2011), “...provide[s] a basis for positive self-image and healthy identity” (King, Smith, & Gracey, 2009, p. 77). In the following section I will review the definitions of culture and cultural identity that

were provided in Chapter 1, and explore the importance of cultural identity in relation to Indigenous children's health.

## **2.4 Enhancing Indigenous Children's Health: A Focus on Cultural Activity and Cultural Identity**

Various definitions of culture exist, many of which stress the idea that culture is emergent and changes over time (King et al., 2009; McIvor, Napoleon, & Dickie, 2009). For the purposes of this thesis, culture will be defined as “[the] systems of belief, values, customs, and traditions that are transmitted from generation to generation through teachings, ecological knowledge and time-honoured land-based practices” (McIvor et al., 2009, p. 7). I chose to use this definition for two main reasons: (1) it was developed by a First Nations scholar, Dr. Onawa McIvor, who studied the concept of culture within Indigenous communities, and (2) it was developed out of a recent review of the literature in Canada regarding the connections between health and culture, which is also the focus of the present study. Importantly, McIvor et al. (2009) acknowledged that culture may be viewed differently by different people, and that “...each community, particularly urban communities, may define and experience it differently” (p. 7). Moreover, cultural occupations are defined in this thesis as occupations associated with being First Nations. Stemming from our definition of culture, cultural occupations are those that are passed down through generations via teachings, direct observation, and first-hand experience. According to Boerema et al. (2010), cultural occupations “...maintain family and cultural connections... and keep customs alive” (p. 82). Of particular relevance to this thesis, participation in cultural occupations has been associated with a stronger sense of cultural

identity, a greater sense of belonging, and increased levels of health and wellness among Indigenous children (Greenwood & de Leeuw, 2012; Kral, 2012).

Within the Indigenous context, cultural identity has been defined as “a complex of features that together shape how a person thinks about herself or himself as an Aboriginal person” (RCAP, 1996, p. 523). Despite the various health challenges that Indigenous children face, “many Aboriginal communities believe that they can overcome these challenges by fostering a sense of cultural identity in their children” (Public Health Agency of Canada, 2013, para. 7). Cultural identity is “...central to health and well-being” (Kirmayer et al., 2003, p. S21) and, among other things, is associated with lower rates of diabetes and suicide, and greater educational attainments among Indigenous youth (Kral, 2012; Smith et al., 2010; Stewart et al., 2008).

Cultural identity, as experienced by individuals, is associated with a sense of community belonging (Kenyon & Carter, 2011) and is influenced by the community’s collective identity (Belanger, Barron, McKay-Turnbull, & Mills, 2003; Kirmayer et al., 2003; Tiessen, Taylor, & Kirmayer, 2009). Within Indigenous communities, an individual’s identity is often linked to that of the larger community, “...since other people belonging to one’s community, the land and its animals are all viewed as inherently a part of the self” (King et al., 2009, p. 77). As well, the health of an individual is often mirrored by the health of his or her community, as demonstrated by Chandler and Lalonde (1998) who studied cultural continuity within Northern Inuit communities. According to their study, communities with greater cultural continuity – that is, those with greater control over their programs and services – were found to have lower suicide rates (Chandler & Lalonde, 1998). Following this study, Hallett et al. (2007) looked at the

connection between language use and suicide, and found that suicide rates were lower in Inuit communities with higher knowledge of their language. Thus, markers of cultural continuity, including control over services and knowledge of an Indigenous language, are indicative of a stronger collective identity, and associated with a healthier community and healthier individuals. Researchers have supported the connections between individual and community identity, as well as the links between language use and health, in various Indigenous communities across Canada (e.g., King et al., 2009; McIvor et al., 2009).

In addition to learning an Indigenous language, cultural identity is enhanced by engagement in cultural occupations, such as hunting, fishing, and dancing (Kenyon & Carter, 2011; Kral, 2012; RCAP, 1996), as well as by learning about culture through traditional teachings that are largely passed down through Elders (King et al., 2009; RCAP, 1996). Moreover, by enhancing cultural identity, traditional activities and teachings are "...protective factors against certain ailments like alcoholism, depression, suicide, and even as a buffer against the effects of racial discrimination" (McIvor et al., 2009, p. 17). Community-based programs that support engagement in cultural occupations and provide opportunities for traditional teachings are desired by Indigenous children and youth (RCAP, 1996), and help to support cultural identity and promote overall health (Greenwood & de Leeuw, 2012; King et al., 2009; RCAP, 1996).

**2.4.1 Challenges to cultural identity for Indigenous children.** A few studies and reports in Canada have focused on the challenges that Indigenous children and youth face in developing and maintaining their cultural identity (e.g., Belanger et al., 2003; RCAP, 1996). As explained previously, a person's identity is largely tied to the collective identity of their community (Belanger et al., 2003; Kirmayer et al., 2003; Tiessen et al.,

2009). Unfortunately, however, processes of colonization and racism continue to disrupt the identity of many Indigenous communities across Canada, through “various Indigenous-specific factors, such as loss of language and connection to the land, environmental deprivation, and spiritual, emotional, and mental disconnectedness” (King et al., 2009, p. 77). The inter-generational trauma that has emanated from these processes continues to impact the health and identity of the current generation of Indigenous children, and likely many generations to come (Greenwood & De Leeuw, 2012). Furthermore, similar to the notion of culture, identity is constantly evolving and is “...created out of interactions with a larger cultural surround, which may impose disvalued identities and marginalized status” (Kirmayer et al., 2003, p. S21). While cultural expression and Indigenous identity are more politically and socially accepted now than in recent history, Indigenous children are still subject to the racism and neo-colonialist policies that pervade society today (Belanger et al., 2003; RCAP, 1996). Even in the media, Indigenous children are besieged by inaccurate, racist depictions of what it means to be native (King et al, 2009; RCAP, 1996). Thus, marginalization and racism continue to play a significant role in shaping Indigenous children’s cultural identity, and how they view themselves as an Indigenous person (Belanger et al., 2003; King et al., 2009; RCAP, 1996).

In addition to dealing with racism and marginalization, urban Indigenous youth may face additional challenges that discourage the formation of a strong sense of self and/or contribute to greater health problems. First off, urbanisation, defined as “the growth of cities and urban-to-rural migration” (Gracey & King, 2009, p. 69), has been associated with “high-calorie, high-fat, high-salt, and low-fibre diets, changing infant

feeding practices, decreased physical activity, overcrowding, and environmental contamination” (Gracey & King, 2009, p. 69), all of which are associated with a number of lifestyle diseases common among Indigenous children, such as type II diabetes (Gracey & King, 2009). Secondly, residential instability, defined as “frequent migrations back and forth from cities to reserve communities” (King et al., 2009, p. 79) is increasingly common in First Nation families with young children (King et al., 2009). Residential instability is associated with poor health and well-being, as it is difficult for Indigenous children to form a strong sense of belonging when they are constantly moving and unable to maintain social ties (King et al., 2009). Finally, Indigenous children who live in urban areas may have limited or no access to traditional knowledge and activities, making it difficult to develop a positive cultural identity. Nevertheless, reports have shown that Indigenous youth want to learn about their culture, and “what it means to be an Aboriginal person in the modern world” (RCAP, 1996, p. 148). While cultural identity is often linked to the land (Big-Canoe & Richmond, 2014; Wilson, 2003), and is enhanced through living close to one’s reserve (Belanger et al., 2003; RCAP, 1996), studies have shown that urban Indigenous youth can nevertheless develop a strong sense of identity, provided they have access to cultural resources and supportive environments (Belanger et al., 2003). These ideas support the notion that cultural programs aimed at urban Indigenous children and youth are important to health, and would strengthen one’s cultural identity and sense of community belonging. Moreover, in the words of Greenwood & de Leeuw (2012):

If Aboriginal children are provided opportunity for growth and development that fosters and promotes cultural strengths and citizenship, health disparities resulting



from the impacts of colonialism will be lessened. This may, in turn, lead to self-determination, which is a distal determinant of Aboriginal children's health. (p. 6)

## **2.5 Health Programs for Indigenous Children in Canada**

Throughout Canada, a number of organizations have created strategies to develop effective health programs for Indigenous children. In 2011, for example, the Health Council of Canada published a report entitled 'Understanding and Improving Aboriginal Maternal and Child Health in Canada'. In this report, the Health Council of Canada (2011) provided a list of promising practices across the country as well as important suggestions, put forth by Indigenous communities, on how best to create programs for Indigenous children. Suggestions throughout the report included: (1) focusing on wellness rather than illness by building relationships and concentrating on community strengths; (2) integrating IK throughout the programs and providing access to cultural activities; and (3) incorporating an holistic approach to health by involving families and communities (Health Council of Canada, 2011). While the first two of these points have been largely discussed throughout this literature review, the final point, regarding family and community-wide approaches, is discussed in the following section.

An important point articulated by the Health Council of Canada (2011) was that "to authentically incorporate traditional practices, it is not enough to lay a veneer of traditional knowledge over a mainstream Western medicine approach" (p. 24). Programs developed to improve Indigenous children's health must be built upon IK and developed by, or in collaboration with, the communities involved.

**2.5.1 An holistic approach to health: Involving the family and the community.** Maintaining relationships are an important component of holistic health, and

include relationships with oneself, one's family, one's community, and with the land (Greenwood & de Leeuw, 2012; King et al., 2009). Programs aimed at promoting Indigenous children's health should therefore support these relationships and foster their growth. Family-oriented programs that involve the community are much more beneficial and conducive to good health than programs aimed exclusively at the individual (Greenwood & de Leeuw, 2012; Health Council of Canada, 2011). As the Health Council of Canada (2011) explained in their recent report, "the entire community – a healthy community, must be involved in connecting and supporting mothers and children, including fathers, elders, youth, aunts, uncles, grandmothers, grandfathers, friends, neighbours, and the political leadership" (p. 23). The present study aimed to incorporate the community by hiring First Nations youth from the children's communities. Volunteers who took part in the Bimaadiziwin Learning Experience (BLE) were community members as well, as were most members of the research team. Family members of the camp participants were encouraged to attend on the final day of the BLE, to spend time with their children and take part in a feast. Last but not least, Elders were present throughout the entire BLE as an important resource for the children at the camp. The importance of Elders in transmitting IK is discussed in the following section.

**2.5.2 Involving Elders as teachers.** In First Nation communities, Elders are not defined by age, but rather as people who "represent an essential connection with the past; they are keepers of the community knowledge and supporters of its collective spirit" (King et al., 2009). Elders are viewed as leaders in their community, and have traditionally taken on the role of passing down wisdom and IK to younger generations (Kral et al., 2011; Darnell, 2009; Varcoe, Bottorff, Carey, Sullivan, & Williams, 2010).

This transfer of IK is thought to enhance the health, well-being, and cultural identity of First Nations children and youth (Hallett et al., 2007; Postl, Cook, & Moffatt, 2010).

Studies have shown that First Nations children consider their parents, grandparents, and Elders to be important sources of cultural knowledge, as well as knowledge about healthy foods and activities (Pigford et al., 2012). Youth interviewed for the Royal Commission Report on Aboriginal Peoples (1996) expressed a need to learn from their Elders, as did youth who completed the 2008-2010 Regional Health Survey (FNIGC, 2012). Moreover, 15.4% of First Nations children live in homes that include a grandparent, as compared to only 3.8% of all children in Canada (FNIGC, 2012). Elders and grandparents are therefore widely accessible, yet are often not approached by children who want to learn (Kral, 2012; Varcoe et al., 2003). These findings point to the importance of involving Elders and other family members in health-promoting programs for First Nations children. Elders are an important source of influence, and a resource for health that is not often used (Varcoe et al., 2010). At the BLE, Elders were present each morning of the camp, to give an opening prayer, as well as throughout the day to provide teachings, observe the activities, and answer any questions that the children may have had.

## **2.6 Conclusions and Support for the Present Study**

To date, much of the research focused on understanding what health is and/or what influences health for Indigenous children has relied on the perceptions of parents and other guardians. Children are rarely seen as experts in matters that affect them (Kalnins et al., 1992), despite the fact that “children are active participants in the construction and determination of their experiences” (O’Kane, 2008, p. 125). Giving

children a voice in research will allow their opinions to be heard and will ultimately lead to more meaningful information (McHugh & Kowalski, 2010), and better health programs (Graham & Stamler, 2010). This is especially important for Indigenous children, not only because they make up one third of the total Indigenous population (AFN, 2008) and have poorer health than the average Canadian child (Gracey & King, 2009), but because they are the leaders of tomorrow's communities (Greenwood & de Leeuw, 2012). Involving Indigenous children in research will empower them to take control of their health (Kalnins et al., 1992) and to gain the confidence and determination needed to one day guide their communities.

While a few studies have explored Indigenous children's perceptions of health, the majority of these studies have been conducted with children over the age of 12 years. As a result, very little is known about how younger children experience and understand health. Moreover, while a significant body of research has explored the connections between culture, health, and identity, including a few studies within the field of occupational science, very few have done so from a First Nations children's perspective. The present study will address the identified gaps through pursuing two important objectives: (1) understanding how First Nations children think about their health, with a focus on occupations connected to health; and (2) exploring how these children connect health and culture. Moreover, due to the fact that cultural identity is enhanced through engagement in cultural occupations, this study occurred within the context of a week-long summer culture camp, the BLE. In the following chapter I will discuss the BLE as well as the methods we used to achieve our research objectives.

## **Chapter 3**

### **3 Methodology and Methods**

This chapter begins with a discussion on the use of Indigenous Knowledge (IK) as a guiding epistemology in this study, followed by a description of my own critical constructivist lens. The methodology that frames this research, community-based participatory research (CBPR), is then discussed, as well as the ways in which our research team – including myself, other researchers from Western University, staff from the Southwest Ontario Aboriginal Health Access Centre (SOAHAC), and our Research Assistants (RAs) - worked collaboratively to create the Bimaadiziwin Learning Experience (BLE) and all research activities, including a painting exercise and sharing circles. The purpose of these activities was to achieve our primary research objectives, which were: 1) to understand how First Nations children think about their health, with a focus on occupations connected to health; and 2) to explore how these children connect health and culture. A third objective, to generate feedback from the children about the BLE, was also achieved through sharing circles on the final day of camp. The research methods are described in this chapter, as are the participants, the research setting, and the process of data analysis. Finally, a description of how I address subjectivity and reflexivity is provided, followed by a description of steps taken to enhance the quality of the present research study.

#### **3.1 Methodology**

**3.1.1 IK as a guiding epistemology.** IK refers to the traditions, beliefs, and values that enable Indigenous people to maintain respectful and healthful relationships with the natural environment (e.g., with plants and animals) and the social environment

(e.g., with family, friends, and ancestors) (Little Bear, 2009; Richmond, 2014).

According to Brant-Castellano (2000), IK “...derives from multiple sources, including traditional teachings, empirical observation, and revelation [dreams, visions, and intuitions]” (p. 23). IK is dependent upon place, and is highly personal and contextual; as a result, no universal definition of IK can exist (Kovach, 2009). Nevertheless, as Little Bear (2000) has said, “there is enough similarity among North American Indian philosophies to apply the concepts generally” (p. 77). IK emphasizes interconnectedness among all things, including people, animals, and the cosmos (Richmond, 2014), and is often conveyed orally, through language, as well as through art (Kovach, 2009; Richmond, 2014). Moreover, IK is an applied way of knowing, meaning knowledge is gained through practice and experience (Richmond, 2014). In relation to children, learning is viewed as happening through observation, and children come to know their culture through watching their Elders and being out on the land (Richmond, 2014).

The IK that guides this research is based upon Ojibway, Lenape, and Oneida teachings and practices, as these were the Nations represented on our research team. Customs and traditions from each of these groups were followed throughout the research process. For example, tobacco bundles were offered to Elders in exchange for their wisdom and guidance throughout the project, and for leading a smudge each morning of the BLE. Offering tobacco to the Elders was an act of reciprocity and respect, and helped to ensure that our research was conducted in a “good way” (Kovach, 2009, p. 146). Moreover, throughout the BLE, the children engaged in a variety of cultural occupations, in order to enhance their cultural knowledge. Among these activities were archery lessons, a medicine walk with a local Elder, soapstone carvings, and drum making. A

more detailed schedule of the camp, including a full list of activities, is provided in Appendix A.

**3.1.2 A critical constructivist lens.** Many Indigenous researchers who use IK as a guiding epistemology also claim to follow an ‘Indigenous methodology’ in their research (e.g., Kovach, 2009; Lavallée, 2009; Loppie, 2007). However, as a non-Indigenous researcher, I hesitate to use this term. Methodologies are a combination of methods and epistemology (Kovach, 2009); while IK is the primary epistemology guiding this research, I cannot claim it as my own. As Kovach (2009) states, “epistemology ought to be congruent with life choices in general, not just in research” (p. 120). As a non-Indigenous researcher, I cannot claim IK to be my own source of knowledge, despite my deepest respect for all that it entails. Thus, rather than labeling this research as following an ‘Indigenous Methodology’, it was framed instead as part of a CBPR study. A detailed description of our CBPR process is explained in the next section of this chapter.

I think that one of the key challenges facing non-Indigenous researchers doing CBPR or similar work with Indigenous communities is the tension that arises between recognizing IK as a legitimate way of knowing, while simultaneously acknowledging our own assumptions about knowledge. I, for instance, was brought up in a world of Western science, which, according to Little Bear (2000), is characterized by a value system that is “linear and singular, static, and objective” (p. 82). Similarly, in their report on Indigenous ways of knowing, Cochran et al. (2008) describe Western research as ‘empirical’ with the goals of obtaining validity and reliability. While this is true of positivist and postpositivist research, which has dominated Western science for centuries, various ‘alternative’

paradigms, such as critical theory and constructivism, make room for such things as subjectivity and the existence of multiple realities (Guba & Lincoln, 1994).

Despite my upbringing in a largely postpositivist knowledge system, I approach this research from a critical constructivist lens. According to Guba and Lincoln (1994), critical theorists believe that various “social, political, cultural, economic, ethnic, and gender values” (p. 110) shape one’s perception of reality. Constructivists, likewise, believe that reality is shaped by culture and experience (Guba & Lincoln, 1994). The realities or truths found in the research findings are therefore a co-construction of both the researchers’ and the participants’ interpretations of reality. While we strove to uncover children’s perceptions of health in this study, these perceptions were influenced by a multitude of factors, including the interactions among children and researchers, the differing values of all those involved, and the greater sociopolitical and cultural contexts (Ponterotto, 2005).

In addition, researchers within occupational science have recently called attention to the importance of alternative paradigms within the field. According to Kinsella (2012), “interpretive and critical approaches offer significant epistemological frameworks for advancing the knowledge base of the field [of occupational science] precisely because they draw attention to complexity and context as has been called for in research practices” (p. 77). By framing this research within a critical constructivist lens, this study aims to advance the field of occupational science by exploring how First Nations children understand health, specifically the occupations they associate with health, and how these understandings are influenced by their social, physical, and cultural environments.



**3.1.3 Community-based participatory research.** This study forms one part of a larger CBPR study. There is a substantial body of literature suggesting that CBPR is the primary methodology of choice when engaging in research with Indigenous people. Historically, academic research has “been *on* rather than *by*, *for*, or *with* Indigenous peoples” (Castleden, Morgan, & Lamb, 2012, p. 163), and, because of “inappropriate methods and practices” (Cochran et al., 2008, p. 22), has caused a lot of harm. Furthermore, as Winona Wheeler (2001), an Indigenous scholar from Manitoba has stated, “outside solutions... simply do not work in our best interest. We are the only ones with the insight and capabilities to identify our ‘problems’ and come up with our own answers” (p. 101). Research addressing Indigenous issues should thus involve Indigenous people, in all aspects of the research process. CBPR is one way to engage members of the community and to address issues that are both practical and important to First Nations people.

CBPR is “... a collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each brings” (Minkler, 2005, p. ii3). Ideally, CBPR begins at the community-level, where community members define the issue of concern and the research questions to address it. In this study, SOAHAC expressed interest in creating a program aimed at promoting the health of First Nations children, and subsequently approached my co-supervisor, Dr. Richmond, for guidance, resources, and support. Dr. Richmond and SOAHAC had previously collaborated on a successful research project, examining the social and environmental determinants of food choices for First Nations people in and around London. The partnerships and trust that were established through this project provided a basis for this study. Without these pre-

existing partnerships and trust, the present study would not have been possible, or would have taken significantly longer to develop.

Ideally, community members should be involved in all aspects of CBPR, from the formation of research questions to the dissemination of research results. CBPR is a flexible process, however, and can unfold in a variety of different ways; some CBPR projects involve the community more than others, depending on the desires and the capacity of the community involved (Minkler, 2005). Within this study, the executive director and various staff at SOAHAC were actively involved in preparing for, implementing, and evaluating the BLE and all research activities.

**3.1.4 A decolonizing agenda.** An important component of engaging in CBPR with Indigenous communities is highlighting a decolonizing agenda (Greenwood & de Leeuw, 2012; Kovach, 2009). According to Kovach (2009), “the purpose of decolonization is to create space in everyday life, research, academia, and society for an Indigenous perspective without it being neglected, shunted aside, mocked, or dismissed” (p. 85). The partnerships that were developed throughout this study served as a method of decolonization as they put the community “at the centre of the research” (Big-Canoe & Richmond, 2014, p. 129), and allowed the community to decide upon the issues of importance and how to address them. The ideas and objectives put forth by SOAHAC were prioritized throughout the research design, allowing a meaningful and community-specific study to emerge. Moreover, the staff at SOAHAC, especially the RAs, were given space throughout the process to contribute significant ideas and design a successful summer camp for children in their communities. Throughout this chapter I aim to be transparent in discussing these research decisions and the ways in which they were made.

## **3.2 Study Development**

**3.2.1 Planning the Bimaadiziwin Learning Experience.** Initial meetings to discuss this project began in September 2012 and occurred at both the London and Chippewa SOAHAC sites. Various directors and staff at SOAHAC, including dietitians and traditional healers, as well as researchers from Western University, attended these meetings and made up the research team. While certain individuals were present at the majority of meetings, and had a strong voice throughout the project, others contributed on a less-frequent basis, whenever their schedules would permit. It is therefore difficult to define the research team in terms of exact numbers, but a multitude of Indigenous and non-Indigenous people were involved. Moreover, all of those involved agreed upon the importance of developing evidence-informed programs for urban and on-reserve First Nations children.

Initial ideas for this project centered around creating a Traditional Teaching Program (TTP), which would bring together members of the Indigenous community, and provide a mechanism for transfer of IK between Elders and youth. Past research has shown that the transfer of IK is integral to improving the health, well-being and cultural identity of First Nations children (Hallett, Chandler, & Lalonde, 2007; Postl, Cook, & Moffatt, 2010); the TTP would provide a space and place for this knowledge transfer to occur. In order to determine the effectiveness of such a TTP, however, team members believed that measures of health would need to be taken pre and post program, and then compared. Various quantitative measures were discussed, such as weight and height measurements, but none seemed to encompass an holistic, First Nations view of health, which was especially important to those at SOAHAC. How could one measure spiritual

well-being, for instance? And how could one do so without separating it from emotional, mental, and physical health? After much discussion, a joint decision was made to forgo a quantitative approach and focus, instead, on qualitative methods to understand children's perceptions of health. After all, qualitative methods allow space for subjectivity and interpretation, which are key characteristics of both IK, our guiding epistemology (Kovach, 2009), and a critical constructivist view (Guba & Lincoln, 1994).

After setting quantitative approaches aside, our team decided that in order to develop better health programs for First Nations children, we needed to understand how they view health (Graham & Stamler, 2010). We wanted to know what children thought about health and what knowledge they might be missing. We wanted to explore if and how children connected health and culture, given previous research supporting an interconnection. Our research team continued to work collaboratively throughout the year, meeting once or twice a month to brainstorm ideas for this project. We discussed working with public schools, in London and on-reserve, to collect qualitative data with First Nations children. When a researcher from Western University suggested hosting a summer camp instead, SOAHAC embraced the idea whole-heartedly.

More specifically, SOAHAC was interested in creating a culture camp, with the idea that children's health could be improved through fostering a sense of cultural identity (Royal Commission on Aboriginal Peoples (RCAP), 1996). Culture camps have been defined as "a gathering of old and young people to exchange and share cultural knowledge" (Pigford, Willows, Holt, Newton, & Ball, 2012, p. 12). According to the RCAP report (1996), culture camps "provide an excellent way to begin to establish cultural identity and to instill the confidence Aboriginal youth will need to confront the

challenge of rebuilding their communities” (p. 151). Due partly to the fact that children were recruited through SOAHAC, an Indigenous health centre, as well as through posters at friendship centers and community centers, it was assumed that the children had some background knowledge about their culture. Nevertheless, creating a camp would provide an additional opportunity for children to learn about their culture, gain invaluable insight from their Elders, and learn values and skills that they may carry through their lives.

During one of our team meetings, an Elder at SOAHAC expressed concern over using the term ‘camp’ in our study. She explained that the term ‘camp’ may carry a negative connotation among some Indigenous communities due to its association with institutions, the legacy of residential schools, and other camps throughout history (e.g., the concentration camps of World War II). Therefore, rather than advertising the program as a camp, we decided to call it the Bimaadiziwin Learning Experience (BLE). Despite this decision, however, our team continued to use the term ‘camp’ when referring to the BLE. During the BLE itself, the children also used the term ‘camp’ to describe the program. Therefore, throughout this thesis, I fluctuate between using the terms ‘camp’ and ‘BLE’, to reflect the interchangeability of these words throughout the project.

The term ‘Bimaadiziwin’ translates from the Ojibway language into “being well”. This term was used previously by our research team, in a grant that we submitted to the Canadian Institutes for Health Research (CIHR) for this project. The grant was entitled ‘*Niaaba Biidoda Anishinaabeg Bimaadiziwin*’, or ‘let us bring back a good way of life’.

Once the decision to hold a camp was made, meetings were held to discuss specific details surrounding the BLE, such as the age range of those involved. Team members from SOAHAC wished to target pre-adolescent youth, who were beginning to

develop their cultural identity (Phinney, 1990). Cultural identity has been defined as “a complex of features that together shape how a person thinks about herself or himself as an Aboriginal person” (RCAP, 1996, p. 523), and is associated with higher educational attainment and better overall health (Smith, Findlay, & Crompton, 2010; Stewart, Riecken, Scott, Tanaka, & Riecken, 2008). Indigenous children today have been described as living between two worlds “... that promote vastly different values and expectations” (Thibeault, 2002, p. 154). It is often difficult for Indigenous children to develop a strong sense of cultural identity when navigating through these worlds and attempting to balance the collectivist values of their Indigenous communities with the individualistic values of the larger society (Darnell, 2002; Kirmayer, Simpson, & Cargo, 2003; Thibeault, 2002). Moreover, while cultural identity is enhanced through participation in cultural activities (Kenyon & Carter, 2011; Kral, 2012; RCAP, 1996), only four out of 10 Indigenous children partake in such activities (Smith et al., 2010). For all of these reasons, a collaborative decision was made to target pre-adolescent First Nations children, between the ages of 10 to 12 years, for participation in the BLE. Moreover, past research has shown that group activities with children, specifically research activities such as sharing circles, work best if the children are within a two-year age span (Hennessy & Heary, 2005). Due to the research component in this camp, I strongly encouraged a limited two to three year age range as well.

Originally, the BLE was conceptualized exclusively for on-reserve First Nations children, because it seemed unfeasible to bring children from London all the way to the SOAHAC Chippewa site, a forty minute commute, where our camp would be held. However, the more our team discussed the BLE, the more we thought that First Nations

children in London, who might have fewer opportunities to experience their culture and get out on the land, could benefit from participation. According to the 2011 National Household Survey (NHS), approximately 63% of First Nations people living in Ontario with registered Indian status live off-reserve, and approximately 25% of this population is under the age of 15 (Statistics Canada, 2011). In comparison to children living on-reserve, these children are often more isolated from their Indigenous culture and less likely to develop a strong cultural identity (RCAP, 1996). The BLE would provide an opportunity for urban First Nations children to experience their culture, through participating in traditional games and ceremonies, and learning various teachings that are relevant today. After much discussion with team members from SOAHAC, a joint decision was made to allow any First Nations child to attend, as long as they fit within the 10 to 12 year age range. In order to bring children to Chippewa from London, SOAHAC generously donated the use of their 12-passenger van.

In terms of the specific research methods that occurred during the BLE, a plethora of ideas were tossed around; the specific research methods that were chosen, i.e., a painting activity and sharing circles, are described in this chapter, with explanations as to why these were selected. All decisions concerning the research followed the principles of CBPR, meaning they were made collaboratively, with extensive input from team members at SOAHAC. The conversations surrounding the research methods also revolved around the principles of Ownership, Control, Access, and Possession (OCAP). Decisions concerning who would own and have access to the data, for instance, were largely made by SOAHAC, with input by team members from Western University.

Further information on the principles of OCAP is provided in the Ethical Considerations section of this chapter.

In January 2012, our research team decided to hire four First Nations youth to work as Research Assistants (RAs) and camp counselors at the BLE. Hiring these youth would reduce the team's workload and provide opportunities for the youth to learn about their culture, give back to their community, and get paid while doing it. Prior to hiring the youth it was unclear as to who would run the BLE, and I was worried that a lot of the responsibility would fall on my shoulders. Suffice it to say that I was extremely relieved when our team decided to hire the RAs. I was able to concentrate on the research component and spend less time worrying about the content of the camp, such as the activities and teachings, as well as specific camp logistics, like what the children would eat and how they would get from point A to point B. In addition, staff at SOAHAC believed that children attending the camp might be more willing to talk about their health and culture if the counselors were also First Nations (Hennessy & Heary, 2005). Moreover, our research team viewed the RAs as positive role models for the children, as they were well-educated and passionate about creating positive change in their own communities. As First Nations youth involved in a national youth action plan called 'Feathers of Hope' have said, "having a person that we look up to... shows us what is possible and provides the inspiration that we can achieve anything" (p. 102). The process we took to hire the RAs is described below.

**3.2.2 Research assistants.** A team member from Western University developed the first draft of a job advertisement for the RA position, which was then reviewed by the Health Services Director at SOAHAC. The job advertisement was posted at the



SOAHAC sites in London and Chippewa, as well as on the SOAHAC website (<http://www.soahac.on.ca/?page=home>) and on Facebook.

Interviews for the RA positions occurred on July 3, 2013. Four members of the research team took part in the interview process, which was a rigorous, day-long affair. Members of the research team met in the early morning to discuss the criteria that an eligible and competent RA would possess, including, but not limited to, experience working with children, relevant camp experience, ability to work independently, and a creative mindset.

Two males and one female were hired through this process; another female, who was already working at SOAHAC as a summer student, was assigned to this project as well. All four RAs were First Nations, between the ages of 18 to 30, and were currently working on, or had recently completed, their undergraduate degree at Western University.

The RAs began work on July 8, 2013, and worked out of the Garden Learning Centre (GLC) at SOAHAC. Apart from the research-specific activities that were designed in collaboration with the entire research team, the RAs were responsible for planning and executing the entire BLE, including meals, transportation, supplies, and teachings. Various members of the research team, including myself, met with the RAs once a week to discuss their progress and to offer assistance in planning the BLE. Attendance at these meetings varied, depending on who was available; various Elders and staff at SOAHAC were involved in key decisions throughout, for example in planning the specific teachings and ceremonies that would occur each day. Minutes from these meetings were typed up by an RA or a team member from Western University and distributed to the broader research team.

**3.2.3 Logo for the BLE.** While preparing for the BLE, the four RAs decided that a logo was needed for the camp. Fortunately, one of the RAs had a connection to a local First Nations artist who designed the logo for the BLE. This logo, depicting several traditional symbols including the medicine wheel, a turtle, and an eagle, is shown below in Figure 2.



*Figure 2. Logo for the Bimaadiziwin Learning Experience*

### **3.3 Overview of the BLE**

The BLE was a week-long summer culture camp that occurred from August 19 to August 23, 2013. Twenty children aged 10 to 12 years attended this camp, which was free-of-charge and included meals and snacks every day. SOAHAC and the Indigenous Health and Well-Being Initiative (IHWI) at Western University funded the BLE. SOAHAC also provided a vast amount of support through the provision of space, resources, and employee support for the RAs. In addition, various community members were paid to help out at the BLE and assisted in shopping for supplies, preparing the food, and teaching the children lessons. Many of these people were relatives or friends of

the RAs, and had previous connections with the children as well; the relationships that were retained, renewed, or created during this process helped to foster a strong sense of community.

On the first day of the BLE, children were divided into four groups of five people; each group was given black, yellow, red, or white t-shirts that symbolized the four quadrants of the medicine wheel. The camp logo (Figure 2) was also imprinted on the back of each t-shirt. Each colour group was led by one of the four RAs. These groups were used for various activities during the week, including the sharing circles, which were a research component in the camp. A total of three research activities specific to this thesis occurred during the week; two on the first day of camp (a painting activity and sharing circles) and one on the final day of camp (another set of sharing circles). Details about the research activities are provided below.

In addition to the research component, children partook in various cultural activities during the BLE, including a field trip to Skah Nah D'Oht Iroquois Village and a medicine walk with a local Elder. Children were exposed to various traditional foods, including three sisters' soup and fresh veal, and were taught how to make various crafts, including drums, dreamcatchers, and soapstone carvings. A week-long schedule of the BLE is provided in Appendix A.

### **3.4 Ethical Approval and the Principles of OCAP**

Ethical approval for this study was received from the Non-Medical Research Ethics Board at Western University. A research agreement with SOAHAC was also created and signed by the Primary Investigator from Western University and the

Executive Director at SOAHAC, outlining certain ethical procedures, such as maintaining anonymity and confidentiality, which had to be followed throughout the project.

In addition to the standard ethical procedures that are outlined in most research agreements involving human participants, this research agreement made reference to the principles of OCAP. These principles were designed by the Steering Committee of the First Nations Regional Longitudinal Health Survey to enhance self-determination in research with First Nations communities (Schnarch, 2004). Within this study, Elders and staff at SOAHAC actively participated in co-creating all activities and questions throughout the research process; this helped to ensure that activities and questions were culturally appropriate, and reflective of what the community would like to learn. In addition, RAs, Elders, and other staff at SOAHAC were given the opportunity to discuss the preliminary findings, give insight into the importance of these findings, and control what was subsequently written up or published.

The main purpose of CBPR is to create research that provides community partners with the information they need to address their own issues, and, in this case, to create effective health programs for First Nations children. Hence, as outlined in the research agreement with SOAHAC, any report or publication beyond this thesis will be submitted to SOAHAC prior to any other organization or journal. In addition, SOAHAC owns the primary data pertaining to this project; copies of all transcripts were sent to SOAHAC for their records and will remain their property until they wish to destroy them.

### **3.5 Methods**

The research methods used within this study included a painting activity, sharing circles, and participant observation. Descriptions of these methods, as well as information

on inclusion criteria, study site and recruitment, participant demographics and data analysis are provided in this section.

**3.5.1 Inclusion criteria.** Individuals who were between the ages of 10-12 years, were identified by their parent/guardian as First Nations, and were participants in the BLE were eligible to participate in this study.

**3.5.2 Study site and recruitment.** The BLE and all research activities occurred in the GLC or in the main building at SOAHAC's Chippewa site. This location was chosen because it has suitable facilities to run a week-long day camp, including bathrooms, a kitchen, a large room for activities, and adequate space for outdoor games. The GLC is also central to three First Nation reserves (Chippewas of the Thames First Nation, Oneida Nation of the Thames, and Munsee-Delaware Nation); transportation was provided for all camp participants coming from the city of London, which is approximately a 40 minute commute.

Participants were recruited by the RAs using multiple strategies. Recruitment packages, including posters, application forms, and letters of information, were displayed at the SOAHAC sites in London and Chippewa, as well as on the SOAHAC website (<http://www.soahac.on.ca/?page=home>). Recruitment packages were also distributed via email to all First Nations people on SOAHAC's electronic mailing list. In addition, RAs distributed recruitment packages at various community events and in various community centers, including the N'Amerind Friendship Centre in London. A social media site (Facebook) was also used to advertise the camp.

**3.5.3 Participants.** Overall, this study involved 20 participants, including 11 girls and 9 boys. Children were between the ages of 10 (n=5), 11 (n=10), and 12 (n=4)

years. The information sheet of one participant was misplaced after the BLE, therefore his exact age is unknown. Eighteen participants were present on the first day of the BLE and thus participated in the first two research activities. Two of these participants were not present on the final day of the BLE, but two other children, who did not show up on the first day, were present instead. Thus, 18 participants were also involved in the final set of sharing circles.

All participants in this study were identified by their parent or guardian as a First Nations person, and were members of four First Nation communities in Southwestern Ontario, including Oneida Nation of the Thames (n=10), the Chippewas of the Thames First Nation (n=8), Walpole Island First Nation (n=1), and the Chippewas of Kettle and Stony Point First Nation (n=1). Oneida Nation of the Thames and Walpole Island First Nation have similar on-reserve populations of approximately 2000 people (Aboriginal Affairs and Northern Development Canada, n.d.; Walpole Island, 2014), while the Chippewas of the Thames First Nation and the Chippewas of Kettle and Stony Point First Nation are slightly smaller, with approximate on-reserve populations of 935 and 800 respectively (Statistics Canada, 2013). It is important to note that on-reserve populations do not represent the total population from each community, as many community members live off-reserve, for example in cities such as London, Ontario. In fact, throughout Canada, only 49% of First Nations people live on-reserve, while 51% live off-reserve (National Collaborating Centre for Aboriginal Health, 2013). At the time of this study, approximately half of the participants lived on reserve (n=11), while the other half lived in the city of London (n=9).

London is home to approximately 6,845 self-identified Indigenous people, which represents about 1.9% of the city's total population (Statistics Canada, 2013). Of this 1.9%, nearly three quarters identify as being First Nations (Statistics Canada, 2013). Moreover, the Indigenous population in London is on the rise; between 2001 and 2006, the Indigenous population grew by nearly 10% (Statistics Canada, 2013). Similar to the trends seen across Canada, the Indigenous population in London is young; approximately 30% are under the age of 15, as compared to 18% of the non-Indigenous population (Statistics Canada, 2013). In 2006, the median age of Indigenous people living in London was 26.6 years, in comparison to the non-Indigenous median of 38.6 years (Statistics Canada, 2013).

A detailed description of each participant in the BLE, including their age and First Nation community, is provided in Table 1.

Table 1

*Demographic Information of Study Participants*

Participant pseudonym	Gender	Age	Home community
Alexandra	F	10	Kettle and Stony Point First Nation
Amanda	F	11	Oneida Nation of the Thames
Autumn	F	11	Chippewas of the Thames First Nation
Colin	M	11	Chippewas of the Thames First Nation
Dakota	M	11	Oneida Nation of the Thames
Dana	F	11	Chippewas of the Thames First Nation
Darian	F	11	Oneida Nation of the Thames
David	M	11	Chippewas of the Thames First Nation
Hayley	F	10	Chippewas of the Thames First Nation
Jenny	F	11	Chippewas of the Thames First Nation
Jesse	M	11	Chippewas of the Thames First Nation
Marian	F	10	Oneida Nation of the Thames
Olivia	F	12	Oneida Nation of the Thames
Owen	M	12	Oneida Nation of the Thames
Raya	F	12	Oneida Nation of the Thames
Sara	F	10	Walpole Island First Nation
Shane	M	11	Oneida Nation of the Thames
Tyler	M	10	Oneida Nation of the Thames
Zach	M	Unknown	Oneida Nation of the Thames
Jordan	M	12	Chippewas of the Thames First Nation

*Note.* Participants are listed in alphabetical order.



**3.5.4 Informed consent.** Informed consent was received from parents or guardians on the first day of camp, when they dropped their children off at the GLC or a designated drop-off site. Eleven children (those who lived on-reserve) were dropped off directly at the GLC by a parent or guardian, and nine children from London were picked up either at the N’Amerind Friendship Centre in downtown London or from their individual houses. A representative from Western University (myself or another researcher) was present at all drop-off locations on the first day of camp to discuss the research study and answer any questions that the parents or children had. An RA was also present at all drop-off locations to meet the children and assist in receiving consent.

Children were also informed that a research study was occurring at the camp; assent from the children was received on the first day of camp, prior to the first research activity (the painting). As a group, the children were informed by one of the RAs about the purpose of the research, and given a chance to ask questions and/or inform their counselors (the RAs) if they were uncomfortable and/or did not want to participate in the study. None of the children asked such questions or expressed concern about the research.

**3.5.5 Data collection.** In order to capture a greater understanding of children’s perceptions of health, and to enhance the credibility of the research results (Tracy, 2010), this study employed multiple methods of qualitative data collection. Two research activities, a painting activity and sharing circles, occurred during the first day of the BLE. A second set of sharing circles occurred during the last day of the BLE. In addition, observational notes were taken throughout the week of the BLE, to further capture

children's perceptions of health, how they connected health and culture, and to reflect on the camp activities. All of these research activities are described below.

***Roles of team members.*** The RAs were in charge of leading the painting activity as well as facilitating the sharing circles. Past research has shown that "...whenever possible, consideration should be given to matching the moderator and the group, particularly if the moderator's race, accent, or gender is likely to be relevant to the group discussion" (Hennessy & Heary, 2005, p. 242). As predicted by team members at SOAHAC, the children seemed at ease in talking to the RAs, possibly because they shared the same culture and could understand each other's stories more so than an outsider, such as myself, might. In the final sharing circles, the children's comfort may have also increased because the RAs, as camp counselors, had formed relationships with the children. In the weeks leading up to the BLE, however, I was extremely nervous about the research activities; compared to the RAs, I had little control over what would happen, such as which prompts were used with each child. Despite my stress, however, I had to keep in mind that the purpose behind the research was not strictly for my own dissertation, but for the greater good of the community. SOAHAC strongly urged the RA-moderator role, and the RAs themselves felt confident in their part. In the end, I saw the importance of having the RAs lead the activities, while I took a backseat role and interjected to help facilitate discussion.

Throughout the BLE, I took on the role of overt participant-observer. In addition to taking part in camp activities, I handwrote two types of notes: observational notes and reflexive notes. Observational notes were taken during various camp activities, including the painting activity and sharing circles, as well as over nutritional breaks and at the end

of the day. These notes mainly described the activities, behaviours, and ideas of all participants as they related to health and culture. In addition, throughout the BLE, as well as the months preceding and following the BLE, I wrote reflexive notes to capture my own thoughts and understandings about the research process, and to record what I learned about traditional knowledge and the connections between occupation, culture, and health. In subsequent chapters, I weave these notes throughout my writing to enhance the credibility of the research findings, and the authenticity of this thesis (Tracy, 2010).

In addition to my own role and those of the RAs, many other team members assisted in the specific research activities. Two students from Western (a PhD student and a postdoctoral fellow) and a staff member from SOAHAC were present throughout the BLE and assisted in taking observational notes about the research and non-research activities. In addition, two faculty members from Western University (one of my supervisors and another committee member) were present on the first day of the BLE to assist in receiving consent and to take observational notes during the first two research activities. After each research activity was complete, these team members met to debrief and to give their notes to me for later use.

***Research activity 1: Painting.*** Arts-based approaches, such as drawing and taking pictures, are commonly used in research with children, and are often employed alongside other data collection techniques, such as interviews and focus groups (Driessnack & Furukawa, 2012). Arts-based approaches “...have the potential not only to facilitate communication between the researcher and the child participant but also to empower children in relation to the adult researcher in the process” (Driessnack & Furukawa, 2012, p. 7). Nevertheless, in reviewing the research that has been done with Indigenous children

in Canada, surprisingly few studies have incorporated art as a data collection technique. One exception of relevance to the focus of this thesis is a study by Pigford et al. (2012). This study used drawing and pile-sorting activities to elicit discussion in a series of focus groups with First Nations children aged 8 to 10 years. Drawing and pile-sorting allowed the researchers to explore children's perceptions of food, activity, and health, and to use this pictorial information to question the children further (Pigford et al., 2012). Arts-based approaches are child-sensitive techniques, and allow deeper insights to emerge that could not have been achieved through traditional, adult-centered methods such as interviews and focus groups (Driessnack & Furukawa, 2012). More importantly, perhaps, is the fact that arts-based approaches fit with Indigenous ways of knowing, and are a common method of sharing information in Indigenous communities (Richmond, 2014). Many Indigenous artists from across the world, such as Norval Morriseau, have used art to express important concepts in the Indigenous Knowledge system, such as the interconnectedness of people, animals and the spiritual world (Richmond, 2014). Moreover, when discussing data collection techniques with team members from SOAHAC, many suggested using art, such as paintings or masks, to explore children's perceptions of health.

A collaborative decision with SOAHAC was made to incorporate painting as a data collection technique, with the goals of easing communication between the children, RAs, and researchers, and to allow deeper understandings to emerge. On the first morning of the BLE, a local Elder was brought in to conduct an opening ceremony with a smudge. Smudging in the morning rid people of negativity (Lavallée, 2009) and set the mood for the cultural activities ahead. Once smudging was complete, children were

brought outside to engage in physical activity (i.e. play ‘Lady, Hunter, Bear’, a form of tag), followed by a snack. Finally, once snack time was over, participants (n=18) were asked to sit at a table inside the GLC and listen to one of the RAs describe the research study. After being provided with time to ask questions, participants were given a large blank canvas and asked to paint individual pictures in response to the question “what does being healthy look like to you?”. This question was developed through consultation with team members at SOAHAC and Western University, who agreed that the phrasing of the question, specifically the word ‘look’, was important in priming the children to express their thoughts visually, through art.

Acrylic paints were provided for the participants to use; participants were able to choose the colours that they wanted as well as the size of their paint brush. All participants engaged in this activity at the same time, in a group setting. Participants were allowed to choose where to paint within the GLC, either at a table or spread out on the floor. While some participants chose to work in silence, others engaged in group discussion while completing the activity. Throughout the painting activity, the RAs and various researchers from Western University circled the room and encouraged children to paint. In order to discourage participants from copying the ideas of their friends, the RAs and the researchers encouraged participants to use their imagination and create something different from those around them. Most of the children understood the exercise and subsequently painted what being healthy looked like to them. A few children appeared not to understand the research question, or had no idea what to draw; in these circumstances, various questions were used to help evoke ideas, such as “what does a healthy person look like?”, or “what activities does a healthy person do?”. These

questions were developed in partnership with team members at SOAHAC, with the aim being to help out the children but not to lead them. Nevertheless, a few children were confused about the activity, and expressed their confusion within the sharing circles. Owen, for example, reported to his group that “I didn’t know what we were supposed to paint, so I just painted the wampum belt, but then now it’s a blueberry... [An] up-close picture of a blueberry”. Owen also explained “...they told me to draw a fruit”, but did not remember who it was that gave him these instructions. Other children claimed to make mistakes in their painting, such as Colin, who said, “It started off as a big apple right here... And like a couple of blueberries and strawberries, and other stuff... I messed up though”. Owen and Colin’s paintings turned out as one solid colour, as shown in Figures 3 and 4.



***Figure 3. Owen, age 12***



***Figure 4. Colin, age 11***

In addition to circulating the room and offering assistance in the form of prompts and support, I took observational notes about the concerns and questions of all those involved. Three participants, for example, asked to start over and were given a new blank canvas. One of these participants had accidentally spelled the word ‘apple’ incorrectly; after being laughed at by participants around him, he got a new canvas and started again. I also noted that two other participants were copying from a comic book that they had

brought from home; when I asked if they could use their imagination instead, they told me that in fact they were. One of these participants even asked if I could copy the figure for him, as he seemed embarrassed at his own drawing skills. Reluctantly I agreed to draw an outline for the boy, so long as he painted about health.

Most participants completed the activity within 60 minutes; those who were done early went to play outside. Some participants requested extra time, however, and were told that they could complete their painting on another day, when there was more time. Unfortunately, because the sharing circles occurred on the same day as the painting activity, a small number of the paintings were not complete in time to share the finished piece.

Later in the week, in the final set of sharing circles, some of the children recalled the painting activity as one of their favourites throughout the week. Marian, for example, said that one of her favourite activities of the BLE was “when we got to paint what health means to you”. Of course, it is hard to please everyone. One of Hayley’s least favourite activities was the painting, “...because I’m more of a drawer than a painter”.

Photographs of all paintings were taken on the first day of camp, in order to review them later for research purposes. These photographs are provided in the Results chapter of this thesis (Chapter 4). A few of the photographs were intentionally cropped, to remove the child’s name and maintain anonymity.

Participants had the option of taking their painting home at the end of the first day or leaving it in the GLC, to be displayed during a Feast and celebration on the final day of camp. Children who had left their paintings throughout the week were encouraged to take them home after the Feast.

Within this study, consistent with its critical constructivist location, it is understood that the children's paintings were influenced by "[a] variety of contexts, settings, and perceived demands" (Bradding & Horstman, 1999, p. 171). Children's realities, as well as our own, are shaped by social, cultural, and political environments; children's drawings will reflect these environments and the leading discourses, in relation to health and well-being, that exist in society today (Backett-Milburn & McKie, 1999). Furthermore, during the research activity, children may have struggled with drawing certain concepts. If what they wished to show was too complex or difficult to draw, children may have chosen to draw something simpler, even if it was not what they truly wished to show (Pridmore & Bendelow, 1995). To resolve these issues and gain a deeper understanding of the children's art, the painting activity was followed by sharing circles. These sharing circles gave children the opportunity to discuss their paintings and to elaborate upon what they created, or wished to create.

It is important to note that the painting activity was not used diagnostically; in other words, the paintings that the participants created were not used to assess their intellect or development in any way. In the past, drawings have been used by psychologists and other mental health professionals to diagnose problems or personality disorders in children (Piko & Bak, 2006; Pridmore & Bendelow, 1995). The purpose of the painting activity was clearly conveyed to the children; we consistently told them that there was no right or wrong thing to draw, and that they could explain their thoughts later, in the sharing circles.

During the week prior to the BLE, the RAs created paintings as well. The RAs explained to me that they wanted to give back to the children and to explain their own



perceptions of health, once the children had shared theirs. This notion of reciprocity is consistent with an Indigenous worldview (Kovach, 2009). As Kovach (2009) states, “because of the interconnection between all entities, seeking... information [with Indigenous people] ought not to be extractive but reciprocal, to ensure an ecological and cosmological balance” (p. 57). At the end of each sharing circle, once all the paintings had been described, the RAs revealed their paintings and explained what health meant to them, as a First Nations person.

***Research activity 2: Sharing circle A.*** After considering the use of focus groups in this study, our research team agreed that sharing circles would provide a more culturally-appropriate forum for gathering information. Similar to focus groups, sharing circles involve multiple participants but are characterized by formal turn-taking rather than spontaneous discussion (Watson et al., 2012). Sharing circles are a culturally relevant method for research with Indigenous people, as they “reflect Indigenous people’s values of sharing, supporting each other and respecting life experiences through the use of personal interaction” (Rothe, Ozegovic, & Carroll, 2009, p. 336), and are consistent with an oral, First Nation’s way of sharing information (Richmond, 2014). Moreover, because group exercises are common for school-aged children, “children are generally comfortable and familiar with the process of discussing matters in groups” (Darbyshire, MacDougall, & Schiller, 2005, p. 420). Children may also feel more comfortable in sharing circles as opposed to individual interviews because of the power dynamic; by involving more children than adults in the research setting, children may feel as though they have more power and control over the situation (Hennessy & Heary, 2005).

After reviewing the research that has been done with Indigenous children and youth in Canada, two studies were identified as having utilized sharing circles as a method of data collection (Shea, Poudrier, Thomas, Jeffery, & Kiskotagan, 2013; Watson et al., 2012). Shea et al. (2013) used a variety of data collection methods, including sharing circles, to explore teenage girls' experiences of health in their First Nation communities. Some of the girls within this study liked the sharing circles better than interviews, "... as they were more social" (Shea et al., 2013, p. 286). Watson et al. (2012) also conducted sharing circles, but with younger children aged eight to 12 years. These sharing circles were not successful, however, as the children were not comfortable disclosing personal information in a group setting (Watson et al., 2012). Similar to the research that occurred within the BLE, Watson et al.'s (2012) research occurred within a camp setting. In their study, however, community researchers, rather than camp counselors, facilitated the sharing circles. In order to increase comfort within this study, camp counselors (the RAs) facilitated each sharing circle, and helped to create a comforting and culturally safe environment. In addition, the children presented their paintings in the sharing circles, and thus had a specific object to talk about. Because the children had painted their pictures the same day, and were informed about the subsequent sharing circles, they were already thinking about health, and were prepared for the discussion that ensued. Using the paintings within the sharing circles may have relieved some of the feelings of unease that were reported by Watson et al. (2012).

It has been suggested that focus groups with children involve no more than four to six participants, to ensure that shy children feel comfortable and that there are at least three children who will talk (Heary & Hennessy, 2002). For this reason, four to five

children participated in each sharing circle in this study, as well as one facilitator (the RA) and one assistant moderator (myself or another team member from Western University). Thus, four sharing circles, with four to five participants per circle, occurred at the same time, on the first day of camp. This activity took place in the GLC and in the main building at SOAHAC's Chippewa site; each sharing circle was located in a separate room, to minimize noise and distractions. The four rooms were different in shape and size, however, and thus the seating arrangements varied from group to group. Participants in each sharing circle were able to choose their own seats, which may have increased comfort levels further and helped to reduce the power dynamic (Heary & Hennessy, 2005). However, by choosing their own seats, children were also able to sit beside their friends and, at times, became quite distracted. To further increase comfort levels, pencils and paper were also provided for children who wished to write down their answers. These materials were not used for this intended purpose.

During the sharing circles, each child was asked to explain their painting. In addition, children were asked to discuss four open-ended questions about their perceptions of health, including what they do to be healthy. In following the principles of CBPR, these questions were developed in collaboration with SOAHAC and the RAs. The iterative, community-based process of creating these questions helped to ensure that they were meaningful to the community, as well as "meaningful in an academic sense" (Big-Canoe & Richmond, 2014, p. 130). Each RA was given a cue card with these questions, as well as a variety of prompts to use for each one. The question guide for this activity is located in Appendix B.

Within each sharing circle, a kettle stone was passed from child to child; whoever held the stone was allowed to speak, and all others were asked to listen. Talking sticks or eagle feathers are commonly used in sharing circles, within a research setting or not (Lavallée, 2009). The kettle stones used for this activity were a familiar cultural symbol to many of the children and came from Kettle and Stony Point First Nation, which is about 75 kilometers west-northwest of London. For the most part, the children were respectful of each other's ideas and followed the talking stone rule. Within each sharing circle, however, there seemed to be one or two children who took it upon themselves to entertain the group, telling jokes and playing games throughout the research activity. The RAs, as well as the assistants, had to constantly remind the children to follow the talking stone rule, and to focus their conversations on health. While this was frustrating to me and the other assistants, I had to remind myself that the participants were only 10 to 12 years old, and likely not used to participating in research, especially within the context of a summer camp.

Within each sharing circle, the assistant moderator had three jobs: to operate the audio recorders (two per room), to take hand-written observational notes about the discussion that occurred, and to assist the RAs in asking relevant questions. The notes that the assistants (including myself) took were used to inform my research and to add richness to the data. The questions that the assistants asked were also important in adding depth to the research findings. In the sharing circle that I assisted, for instance, one of the children briefly mentioned the existence of good and bad sugars in food, before passing on the stone to the next participant. Had I not asked the first boy to follow up on his idea, I might never have understood what 'good sugar' and 'bad sugar' meant to him.

Due to the fact that all four sharing circles occurred at the same time, I could only be present at one. While I took notes during this activity and interjected when I felt more prompting was required, I still felt anxious about the proceedings in the other three circles. My anxiety was reduced somewhat by the practice sessions that we held with the RAs in the weeks preceding the BLE. During these practice sessions, members of our research team sat in a circle and drew a quick picture about health. The RAs then took turns asking us about our drawings, and brainstorming prompts that they could use with the children. Various researchers from Western University, as well as staff from SOAHAC who had experience doing research and/or working with children, were able to offer guidance and advice, and increase the RAs' confidence in running research-oriented sharing circles.

All in all, the children had interesting and important ideas about health, which are explored in the Results chapter of this thesis (Chapter 4). All of the sharing circles were audio-recorded, with permission from both the parents and the children. Each sharing circle lasted between 25 to 40 minutes.

***Research activity 3: Sharing circle B.*** On the final day of the BLE, after a snack and an outdoor break, a final set of sharing circles took place. Similar to the sharing circles on the first day of camp, these occurred within the GLC and in three other rooms within the main building at SOAHAC. The children (n=18) remained in the same room and in the same groups that they were in on Monday, and throughout the week, with the same RA asking them questions. Each sharing circle thus involved four to five participants, one RA, and one assistant moderator (myself or another team member from Western University).

During these sharing circles, children were asked various questions about the BLE, such as what activities they liked and did not like, and what they learned throughout the week. Most questions were open-ended and designed to encourage reflection on the week's activities. To fulfill SOAHAC's evaluation needs, however, a few questions involved yes or no answers, such as "do you feel that you've increased your knowledge of healthy eating practices?". The full question guide for this activity is located in Appendix C. The yes/no questions were provided by team members at SOAHAC, and all other questions were created in collaboration with SOAHAC.

Within the sharing circles, children were asked to obey the same talking stone rule from the first set of sharing circles. Similar to the sharing circles on Monday, the assistant moderators also took hand-written observational notes about the discussion. Sharing circles were audio-recorded and lasted between 20 to 30 minutes.

**3.5.6 Data analysis.** Once the BLE was complete, I transcribed, verbatim, the audio recordings from all sharing circles using iTunes and Microsoft Word. To ensure accuracy of the transcripts, I compared the completed transcripts to the audio recordings twice. Through this process of transcribing and checking I was able to immerse myself in the data and better understand what happened in the sharing circles, especially those I could not attend. Once the transcripts were complete, I created pseudonyms for each participant, and replaced each real name in the transcript with its pseudonym. Transcriptions were then imported into NVivo 9 qualitative data analysis software, and I performed a thematic analysis on the data, guided by our research objectives. Initial codes, referred to in NVivo as 'nodes' (n=134), were created inductively through a process of line-by-line coding, using key in vivo terms (Strauss &

Corbin, 1990; Coffey & Atkinson, 1996). I then printed a summary of these codes and discussed them at a committee meeting. My committee helped me to reduce or expand the codes accordingly, and to think critically about the codes I had made. For example, within this meeting I realized that several of my codes, including ‘siblings’, ‘grandparents’, ‘parents’, and ‘cousins’, could fit together under the umbrella category ‘family’. At this meeting I also presented a mind map of my initial thoughts on how the findings fit together. My committee encouraged me to keep working on this map, making sure to use words that emerged from the data. For example, my committee suggested that I use the term ‘being active’, which came from the children, rather than ‘exercise’, which came from my own Health Sciences interpretation of what the children meant to say. According to Pridmore and Bendelow (1995), using the children’s words “... can allow the child’s lived experience to be better represented than by the use of pre-determined and ‘a priori’ adult categories” (p. 486).

Throughout this process of reorganizing and interpreting the data, I began to link relevant categories together to form key concepts or themes (Coffey & Atkinson, 1996). I noticed, for example, that many of the categories had to do with the children’s social environment, and the various people, including family members and friends, that influenced their perceptions of health. I therefore began to link these categories to create one of my main themes, which I eventually labeled ‘The Importance of Learning and Doing with Others’.

In following the principles of OCAP and CBPR, and to ensure that the findings were meaningful and relevant to the community, the codes and themes that I developed were also discussed with team members from SOAHAC. In December 2013, a few

students, including myself, organized a lunch meeting at the SOAHAC Chippewa site, and invited all those who could attend, including the four RAs from the BLE. Unfortunately, none of the RAs were able to attend, but several staff, including a few Elders, came to the meeting and gave insight into the importance of what we found. At this meeting I presented the preliminary results, and asked for feedback on the various themes. I also brought copies of all the children's paintings, which allowed team members to give important feedback on symbols and patterns that they saw. For example, several of the staff picked up on the wampum belt pattern that appeared in many of the paintings, and commented on the importance of using this symbol. A few staff commented that although the children did not have the words to explain why, they inherently knew that the wampum belt represents - and is intricately linked to - the health of First Nations people. The Director of Health Services discussed the lack of a link between culture and health in both the children's paintings and the sharing circle discussions. He emphasized the need to understand the historical traumas that have severed this link, as well as the reasons why intergenerational knowledge is rarely passed down and not often practiced.

After meeting with SOAHAC I continued to analyze the data, paying close attention to what my team members had said. Throughout this process I strove to incorporate my own observational notes and those of the other assistant moderators, which helped me to understand the importance of certain themes. For example, one of my observations throughout the BLE was that most of the activities that the children enjoyed were activities done with others, such as friends and family members. In writing up the second theme of my results, "The Importance of Learning and Doing with Others", I



incorporated these observations to show the theme's significance not only in the transcriptions, but in the children's everyday lives and experiences at the BLE.

***Paintings.*** In addition to the transcripts and observational notes, the paintings were used to add richness and depth to the results, and were viewed as “factual rather than symbolic” (Pridmore & Bendelow, 1995, p. 482). Despite the fact that each painting was a construction of the child's reality, and influenced by a variety of factors including the researchers and the research setting, we tried not to place meanings on the paintings that were not induced by the child (Horstman, Aldiss, Richardson, & Gibson, 2008; Piko & Bak, 2006; Pridmore & Bendelow, 1995).

Through coding the data and discussing these codes with my committee and SOAHAC, five main themes emerged from the findings: 1) Enhancing Health Through Engaging in Occupations; 2) The Importance of Place in Children's Occupations; 3) The Importance of Learning and Doing with Others; 4) Healthy Bodies and Healthy Minds; and 5) Evaluating Our Experience. These themes are explored in the Results chapter of this thesis (Chapter 4).

### **3.6 Addressing Reflexivity and Subjectivity**

As a young non-Indigenous researcher with a background in Health Sciences, I inevitably came into this research with my own perspective on what it means to be healthy. Health Sciences, in the Western world, has long been entrenched in the biomedical model of health, which focuses on physical conditions and defines health as the absence of disease (Engel, 1977). Within the past few decades, the World Health Organization (WHO) has updated their model, defining health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or

infirmity” (2003). While this biopsychosocial model encompasses a more holistic notion of health, it is still inherently different from the model that guides this research: the medicine wheel. For this reason among others, working with SOAHAC has been a learning experience for me. While I understand that the medicine wheel encompasses four aspects of health – physical, mental, emotional, and spiritual – and considers good health to be a balance between these aspects, I am far from understanding all that this entails. With four years of undergraduate training in the Western model of health, I often find it challenging to think about health differently, and to understand, for example, how the spiritual aspect is just as important as the physical. While I strove to maintain a holistic, First Nation’s view of health throughout this study, my own presuppositions influenced what was found.

Despite my own assumptions about health, many members of the research team are First Nations, including my co-supervisor Dr. Richmond and many of the staff from SOAHAC. Thus, given the collaborative nature of this work, this research was informed by an insider, First Nation’s perspective on what it means to be healthy and well. Oftentimes, when my thoughts and ideas aligned with a Western view of health, my team members advised me to think more holistically. For example, my first idea for the painting exercise was to have children draw a healthy or unhealthy person, and write what makes them healthy or unhealthy. This research method, called the ‘draw-and-write’ technique, has been used previously to understand children’s perceptions of health (Pridmore & Bendelow, 1995). However, when I presented this idea to my committee, I was quickly reminded that focusing on the physical body was not in line with a First Nation’s view. The final idea we developed, to have children paint their answers to the

question “what does being healthy look like to you?”, encompassed a more holistic notion of health and allowed children to think beyond the physical realm. The suggestions made by my committee and by SOAHAC allowed this research, and the questions we asked, to be more in line with local and cultural contexts.

In reflecting on this project, it is important to realize that this research was conducted through a highly interdisciplinary lens. At Western University, my home is in Occupational Science; the students and professors within this field have broadened my understanding of occupation and the importance of meaningful occupations to the health and well-being of children and communities. However, much of what I learned about Indigenous health, and the complex interplay between health, identity, and the land was gained through my connections to the Department of Geography. Over the past two years, I have been fortunate to be part of the Indigenous Health Laboratory, located in the faculty of Social Science, and directed by my co-supervisor, Dr. Richmond. Students in this lab, at both the Master’s and PhD levels, have provided me with further insight into land-based ideas about health. Being surrounded by health geographers has added breadth to my own understanding and to the ways that I think about Indigenous children’s health. The ideas for this study, including the questions that we asked and the ways we approached analysis, were thereby informed by multiple disciplines and multiple ways of thinking. Given my constructivist approach, it is also acknowledged that these lenses influenced how the data were read and interpreted. As mentioned throughout this chapter, I continually engaged in various forms of reflexivity to both understand my own contribution to the co-construction of knowledge and to ensure an openness to what children were expressing through their art and in discussions.

In addition to my own perspective and those of my colleagues and co-supervisors at Western University, many other perspectives were incorporated throughout the research process, including those of the RAs and the staff at SOAHAC. While at times these perspectives seemed to clash - as everyone had different ideas on how best to develop this project - my research certainly benefitted from the wide range of knowledges and experiences that our team possessed.

Throughout this project I wrote a reflexive journal to capture my experiences. Within this journal I recorded all research decisions, including the reasons behind these decisions, as well as my thoughts and opinions in relation to the research process. For example, one of the struggles that I encountered in doing this research was the tension between following the principles of CBPR, which require a certain amount of flexibility, while concurrently following the deadlines my graduate program had put in place. It was difficult to track my progress and make personal deadlines when so much of the research was out of my control, or required input from numerous people with different schedules. Even when meetings were planned well in advance, they were often postponed or delayed, and ran longer than expected. An hour could pass in the blink of an eye, sharing stories and eating food, without any research decisions being made. Moreover, whenever I had a plan for my research – an idea of how things would go – this plan would inevitably change. For example, in the weeks leading up to the BLE, I cannot recall how many times my question guide changed; even when everyone seemed to agree on the questions, they would nevertheless change at the very next meeting. The challenges that I faced in the research process were inherent in the methodology that is CBPR, but they were challenges that I had to learn, and overcome, myself. No one warned me about the

stress I would feel in having to rewrite my research plan over and over, and still have no idea how my research would turn out.

Yet, despite my stress and all of the challenges that arose, I learned two important things while working on this project: 1) sharing stories and eating food was not work in the Western sense, but the kinds of relationships that were formed in this way were instrumental to the success of my research, and were central to the work getting done; and 2) research, especially CBPR, requires a certain level of trust and a whole lot of faith. “Trust the process” was a line my committee gave me, over and over again, and a line I now give myself. Everyone on our team wanted the camp and the research to work; I only had to trust the process, and know that, whatever happened, it would be okay. Every little change – every question that was revised – only made the research better. Moreover, because my supervisors had done CBPR before, and were accustomed to the deadlines my school had put in place, they helped me to move the research along, and kept our team on track. I am thankful for the guidance and support that my committee and SOAHAC provided, and feel blessed for the relationships that developed along the way.

### **3.7 Enhancing Quality in the Research**

Throughout this project I was constantly considering how to enhance the quality, not only of the findings, but of the entire research process. In quantitative designs, high-quality research is largely determined by the extent to which a study achieves reliability and validity. In Health Sciences, the gold standard of these designs is the randomized-controlled trial (RCT), where every factor is strictly controlled, from the research setting to the subjects involved. Attaining quality in qualitative research is much less clear-cut; reliability and validity do not fit well with constructivist assumptions, yet other standards

must be achieved to distinguish a good study from a bad one. While some researchers have attempted to create a list of such standards (e.g., Caelli, Ray, & Mill, 2003; Morrow, 2005), others have argued that such a list is limiting and cannot encompass the entire spectrum that is qualitative research (Tracy, 2010). Rather than limiting this discussion to the criteria outlined in one of these lists, which largely stem from Western knowledge systems, I instead turn to the CBPR literature to examine the factors that define good quality research within Indigenous communities. In this section I will briefly outline a few of these factors, and review how this thesis – especially the methods that were chosen - aimed to fulfill them.

To me, the first sign that this was high quality qualitative research was that everything came from, or was developed with, the community. According to Brant Castellano (2004), “Aboriginal people have a right to participate as principles or partners in research that generates knowledge affecting their culture, identity and well-being” (p. 98). The issues that we addressed and the objectives of this study were developed in conjunction with SOAHAC, making the research meaningful and specific to the local community. Moreover, the methods we chose to employ in our study were developed in collaboration with SOAHAC. As Cochran et al. (2008) have explained, “it is important to consider the ways of knowing that exist in indigenous communities when developing research methods” (p. 22). The present study was guided by local IK; the painting activity and sharing circles, as well as the activities throughout the BLE, stemmed from this knowledge system, and were considered to be appropriate by all team members involved.

Related to the development of meaningful research and appropriate research methods is the importance of strong, trusting relationships between the researchers and

the community involved. A plethora of researchers have expressed the need for trust in the research process (e.g., Brant Castellano, 2004; Cochran et al., 2008; Durie, 2004; Kovach, 2009). As I explained previously in this chapter, the present study would not have been possible without a certain level of trust between SOAHAC, myself, and the other university researchers. This trust was established prior to the present research study, but was further strengthened in every meeting, through respectful conversations and consideration of everyone's ideas. Moreover, as outlined previously, our research followed the principles of OCAP to ensure that the study was conducted in a good way.

The present study also focused on strengths, which is an important component of high quality research with Indigenous communities. As Cochran et al. (2008) so eloquently stated, “the most insensitive research is the perpetuation of the myth that indigenous people represent a “problem” to be solved and that they are passive “objects” that require assistance from external experts” (p. 22). Through engaging collaboratively with our community partners, and focusing on good health rather than bad, we aimed to emphasize the community's strengths and build positive community capacity.

Another factor that contributed to the quality of this thesis is the fact that I have aimed to be transparent, explaining the methods clearly and reflecting upon what worked well as well as the challenges that we faced. In describing good quality qualitative research, Tracy (2010) labeled this criteria as ‘sincerity’, defining it as “research [that] is marked by honesty and transparency about the researcher's biases, goals, and foibles as well as how these played a role in the methods, joys, and mistakes of the research” (p. 841). While Tracey's (2010) criteria are based upon Western ways of thinking, and were not created to guide good quality research with Indigenous communities, I think sincerity

is an important criteria of the present study, especially given my critical constructivist stance. In the present chapter as well as in Chapter 1 of this thesis, I introduced myself and described my own assumptions coming into this project. Throughout the rest of this thesis I continue to be transparent in describing the successes, challenges, and tensions that arose within this study.

Finally, in addition to incorporating my own voice within this thesis, I strove to incorporate the voices of all those involved, especially those of the children. A number of studies and reports have highlighted the importance of incorporating First Nations children in conversations about their own health (e.g., Blackstock, Bruyere, & Moreau, 2006; RCAP, 1996). By including quotes from all of the children involved, as well as photographs of their paintings, I aimed to more fully convey the children's perceptions, and to show, rather than tell, what we found. These quotes and pictures are intertwined with detailed descriptions of the contexts in which the children spoke, as well as my own – and our research team's – interpretations of the main results. By involving children in this research, and creating spaces for their voices using quotes and paintings, I aimed to further enhance the quality of this thesis.

### **3.8 Conclusion**

This chapter outlined the methodology that framed this research – CBPR – and the ways in which myself and other researchers at Western University worked in collaboration with SOAHAC to create the BLE. The methods that were chosen for my research – paintings and sharing circles – were described in detail, as were the participants, the research setting, and the process of analysis. I aimed to be transparent within this chapter by addressing subjectivity and reflexivity, including the various



struggles I encountered in doing this research. Finally, I addressed the various components that helped to enhance the quality of the present research study. In the next chapter of this thesis I will highlight the results from the painting activity and the sharing circles, and present these results within five major themes: 1) Enhancing Health Through Engaging in Occupations; 2) The Importance of Place in Children's Occupations; 3) The Importance of Learning and Doing with Others; 4) Healthy Bodies and Healthy Minds; and 5) Evaluating Our Experience.

## **Chapter 4**

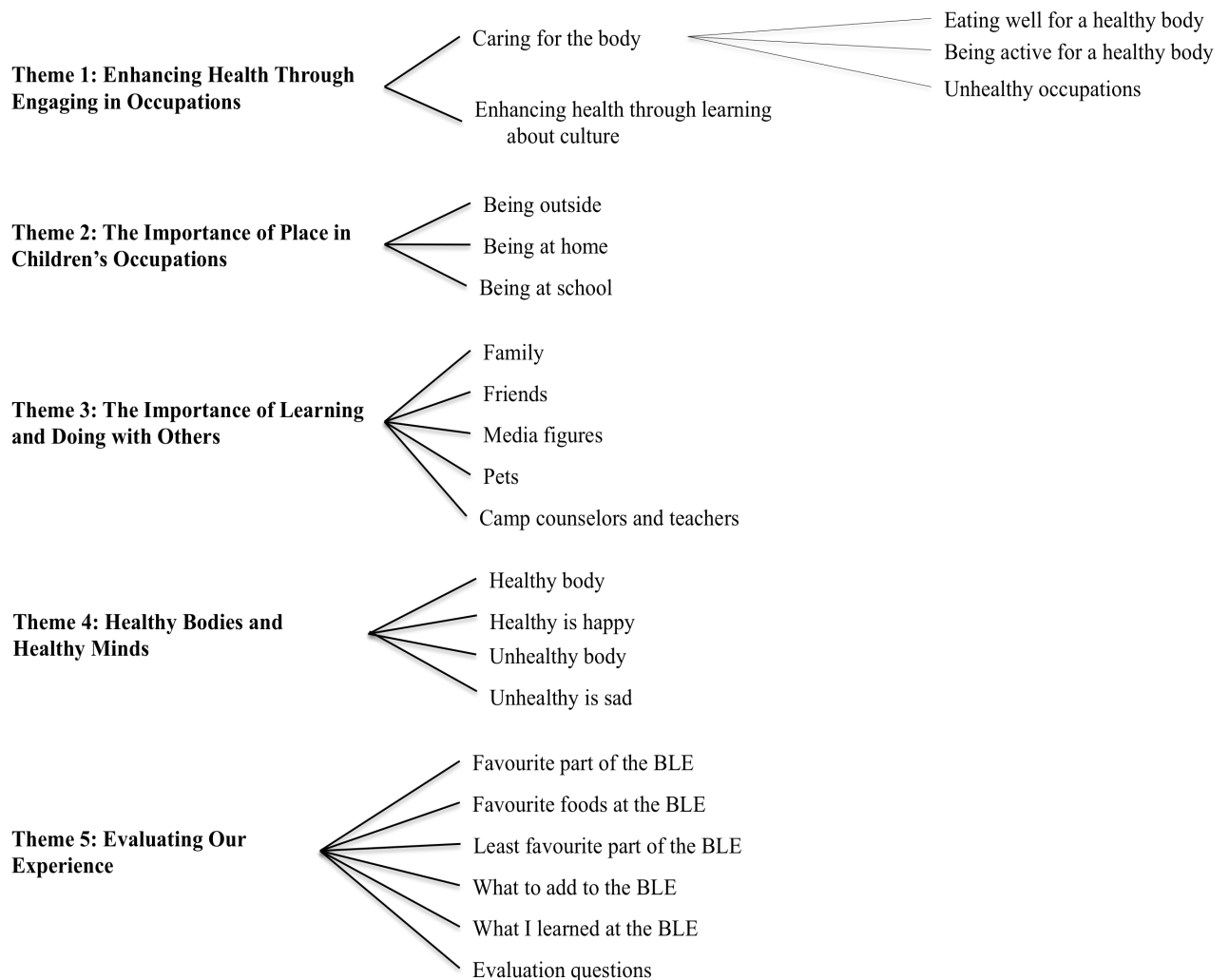
### **4 Results**

Within this chapter the results of the analysis of the data collected through the use of the painting activity and sharing circles are presented. As outlined in the previous chapter, the key objectives of this study were: 1) to understand how First Nations children think about their health, with a focus on the various activities, or occupations, connected to their health, and 2) to explore how these children connect their health with culture. Within this chapter, I begin by introducing the five main themes that emerged from the present study, and provide an outline of these themes in the form of a figure (see Figure 5). I then proceed by discussing each theme in detail, exploring the results through direct quotations and examples of the children's paintings. At the end of the chapter I will summarize the results and provide a brief outline of what will follow in the discussion chapter of this thesis.

#### **4.1 Introducing the Five Emergent Themes**

Five major themes emerged from our analysis of the data. The first theme, 'Enhancing Health Through Engaging in Occupations', explores the various occupations that the children associated with health. These occupations fall into two main categories: occupations related to caring for the body, such as eating well and being active, and occupations related to their culture, such as participating in Pow Wows. The second theme, 'The Importance of Place in Children's Occupations', explores the various physical environments that the children associated with their occupations, including being outdoors and being in school. The third theme, 'The Importance of Learning and Doing with Others', examines the social environments that children associate with their

various occupations, and identifies family, friends, media figures, and teachers as important influences on children's perceptions of health. The fourth theme, 'Healthy Bodies and Healthy Minds', explores children's perceptions of the physical body, such as the diseases they associate with poor health, as well as the emotions connected to being healthy and unhealthy. Finally, the fifth theme, 'Evaluating Our Experience', explores the children's ideas about the Bimaadiziwin Learning Experience (BLE), including their favourite and least favourite activities, and what they learned throughout the BLE. The five themes, as well as sub-themes within each theme, are outlined in Figure 5.



*Figure 5.* Themes and Sub-Themes from the Sharing Circles and Paintings in the BLE

## **4.2 Theme 1: Enhancing Health Through Engaging in Occupations**

‘Enhancing Health Through Engaging in Occupations’ was the first theme that emerged from the data analysis. This large theme incorporates a great deal of the data and covers a broad range of occupations that the children associated with health. This theme was further broken down into two sub-themes that reflect two major links made in relation to occupation: ‘caring for the body’ and ‘enhancing health through learning about culture’. The first sub-theme, caring for the body, explores children’s perceptions related to food and exercise. The second sub-theme, ‘enhancing health through learning about culture’, explores the various occupations that the children associated with their culture, and, at times, explicitly with health. These sub-themes are explored below.

**4.2.1 Caring for the body.** Occupations that the children associated with caring for the body largely revolved around eating well and staying active. Occupations associated with food and eating and those connected with staying active are explored separately in this section. In addition to eating well and being active, a number of other occupations were mentioned by the children in relation to being healthy and caring for the body. Dana, for example, was one of two children who discussed the importance of brushing your teeth and maintaining good hygiene by taking showers.

***Eating well for a healthy body.*** Many of the children associated being healthy with eating particular types of foods that, in turn, were talked about as healthy foods. When asked “what does the word ‘healthy’ mean to you?”, or “what makes a person healthy?”, children responded with phrases such as, “eating the right kind of food” (Alexandra), “to eat healthy” (Amanda), or “eating healthy stuff” (Tyler). Two of the

children's paintings appeared to be solely about food, while ten other paintings had a component that addressed food.

Within the sharing circles, children identified specific types of food and labeled them as either healthy or unhealthy, but rarely both. Fruits, vegetables, and milk were considered by the children to be healthy foods, where as junk food, salt, and oil were considered to be unhealthy. One exception to this finding was sugar. While some children described sugar as an unhealthy food, others made the distinction between good sugar and bad sugar. The foods that the children identified as healthy and unhealthy are described below.

*Healthy Foods.* Fruit was the most common example of a healthy food and was portrayed in 12 of the 18 paintings. The most common fruits that the children drew were apples and bananas, but oranges, grapes, cherries, strawberries, blueberries, and raspberries were depicted as well. Jesse's painting is shown in Figure 6; according to Jesse, "this is an apple. Apples are healthy". Dana's painting, also of an apple, is shown in Figure 7.



**Figure 6. Jesse, age 11**



**Figure 7. Dana, age 11**

Within the sharing circles, when asked to describe their painting and/or a healthy person, 15 of the 18 children talked about fruit. When asked why fruits are good for you,

Olivia answered, “cause they’re nice and sour”, while Dana explained, “they put good stuff in it”. Dakota described the sugar in fruit as being healthy for the body and different from the sugar that is found in junk food; as he explained, “it’s not the bad sugar, it’s the good sugar” (Dakota). Some participants offered less of an explanation as to why fruit is healthy, such as Raya, who simply stated, “...fruit is good for you; it’s healthy”. Fruit was available for the children every morning of the BLE, when they first arrived; it was interesting to observe that each day, the fruit was very popular and nearly disappeared by the time the activities began.

Fruit baskets were a common symbol of being healthy and appeared in five of the 12 paintings that depicted fruit. Most of the children did not explain why they chose to draw a fruit basket, except for Dakota who said, “fruit baskets show you how many different fruits there are...and if someone hasn’t tried it, then people can just look in the fruit basket and try it out”. To Dakota, the fruit basket symbolizes choice; people can choose the fruits they prefer but still benefit from their substance. Dakota and Raya’s paintings are shown in Figures 8 and 9.



***Figure 8. Dakota, age 11***



***Figure 9. Raya, age 12***

Seven participants mentioned eating vegetables as a contributing factor to health. When asked what a person must do to be healthy, Shane replied, “you gotta eat

vegetables”. Shane was the only participant to actually paint vegetables in the painting exercise; when asked to describe his painting, Shane said, “I painted the three sisters... corn, bean, and squash”. The three sisters is a cultural reference to describe the main vegetables of many Indigenous groups; I found it interesting that Shane incorporated this cultural knowledge into his painting. Shane’s painting is depicted in Figure 13. When comparing the amount of discussion regarding fruits versus vegetables, fewer participants spoke about vegetables. Dakota offered a possible explanation for this, saying, “kids... like to eat the fruit better than the vegetables because the fruit has juices... and it tastes really good”.

Milk was mentioned by two children who both considered it to be a healthy food. When asked why milk was healthy, Olivia explained, “the milk keeps you nice and strong, so that you [get] good bones”. Milk was therefore considered a healthy food by Olivia because of its positive physical effect on the body. Milk was not depicted in any of the children’s paintings.

*Unhealthy Foods.* Nine of the 18 children used the term ‘junk food’ to describe food that is unhealthy to consume. Several of the children spoke about other unhealthy foods that could be described as junk food as well, such as “...sugar, potato chips, french fries, [and] hamburgers” (Olivia).

When asked to describe what makes a person unhealthy, responses included: “by not making good choices, and eating junk food all the time” (Alexandra), “playing video games all day and eating junk food” (Hayley), and “a person who isn’t very active, and eats junk food” (Raya). In addition to their focus on junk food, the children seemed to associate being unhealthy with a combination of eating unhealthy foods and being

inactive or making other ‘unhealthy’ choices, such as playing video games. One participant also eluded to the idea that in moderation, junk food may not be bad; when asked ‘what does the word healthy mean to you?’, Colin replied; “it means ... don’t eat too much junk food, eat some fruit, and stay fit”. Thus, according to Colin, eating some junk food is not necessarily unhealthy, as long as others measures are taken to maintain good health, such as eating fruit and staying active.

Oil was described by one participant as an unhealthy food; after being asked “do you know of any traditional activities that are unhealthy?” Olivia described various traditional foods that are cooked in grease and therefore, according to her, are not healthy. These foods included “... our fry bread, our pancakes, [and] our scone dogs” (Olivia). Nevertheless, these foods appeared to be well-liked by the children; throughout the week of the BLE I observed many of the children talking about fry bread and scone dogs. Some of the children expressed their disappointment on the days when fry bread was not served; fry bread was included in the feast on Friday, however, and was certainly enjoyed by the children and their families.

Within the sharing circles, the majority of children who discussed sugar labeled it as an unhealthy food. However, a few children distinguished between ‘good sugar’ and ‘bad sugar’. In the first set of sharing circles, Dakota described the sugar in fruit as good for the body because “...it has vitamins and protein and stuff like that...” Bad sugar, on the other hand, was described by Dakota as “the stuff that you put in tea... and coffee”. He went on to explain, “I think it’s man-made... it’s just really bad for you, because it has bad stuff in it” (Dakota).



The second set of sharing circles brought about a much longer discussion about sugar when the children were asked to describe what they had learned during the week of the BLE. Many of the children discussed knowledge that they had gained from the dietician who had spoken to them about the quantity of sugar in different types of drinks. Zach, for example, stated “I actually learned that coke has more sugar than Monster energy drinks, which is pretty fascinating”. During her talk, the dietician had also distinguished between natural sugars, such as the lactose found in milk, and processed sugars that are used in soft drinks and energy drinks. Darian spoke about this distinction during the final sharing circles, stating “sugar in fruits is natural sugar and is better for you than just pop sugar”.

***Being active for a healthy body.*** ‘Exercising’ and ‘being active’ were common terms used by the children to describe important components of a healthy lifestyle. These components were depicted clearly in three paintings, two of which were painted by the same individual. David painted a picture of a lacrosse stick with the term ‘LAX’ printed above it, an abbreviation of the word lacrosse. David also painted the words ‘Right to Play’ on a separate painting; during informal discussion during the painting activity, David said that Right to Play was in reference to the global organization of the same name that uses play – playing sports or games – to empower impoverished children (Right to Play, 2013). However, within the sharing circles, David did not make reference to this organization, simply describing ‘Right to Play’ as ‘[playing] anything you want, but you got the right’. One of David’s paintings is shown in Figure 10. Alexandra’s painting, shown in Figure 16, also depicted physical activity. Her painting clearly shows

two people playing outside, one on a trampoline and the other on the grass, beside a swing set.



**Figure 10. David, age 11**

In addition to the paintings that clearly represented physical activity, such as David's painting above, several other paintings may have been associated with physical activity. The painting shown below by Sara, for example, portrayed, among other things, a walking trail through a park.



**Figure 11. Sara, age 10**

Within the first set of sharing circles, 17 of the 18 children talked about the connection between “being active” and “being healthy”. When asked to describe what makes a person healthy, answers ranged from “it means staying fit... and doing healthy

things for your body” (Alexandra), “getting exercise” (Hayley), and “stay[ing] fit” (Colin). As mentioned within the ‘Unhealthy foods’ section above, the children often described a healthy person as someone who is both physically active and eats healthy. For example, Raya explained that in order to be healthy, one must “be active and eat healthy foods”. In contrast, an unhealthy person would be “...a person who isn’t very active, and eats junk food” (Raya). A combination of eating well and staying fit are viewed by the children as essential components of caring for the body.

The term ‘play’ was used by the children to describe many of the occupations that they considered to be healthy. Playing sports, or simply just playing, were common examples of ways to stay fit. Various sports, including baseball, lacrosse, soccer, and hockey, were considered by the children to be healthy occupations associated with play. Raya, for example, talked about playing sports and being healthy: “I be healthy by playing baseball, and swimming, and playing with my brothers”. Alexandra also talked about the concept of play when describing how her family stays healthy: “We play outside. Me and my family play outside all the time”. Similarly, when asked to list some healthy activities, Amanda said, “going outside to play, or asking to go and see your friends and play”. Clearly, ‘play’ is an important and common term used by children of this age, and is perceived as a healthy occupation, whether within the context of a specific organized sport or not. Play was often described as happening with other people, but sometimes alone, a topic that is explored further in the third theme, ‘The Importance of Learning and Doing with Others’.

Five children mentioned running as a way to stay physically active or fit. Dakota explained that running on a treadmill is healthy, and Tyler mentioned that “going in the

gym... or running outside” is healthy too. Other occupations that the children associated with being active or staying fit included dancing, going swimming, and riding bikes. Dancing was an interesting example because it was talked about in terms of healthy, physical activities as well as occupations associated with being First Nations. Many of the children told stories about their experiences with dance, specifically in the context of Pow Wows or other cultural ceremonies. Within the sharing circles and throughout the BLE, the children talked about what types of dance they did, as well as who taught them how to dance, and what they wore when they danced. When we asked the children why dancing was healthy, they emphasized physical health in their explanations. Alexandra, for example, said that dancing in Pow Wows is healthy “because you’re being active and you’re just up all day dancing”. Clearly, Alexandra perceived dance to be a healthy occupations because of its physical impact on the body, rather than its emotional, mental, or spiritual significance. The majority of children who talked about dance did so at the end of the first sharing circle, when asked about occupations specific to their culture. Dance will thus be discussed further in the second sub-theme of this section, ‘Enhancing Health Through Learning About Culture’.

***Unhealthy occupations.*** While the children had many examples of occupations that are healthy, very few occupations were described as unhealthy. Most of the occupations that the children labeled as unhealthy were associated with being indoors and being sedentary. Children listed watching television, playing videogames, and sitting indoors as unhealthy occupations, or occupations that an unhealthy person would do. Playing videogames was the most common example of an unhealthy occupation and was discussed by eight of the 18 children. Most children did not give an explanation as to why

videogaming was unhealthy; the two children that did explain mentioned that “your body doesn’t get exercise from that” (Hayley), and “your eyes get [blurry]” (Amanda).

Watching television was similarly described as an occupation that an unhealthy person would do. Interestingly, however, many of the children talked about playing videogames or watching television at home, especially when they were bored and had no one to play with. Dakota, for instance, explained, “I only play videogames because none of my friends live around me, and my sister never comes out, and then [I have] no brothers so I never go outside”. Other children mentioned that video gaming can be a social occupation. When Sara was asked what she does at her cousin’s house, she replied “I usually just play on their Xbox”. Whether playing videogames and watching television were identified as individual or social occupations, the children identified them as occurring inside, rather than outdoors, where, according to the children, many of the healthier occupations take place. The various physical environments that the children associated with healthy and/or unhealthy occupations are further discussed in the second theme of this chapter, ‘The Importance of Place in Children’s Occupations’.

Smoking was mentioned by five of the 18 children as an unhealthy occupation. However, one child appeared confused by this idea, stating, “I don’t get how smoking is bad for you if it’s just tobacco” (David). Tobacco is considered to be a sacred medicine by First Nations people, and is used in ceremonies and for prayer or as an offering of thanks; it is no wonder that children might be confused by the stigma attached to smoking this substance. Raya tried to explain to David that cigarettes are worse for your health than pure tobacco “‘cause they put chemicals in it”. Interestingly, the Research Assistant (RA) leading this group agreed with Raya, stating, “the difference is, we don’t put any

chemicals in it... people grow it in their gardens, they make sure it's healthy, and water it".

In addition to smoking cigarettes, three of the children discussed how a healthy person would "not... go on drugs and stuff" (Colin). Drinking alcohol and doing drugs were perceived to be unhealthy occupations, partly because alcohol "...has all that sugar and it'll get you so fluffy like a cloud" (Olivia). When asked what the term "fluffy" meant, Olivia explained, "like fat...". Thus, according to Olivia, drinking alcohol is unhealthy because it is associated with gaining weight. In addition, Dana talked about the connection between doing drugs and drinking alcohol: "[people] get high, drunk... well that's what they do when they're drunk". To Dana, it seems as though certain unhealthy occupations are connected, such as drinking alcohol and doing drugs.

**4.2.2 Enhancing health through learning about culture.** In speaking about health, most of the children did not discuss specific cultural occupations, such as dancing or smudging, until we asked our final question, "As a First Nations person, what does it mean to be healthy?". Initially, many of the children seemed confused by this question, stating "I don't get that" (Olivia), or "I don't know" (Dana). The RAs leading the sharing circles had to therefore rephrase the question, using prompts such as "what traditional activities are healthy?" or "is there anything specific to your culture, or your way of life, that is healthy?" Rephrasing and clarifying the question seemed to help some of the children, who began to think of examples such as dancing in ceremonies or going hunting and fishing. Still, some children continued to give examples that, at least to me, did not seem like cultural occupations. Olivia, for example, mentioned swimming as a healthy

occupation that she does at home, and Dana mentioned getting exercise and “jogging on the sidewalk” as occupations that a First Nations person would do to be healthy.

Many of the children talked about their culture in terms of learning Indigenous Knowledge (IK). It is important to note that although I use the term ‘IK’ within this context, it was not a term used by the children. Rather than naming this type of knowledge, children spoke about it in terms of specific cultural occupations that they had learned, such as making a teepee or learning how to hunt. Other children talked about learning their traditional language, or using the sacred medicine tobacco to perform various customs and traditions.

While the children had extensive knowledge about their culture and experience participating in various cultural occupations, they struggled to link these occupations explicitly to health. When a connection to health was made, it was most often made to physical health, but rarely to holistic health, or mental, emotional, or spiritual well-being. The IK and the various occupations that the children associated with their culture, as well as the ways they linked them to health, are explored next.

The first visible connection that the children made between health and culture was the incorporation of the wampum belt into a number of their paintings. The wampum belt is a symbol of friendship and cooperation between different nations, and historically a symbol of peace and agreement between First Nations people and European colonizers (Mullers, 2007). In Southwestern Ontario, the wampum belt also represents the sharing of food and other resources between different First Nations, which, in turn, helps to promote health (S. Bressette, personal communication, December 18, 2013).

Four of the children painted the wampum belt, which looked like a string of rectangles and diamond shapes, and was coloured purple in each painting. Interestingly, none of these children were sitting near each other during the painting activity. When asked what the wampum belt represents, Olivia replied, “[it] represents my nation”, and David said, “[it means] like friendship or something like that”. Moreover, when we asked David why he painted the wampum belt, he responded “‘cause I have a lot of friends [of] different nations”. While these children did not explicitly state how their belts were related to health, we can assume, based on the topic of the painting, that they did somehow relate these two concepts even though the connection was not verbally articulated. The meaning of the wampum belt was explained to me further when I shared the children’s paintings with some of the Elders and staff at the Southwest Ontario Aboriginal Health Access Centre (SOAHAC). One of David’s paintings, as well as a painting by Shane, are shown in Figures 12 and 13.



*Figure 12. David, age 11*



*Figure 13. Shane, age 11*

Surprisingly to me, only two children incorporated the medicine wheel into their paintings, a symbol perhaps more often related to health within First Nation communities than the wampum belt. In my experience visiting SOAHAC, for example, the medicine



wheel was always visible, and appeared to be the predominant symbol of health used within the facility. Moreover, I found it especially surprising that only a few children painted the medicine wheel given that the children received t-shirts earlier that same morning with the camp's logo, showing the medicine wheel, imprinted on the back.

Olivia drew a small version of the medicine wheel in the top right-hand corner of her painting. Rather than colouring each quadrant of the medicine wheel in its traditional colours (red, yellow, white, and black or blue), Olivia only painted the red quadrant, explaining "I don't know why I drew that... I think it was just for the colour I am... Red for natives". Interestingly, Olivia also received a red t-shirt that same morning. Olivia's painting is shown below.



***Figure 14. Olivia, age 12***

Zach's painting, shown in Figure 15, depicts a much larger version of the medicine wheel, with each colour represented, and each quadrant taking up one quarter of the page. Zach offered a much longer description of the symbol, saying, "I made the medicine wheel because it's important to our culture and it represents many stuff, but the main part I'm talking about is spiritual, mental, physical, and emotional. So, to me, those are

important keys to being healthy”. Zach was also the only child to explicitly discuss a holistic notion of health, explaining that the four quadrants of health “... all tie together”.



***Figure 15. Zach, age unknown***

In addition to painting the medicine wheel, Zach incorporated another symbol into his piece of art: the crucifix. In sharing his painting, Zach explained, “one half of my family is Christian, and the other [half] believes in the Creator”. Although the crucifix is not often recognized as a symbol of First Nations culture, it certainly represents the complicated history of First Nations people, the strong influence of the church, and the diversity of beliefs that exist today. Incorporating both the medicine wheel and the crucifix into his painting demonstrates the connection Zach made between his own view of health and his family’s beliefs.

Within the sharing circles, other cultural knowledge was brought up by the children, which was in turn connected to health. Tyler, for instance, mentioned that “learning Oneida stuff” is good for one’s health. When asked what he meant by this, Tyler explained, “like learning how to make a drum and a teepee”. Thus, according to Tyler, learning about one’s culture is associated with being healthy. Colin, similarly, linked making drums to being healthy. When asked how it feels to make a drum, Colin responded, “it feels like it’s good to know your traditional nation... [and] it’s happy to

know your own traditions”. By connecting health and happiness, Colin extended the conversation beyond the quadrant of physical health, and highlighted the connection between health and emotion.

Attending and/or participating in ceremonies, including smudging and going to Pow Wows, was brought up as a healthy, traditional occupation by five of the 18 children. However, most of the children did not explicitly link these occupations to health, at least not verbally. According to Colin, for example, to be healthy as a First Nations person “...means to know your language, go to ceremonies, [and go to] Pow Wows...” Colin also explained that in order to be healthy, “I go to Longhouse, [I go] dancing, I like making drums, and I like hunting with my dad”. While Colin stated that hunting and making drums are healthy occupations, he did verbalize why. The children who made a verbal connection between cultural occupations and health often did so by discussing exercise. David, for example, said that a Pow Wow he attended “...was healthy ‘cause we walked around a lot”.

Throughout the sharing circles, it was clear that the children liked to talk about these occupations, and spent more time talking about occupations related to their culture than they did talking about health. Throughout the week of the BLE I also noticed that the children loved comparing cultural occupations in which they had engaged, and sharing stories about going to Pow Wows, dancing in competitions, and going hunting or fishing with their families. The BLE may have thus provided a unique setting for First Nations children to share their stories, and to relate to others who were of the same age, and shared similar cultural interests and experiences.

Smudging was an occupation that five of the children associated with their culture and with health. Alexandra mentioned that smudging is done “for every child that is born for their name”. She went on to explain that “we use medicine to smudge them and it makes them healthy... and it cleans them” (Alexandra). In describing why smudging is healthy, Amanda explained, “because it takes all the bad thoughts away”. Similarly, Zach made a connection between smudging and health when he said, “we smudge, so that’s healthy, [because] it cleanses our spirit”. David also shared his thoughts about smudging when he explained, “they make us healthy by using our own type of medicine, and smudgin’, and doing that thing... when you go around the fire”. Throughout the sharing circles, it was clear that David, Alexandra, and many other children associated smudging and going to ceremonies with good health. Interestingly, the importance of smudging was also demonstrated each morning of the BLE, when an Elder came in to perform a smudge with the children. I found it fascinating that each child had their own way to smudge, and that all of the children were quiet and respectful during this time. Clearly, smudging was viewed as an important occupation by many of the children in this study, and was described as healthy by five children in the sharing circles.

Dancing in ceremonies was a common topic of conversation within the first set of sharing circles, specifically near the end of each circle, when the conversation switched from being healthy in general to being healthy as a First Nations person. While none of the children incorporated the idea of dancing into their painting, Zach told his sharing circle, “If I had a chance to make another painting, I’d make a dancer, ‘cause I, myself, I’m a grass dancer... And to me, dancing’s healthy because it ties in with the medicine wheel and all that again”.

Almost half of the children – five boys and four girls – brought up that they have danced at Pow Wows or in Longhouse, and many seemed excited to share their stories with the group. Some children discussed dancing in competition, while others just danced for fun. Darian, for example, talked about going to Longhouse with her grandmother, and building up the courage to dance with everyone else. Though she felt nervous at first to join the group, she concluded that “it feels better when you go and dance with them” (Darian). Alexandra also discussed the thrill of dancing at Pow Wow, when she said, “it makes me feel excited ‘cause I get to do what I like doing”. Similarly, after being asked how dancing makes him feel, David responded, “pretty hyped!”. Though Darian, Alexandra, and David did not explicitly link dancing to emotional health, they all discussed how dancing makes them feel happy or excited. Moreover, as explained previously, some of the children linked dancing to physical health. Dakota, for example, explained that dancing is healthy “because you keep moving, and your body needs movement so it can be healthy”. Dakota went on to say that “...if you weren’t moving, than someone would have to feed you, and they wouldn’t know how much to feed you, so they might feed you too much or too little”. Clearly, dancing is perceived to be a healthy occupation because it is a physical activity, and allows the body to move. Moreover, a lack of movement or physical activity may lead to other problems, such as consuming an inappropriate amount of food, as Dakota pointed out.

Fishing and hunting were two other occupations that the children associated with being First Nations and being healthy, although it certainly took some prompting for these ideas to emerge. For example, to bring about discussion, one of the leaders asked her group to think of activities that are unique to First Nations people, but healthy

nonetheless. After one child brought up smudging as an example of such an activity, another child brought up the idea of hunting and fishing, explaining that these are healthy “‘cause that’s what [our] ancestors did... before we were born” (Colin). It is interesting that Colin associated certain healthy occupations with those that his ancestors once did. Moreover, Colin explained that when he and his grandfather catch a deer, “we put tobacco down before we kill it... to say thank you, [and] to give back”. While Colin did not verbally articulate how these traditions are related to health, they certainly demonstrate the values of reciprocity and respect so common within his collectivist, First Nations culture (Kovach, 2009). In addition, Colin talked about sharing the deer meat with his family and community; when asked how this makes him feel, Colin agreed that it makes him “feel good”. Though Colin did not verbally connect his feelings to health in any way, he did speak of his actions in terms of doing them with others, and feeling good about it too.

Colin was not the only child to talk about hunting and fishing. Tyler talked about going hunting at another culture camp, which made him feel healthy “‘cause it’s really fun”. When Shane was asked, “what do you do to be healthy?”, he too shared stories about hunting with his uncle and father, though direct connections to health were not verbalized. Colin, Tyler, and Shane all labeled hunting and fishing as healthy occupations associated with their culture, though exactly how they related them to health was not always clear.

Other occupations that the children related to culture, and broadly to health, included making drums and playing lacrosse. Making drums was discussed within the first sharing circles as a healthy occupation, as well as in the second sharing circles as a

favourite part of the BLE. Lacrosse was another popular topic throughout the week of the BLE; every day, more and more of the boys showed up with lacrosse sticks from home, ready to play whenever they had free time. Lacrosse was not a planned activity at the camp, however, and many of the children suggested adding lacrosse to future camps like the BLE. Within the first set of sharing circles, lacrosse was identified as an example of a sport that allows participants to stay physically active, thus contributing to physical health. Later on in the sharing circles, when discussing occupations associated with being First Nations, lacrosse was brought up again. When Darian, for instance, said, “I don’t really care [about lacrosse]”, David replied, “you should! It was the first sport invented”. Moreover, according to Shane, lacrosse is healthy because “it’s called the medicine game... [and] it heals you”. Many of the children at the BLE, especially the boys, have played on lacrosse teams, and all seemed to agree that playing lacrosse is an occupation associated with their culture and with being healthy. Each morning of the BLE I also observed that many of the boys smudged their lacrosse sticks, to remove negative energy and allow for a better game. It is also important to mention that while five boys discussed lacrosse within the context of the sharing circles, only one girl expressed her interest in participating in this sport. Near the end of her group’s sharing circle, when exchanging stories about Indigenous celebrities, Marian shared her encounter with Mong, an Indigenous lacrosse player from the movie *Crooked Arrows*. According to Marian, “he was impressed because I play lacrosse and he does too”.

After discussing culture-related occupations that are healthy, children in two of the first four sharing circles also discussed cultural-related occupations that are not healthy; these conversations, however, only lasted a minute or two as most children could

not think of any examples. The only exception to this was provided by Olivia, who mentioned that many of the cultural foods, such as fry bread and scone dogs, are cooked in grease, which, according to Olivia, is not healthy. No other culture-related occupations were deemed unhealthy by the children.

#### **4.3 Theme 2: The Importance of Place in Children's Occupations**

Whenever the children spoke about an occupation, whether specifically related to health or not, they almost always associated that occupation with a place. It was clear in listening to the children that the physical environment plays an important role in the occupations in which they engage, or see other people do, and whether or not they perceive these to be healthy. For example, the children frequently associated outdoor occupations with being healthy, while indoor occupations were perceived to be less healthy. The various physical environments that the children described, as well the ways in which they were associated to health, are explored in this section.

**4.3.1 Being outside.** The children in this study overwhelmingly associated healthy occupations with being outdoors. Occupations that occur outside, such as participating in organized sports or simply just playing with friends, were viewed as healthier than those that typically occur indoors, such as watching television or playing videogames. When the children were asked questions such as, “what does the word healthy mean to you?”, many of them described scenarios such as “playing outside lots” (Hayley), “going outside to play” (Amanda), and “running outside” (Tyler). In fact, nine of the 18 children specifically mentioned outside as an environment where healthy occupations take place, making outside a healthy place to be.



Outdoor scenes were clearly drawn in six of the 18 paintings. Trees, grass, and the sun were common symbols painted in the pictures to represent the outdoors. Alexandra, for example, painted “a picture of my backyard with me and my brother playing”. Within this painting you can clearly see a trampoline, a swing set, trees, grass, and “an unfinished tree house” (Alexandra); to Alexandra, these were symbols that represented being outside and being healthy. Alexandra’s painting is shown in Figure 16.



***Figure 16. Alexandra, age 10***

Autumn also drew an outdoor scene, with picnic tables, grass, clouds, and the sun. When Autumn was asked, “what do you do to be healthy?”, she simply replied “I go outside”. Autumn’s painting is shown in Figure 17.

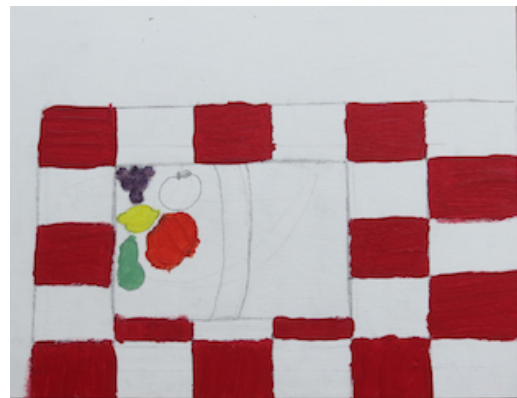


***Figure 17. Autumn, age 11***

Autumn was not the only child to consider outdoor picnics to be a healthy occupation. In fact, three of the other children also painted a picnic scene in their painting. However, it must be noted that two of these children sat directly beside each other in the painting activity, and may have developed the idea together through their discussion. Within the sharing circle, Darian explained her thought process when deciding to paint a picnic scene: “[The] first thing that came to my mind was fruits and vegetables... [S]o then that’s when I thought about the picnic”. In fact, all of the children who drew picnics in their painting also drew fruit, which was considered by the children to be a healthy food. In her picnic scene, Amanda drew what she considered to be her favourite healthy foods: “...strawberries, apples, oranges, bananas, and sandwiches”. Amanda and Darian’s paintings are shown in Figures 18 and 19, respectively.



**Figure 18. Amanda, age 11**



**Figure 19. Darian, age 11**

Healthy occupations that the children described as occurring outside in addition to picnics included playing, running around, and participating in sports. However, many of the children simply considered being outside to be a healthy occupation. In describing what he does to be healthy, for example, David said, “I play lacrosse, I stay outside, I eat, and I go swimming”. Sara also described being outside as a healthy place to be, and

discussed some of the various everyday activities that she does outside: “[I] build forts, climb trees, try and catch snakes, and scare my sisters”. To many of the children, being outside, or “[being] active outside and running around” (Alexandra), was a defining characteristic of a healthy occupation.

Not only did the children consider being outside to be a healthy occupation, or at least a healthy place to be, many of them enjoyed being outside too. I observed this interest everyday at the BLE; between each activity, when the children had a bit of spare time, they almost always went outside, either to walk around the pond behind the Garden Learning Centre (GLC), play lacrosse, or run around with their friends. Many of the children enjoyed searching the field for snakes and toads, and tossing rocks into the pond. When the RAs and I talked to the children, within the sharing circles and throughout the week, they expressed their fascination with the outdoors; when asked to describe her hobbies, for example, Sara said, “I go outside”. Moreover, within the sharing circles on the final day of the BLE, three of the children, including Zach, suggested that in future summer camps, SOAHAC should “add more activities outside”. Most of the structured activities within the BLE, apart from a few outdoor games and the soapstone carving, occurred inside, as the RAs and other assistants assumed the air conditioning would be a welcome addition to most activities.

**4.3.2 Being at home.** Other physical environments that the children described while discussing healthy occupations included being at home, being at school, and being in the community. According to Alexandra, being at home is associated with healthy, physical activity. This idea came across in Alexandra’s painting, which was described as a picture of her backyard. Alexandra, however, was the only child to describe the scene in

her painting as being at home. Within his sharing circle, Colin described how his house is near a river, where he goes fishing: "...our house is right here and then you just go down the road and then there's the river". According to Colin, being close to the river allows him to go fishing often, an occupation he labeled as both healthy and cultural. Olivia also associated being at home with engaging in healthy occupations, when she said "swimming is all I do at home". However, it is unclear from this comment whether Olivia perceived home to be a healthy place to be, because she swims there, or an unhealthy place, because the only healthy activity she does there is swim. Nevertheless, to Alexandra, Colin, and Olivia, home is a place where physical activity can happen, and where one can therefore be healthy.

**4.3.3 Being at school.** Being at school was mentioned briefly by four of the children in the sharing circles, and was not portrayed in any of the paintings. When asked where she learns about health, Alexandra replied, "from school". Similarly, Olivia explained that her gym teacher taught her about being active and eating healthy foods. Alexandra and Olivia both perceived school to be a place to learn about health. Furthermore, in discussing healthy activities, Dakota said, "I play soccer at school". Dakota perceived playing soccer to be a healthy occupation, and school to be a setting where this occupation can take place. A final reference to being at school was made by Colin. When asked, "what does it mean to be healthy?", Colin answered, "it means to know your language". Colin then explained, "I know Oneida", and "when I'm at school we have to introduce ourselves [in our language]". Through this explanation, Colin connected being healthy to learning one's language, and practicing one's language to

being at school. Hence, to Colin, and three of the other children, school is a place to learn about health, or to become more healthy through learning and doing.

#### **4.4 Theme 3: The Importance of Learning and Doing with Others**

Not only did the children associate various occupations with a physical place, but they discussed these occupations in terms of doing them and learning them with others. With the exception of playing videogames and watching television, which were often described as individual occupations, most of the occupations were described as occurring collectively with other people, whether it was friends, family members, camp counselors, or school teachers. Throughout this section I will explore the collective occupations that the children discussed within the sharing circles, as well as the various social networks that the children described as having an influence on these occupations.

It is difficult to tell whether the social environment plays an important role in the children's perceptions of health just by looking at their paintings. Only two children, Alexandra and Marian, actually drew people in their paintings. Alexandra painted a picture of her and her brother playing outside (Figure 16), while Marian drew Finn and Jake, two characters from the children's animated television series, *Adventure Time* (Figure 21). When I asked Marian about this show, she explained that Finn is a human and Jake is Finn's magical pet dog. Marian's brother, Tyler, also drew the magical dog Jake in his painting. In each of their paintings, Alexandra, Marian, and Tyler had their character(s) doing different activities: Alexandra's were running around, Marian's were reading, and Tyler's was eating fruit. Tyler's painting is shown in Figure 20.



*Figure 20. Tyler, age 10*

Within the sharing circles, Darian also described her painting (Figure 19) as having people in it, despite the fact that she did not finish her painting, and did not yet draw the people: “My painting is healthy because it’s people having a picnic outside with fruits, but I didn’t get to finish painting it yet, but they’re outside and they’re eating on the grass, on the picnic blanket”.

Picnics were depicted in three other paintings as well, and each time were described as an activity done with others. After being asked if she goes on picnics alone, for example, Amanda replied “no”, and that she goes with her parents. To Darian, Amanda, and many other children, being healthy looks like being outside, eating healthy foods, being active, and being with others.

**4.4.1 Family.** Many of the occupations that the children described as having an influence on their health were also described as occurring with family. While siblings, cousins and parents were perceived to be involved in occupations related to caring for the body as well as specific cultural occupations, grandparents were almost exclusively discussed in terms of teaching children about the latter.

Siblings were often described as ever-present companions in various occupations. Alexandra was the only child to draw a sibling in her painting, but many of the other children brought up their siblings while discussing healthy activities. When asked “what do you do to be healthy?”, David answered, “I play outside with my sister”, Raya explained, “I be healthy... by playing with my brothers”, and Dakota replied, “...sometimes I like to play with my sister”. Cousins were also mentioned by a few of the children as companions in play and other activities. When asked to describe some healthy occupations, Sara said, “[I] go to my cousins house”. However, when the RA asked Sara what she does at her cousin’s house, she replied that she usually just plays videogames, an occupation that she also described as unhealthy. Thus, the social aspect of seeing her cousins was perceived by Sara to be healthy, but the actual activity in which they engaged – playing videogames – was not considered to be healthy. Overall, the children in this study seemed to agree that engaging with siblings and cousins in occupations such as play is certainly healthy, whether because of the social aspect, the occupation itself, or both.

Parents, like siblings and cousins, were also described as companions in various occupations, as well as role models who teach their children how to be healthy. Colin explained: “after I’m done playing sports, my mom take[s] me to go pick some fruits, and then we start eating ‘em”. Colin’s mother makes what Colin perceives to be a healthy choice, and creates an opportunity for Colin to eat fruit, a healthy food. Raya also made note of the fact that her parents largely control what she eats. In the second set of sharing circles, after being asked if she would eat healthier foods after the BLE, she replied, “I dunno. I don’t buy my own groceries”. Other children also talked about their parents as

role models. When talking about her parents, Hayley explained, “they’re like your role models, so if they don’t make good choices then maybe you won’t make good choices”. Similarly, Colin pointed out that, “you could see your parents do nothing and... you’ll think that’s good to do nothing”. Thus, not only did the children perceive their food choices to be influenced by their parents and family members, but also their way of life, or view towards being active. Last but not least, Amanda expressed the idea that children, such as herself, may influence their parents and/or siblings lifestyle choices, rather than it always being the other way around: “where you have someone to live with... you can tell them to make good choices, not bad choices” (Amanda). It was clear in listening to the children that the social environment, especially one’s family, can play an important role in whether someone makes ‘good choices’ and/or ‘bad choices’.

Learning from grandparents was another common theme within the sharing circles, more so in terms of occupations associated with culture than occupations associated with caring for the body. When discussing hunting and fishing, for example, Colin said “I go [hunting] with my grandpa”, and, “sometimes my grandpa takes me [fishing] and sometimes my dad takes me”. Colin also mentioned that his grandfather taught him how to make a drum, and his grandmother taught him how to speak his traditional language, Oneida. Darian was another child who talked about learning and doing with her grandparents. In discussing dance, Darian said, “sometimes I go to the Longhouse with my grandma... and she tells me to go up and dance”. Similarly, when asked “who taught you how to dance?”, Amanda replied, “my grandma”. Throughout the sharing circles it was clear that grandparents were perceived to be important sources of



traditional knowledge and were often present in the children's lives for various events and activities, such as going fishing and attending Longhouse.

During the week of the BLE, it was interesting to observe that whenever an Elder spoke, whether during the smudging ceremony each morning or throughout the rest of the day, all of the children were completely quiet and respectful. This was not the case when the camp counselors or visiting dietitians spoke; the children would giggle through the lessons and play footsy with each other. When an Elder stepped up to address the children, however, all eyes were on the speaker and all mouths were shut. During the feast on the final day of the BLE, it was also interesting to observe that all of the children stood in line and served their grandparents first, before getting their own food. Throughout this routine, I did not hear any of the children complain, despite the fact that I knew they were hungry and looking forward to this meal.

Another interesting observation that I made when looking through the transcripts was that none of the children referred to their parents, grandparents, or anyone else as an 'Elder'. The term Elder is commonly used in Indigenous communities to refer to someone with extensive cultural knowledge, who has traditionally taken on the role of passing wisdom and IK to younger generations (Kral et al., 2011; Darnell, 2009; Yalmambirra, 2011). Despite the fact that the children perceived their grandparents to be important sources of knowledge, and were very respectful whenever an Elder spoke, they did not use the same terminology that I had grown accustomed to using at SOAHAC. Even when referring to the Elders who had taken part in the BLE, the children used terms such as "that one lady" (Shane), or "that girl" (Darian).

**4.4.2 Friends.** In addition to family, many of the occupations that the children discussed were described as occurring with friends. The importance of friends was introduced by the children at the beginning of the sharing circles, when a few of them described the reasons for including the wampum belt in their painting. Moreover, when asked, “what activities are healthy?”, a few of the children described playing with their friends as a healthy occupation. Amanda, for example, said that a healthy activity was “...asking to go and see your friends and play”. Dana also described walking or jogging on the sidewalk as a healthy activity, and said that she goes walking with “a friend”. According to Amanda and Dana, friends are important people to do healthy occupations with. Moreover, if friends are not available, then children might feel less compelled, or less able, to participate in healthy occupations. Dakota, for example, said, “I only play videogames [at home] because none of my friends live around me”.

**4.4.3 Media figures.** Another important sub-theme from the first set of sharing circles was the influence of media figures on children’s perceptions of health, especially the occupations they saw as positively contributing to health. Two of the children, Marian and Tyler, drew Finn and Jake in their paintings, cartoon characters from the children’s television show Adventure Time. In describing her painting, Marian said, “I painted Finn and Jake, about Finn reading a book [on] how to eat healthy, and Jake’s telling him to read it. Then he’s imagining veggies and fruits and that.” Marian’s painting is shown in Figure 21.



**Figure 21. Marian, age 10**

In reference to his own painting (Figure 20), Tyler said, “It’s Jake eating fruits. He’s off of Adventure Time and he’s a dog, a magic dog.” Neither Marian nor Tyler explained why they chose to draw Finn and Jake, but they clearly had an interest in this television show as they had also brought a comic book, featuring Adventure Time characters, to the BLE.

David was another child who talked about various figures in the media, specifically professional lacrosse players. When discussing how he would change the BLE within the second set of sharing circles, David said, “We’ll have Paul Rabil come in... from [the] Washington Stealth, he’ll come string my stick. And... I’ll bring Johnny Palace here”. David clearly idolized these professional lacrosse players, and thought that bringing Paul Rabil and Johnny Palace to the BLE would add something great to the camp.

**4.4.4 Pets.** In addition to family, friends, and media figures, some of the children mentioned pets as members of their social environments who influence their health and/or with whom they participate in healthy occupations. Four of the children talked about their pet animals within the sharing circles, and two of them associated chasing

their pets around with being healthy. When asked what she does to be healthy, for example, Autumn said, “I chase my cats around the yard”. Shane, similarly, said “I don’t know. I ride my bike, I pet my dogs, and I got a little puppy and it chases me around...”

**4.4.5 Camp counselors and teachers.** One final group of people that were discussed by the children as influencing their perceptions of health, and/or with whom they engage in healthy occupations, were camp counselors and teachers. Many of the children talked about going to summer camps, other than the BLE, and learning about fishing and other activities from the counselors there. At a previous summer camp he had attended, Dakota “... got to play jeopardy on healthy eating”, and learned about “traditional foods, and Canada’s Food Guide”. Tyler learned how to hunt and make drums “... [at] a fishing camp”; hunting and drum-making were considered by Tyler to be healthy, cultural occupations. Smudging was another occupation described in the sharing circles as healthy, and one that you can learn at camp. Olivia, for example, described a local camp she had been to previously, and said “that’s where I learned how to smudge”. A discussion of what the children learned at the BLE is provided at the end of this chapter, under the theme ‘Evaluating Our Experience’.

In addition to camp counselors, school teachers were discussed by two children as having an influence on their understandings of health. Alexandra said that she learned about health in school, and Olivia said:

I learned all about this all year, from my gym teacher. She said that we can’t be a couch potato because if we do, we won’t be active no more, we’ll be couch potatoes. We’ll eat junk food and all that. She said don’t do that, and bring healthy stuff to school, like apple juice, grapes... and other stuff to school.

It must be noted that only one facilitator asked her group to describe where they learned about health. Had we included a specific question in the question guide about where children learn about health, more children may (or may not) have brought up their teachers, and/or the influence of their school environment.

#### **4.5 Theme 4: Healthy Bodies and Healthy Minds**

‘Healthy Bodies and Healthy Minds’ encompasses the children’s ideas in relation to the physical body as well as the mind, and is broken down into four sub-themes. The first, ‘Healthy body’, explores children’s perceptions surrounding what a healthy body looks like, and what a body needs in order to be healthy. This is followed by the sub-theme ‘Healthy is happy’, which looks at the connection children made between health and happiness. ‘Unhealthy body’ is the third sub-theme, and explores children’s perceptions of what unhealthy looks like, as well as the physical ailments and diseases associated with poor health. Finally, ‘Unhealthy is sad’ looks at the various emotions that the children associated with being unhealthy.

**4.5.1 Healthy body.** Throughout the sharing circles it became clear that the children’s perceptions of health centered around the physical body; occupations that were considered healthy were largely considered so because of their impact on one’s physical health. Zach expressed this idea in his description of the medicine wheel, saying, “so to me, that would be healthy ‘cause it’s good for our body”. Similarly, when asked, “why do you think it’s important to be healthy?”, Alexandra replied, “Because it’s good for your body”. Moreover, two of the children explained what a healthy body visually looks like to them. Olivia explained, “a healthy person looks not too chubby, not too skinny, [but] right in the middle. So then kinda fluffy, kinda skinny, not that skinny though”.

Moreover, in reference to the painting activity, Darian said, “Well, I was gonna draw a girl in a bikini, because exercising is healthy too”. The children largely viewed health in the physical sense and described what a healthy body looks like, and what foods and occupations make someone have a healthy body.

**4.5.2 Healthy is happy.** Within the painting exercise as well as the sharing circles, a few of the children connected being healthy with being happy. Zach, for example, made a clear connection between the two, explaining that health is “spiritual, mental, physical, and emotional” and that “emotional [health] means you gotta be happy all the time”. Colin also discussed the relationship between health and happiness in discussing various cultural occupations he does to be healthy, such as hunting and fishing. When asked, “why do you think those things make you healthy?”, Colin replied, “‘cause it’s happy to know your own traditions”. Similarly, when referring to dancing in Pow Wows, Amanda said she feels “happy”, which also makes her feel healthy. According to Zach, Colin, and Amanda, happiness is related to health, and participating in various cultural occupations can certainly make one healthy as well as happy.

**4.5.3 Unhealthy body.** Within the first set of sharing circles, many of the children described specific consequences of eating unhealthy foods and/or refraining from physical activity. Amanda, for example, said that being healthy is important because “if you don’t eat healthy then you can probably die”, and Tyler explained that if you are not healthy, “you might get sick, and get cancer or something like that”. Tyler was not the only child to associate cancer with being unhealthy; Colin, Raya, Dakota and Olivia also mentioned cancer as a consequence of being unhealthy, or as something that an unhealthy person might get. Raya, however, was the only child to identify a specific cause.

According to Raya, the chemicals in cigarettes are bad for the body, and are "...why you get cancer".

Other diseases besides cancer, such as diabetes and heart attack, were discussed by some of the children as diseases that an unhealthy person could get. Two of the children associated eating unhealthy foods with getting diabetes. Hayley explained, "if you don't eat healthy you can get diabetes", and Dakota said, "...if they don't eat lots of good food, and they eat lots of bad food, then they'll get diabetes, and be forced to eat good food". Olivia also said that she has learned about diabetes, mostly from her gym teacher at school. Interestingly, while not referring specifically to diabetes, Olivia said that unhealthy foods are bad for the body "because your body's not used to all that stuff, and your sugar goes up high, that's why you gotta eat healthy food".

In addition to talking about diseases, some of the children within the sharing circles discussed specific parts of the body that can be affected by eating unhealthy foods, or not being active. Amanda said that a person's eyes can get blurry "...if you play on the videogames too much", Colin explained that an unhealthy person's legs "might get shaky and stuff", and Dana said that if a person does not brush their teeth enough, then "your teeth will turn yellow and infected". In addition, Olivia described the consequences of holding your bladder, saying:

I know this for a fact – not to hold in your pee and all that. 'Cause you can hurt your stomach, and it'll cause a bladder issue, and then you'll pass out for four hours... So you don't want to hold in your pee.

Near the end of the first sharing circle, Dakota asked an interesting question: "do you have to be healthy to have a baby?" This question initiated a short debate within the

group. Dana said, “only adults know!”, while Olivia said, “I think yeah, you should be healthy in order to have a baby... so that [the] baby can grow nice and strong and not fluffy”. Unlike Olivia, Dakota explained that being healthy is not a prerequisite to having a baby, but can result in serious consequences:

I think you don’t have to be healthy to have a baby... You can if you want and you don’t have to. ‘Cause if you’re not healthy, and you have a baby, then your baby’s not gonna be healthy, and your baby might have a disability.

In addition to identifying specific diseases related to the physical body of an unhealthy person, some of the children discussed how being overweight is associated with being unhealthy. Olivia said that she wanted her family to be healthy “... so that they don’t grow up to be all fluffy”. Dakota, similarly, said that “if my family’s not healthy, then I’d be influenced to not be healthy, and then I’d be like, big”. According to Olivia and Dakota, being ‘big’, ‘chubby’, or ‘fluffy’ is a result of leading an unhealthy lifestyle, and is what an unhealthy person looks like.

**4.5.4 Unhealthy is sad.** While some of the children connected health and happiness, two of the children connected negative emotions, such as being lonely and sad, to being unhealthy. After being asked, “is it important for your family to be healthy?”, Tyler replied, “yeah, because so none of them won’t get sad”. In the final set of sharing circles, after being asked, “did you learn anything new about health this week?”, Colin replied, “don’t eat too much junk food ‘cause you’ll get lazy and you’ll be lonely”. While the majority of children discussed health in terms of the physical quadrant on the medicine wheel, it was clear that a few of the children also connected emotions, such as being sad or being happy, to their overall state of health.



## **4.6 Theme 5: Evaluating Our Experience**

The main objective of the final set of sharing circles was to understand what the children thought of the BLE, including what activities they liked and did not like, and what they learned throughout the week. Most of the questions were open-ended and designed to encourage reflection on the week's activities. The findings from these sharing circles are organized below in five main sections: 'favourite part of the BLE', 'favourite foods at the BLE', 'least favourite part of the BLE', 'what to add to the BLE', and 'what I learned at the BLE'. In addition, two team members from SOAHAC requested that we ask the children four specific questions, in order to fulfill their evaluation needs. These questions were not open-ended, but required yes/no answers. These questions were asked at the end of the final sharing circles; answers to these questions are shown in Tables 2 to 5. The full question guide for this activity is located in Appendix C.

**4.6.1 Favourite part of the BLE.** When we asked the children to identify their favourite activities from the BLE, answers ranged from playing games to cooking snacks to making crafts. Alexandra and Colin said that playing games was their favourite part, especially the Lady Hunter Bear game (a form of tag) that everyone played on the first morning of camp. Owen and Marian also enjoyed the outdoor components, especially "falling down the hill" (Owen), and, "when we got to make the teepee up on the hill" (Marian). Hayley's favourite part of the BLE was "meeting new people", while Shane explained, "I liked it when [our counselor] tried to gut the fish". Furthermore, three children said that the fieldtrip was their favourite part of the BLE, including Jenny who explained, "my favourite part of the camp was the fieldtrip and making these medicine pouches".

Jenny was not the only child to enjoy the crafts at the BLE. Ten of the 18 children said that making crafts was their favourite part. Five of these children said that the soapstone carvings were their favourite craft, three said that the dreamcatchers were their favourite, and another three identified making drums as their favourite activity.

**4.6.2 Favourite foods at the BLE.** Although not part of the question guide, two of the leaders asked their groups to identify their favourite foods at the BLE. A few of the children identified the fried fish, which was served for lunch on Thursday, as their favourite food. Alexandra, for example, said “the fish was delicious”. Other children did not like the fish, possibly because prior to eating lunch, one of the counselors demonstrated how to gut a real fish. While three children said that they had gutted a fish before, three others refused to watch and did not eat their fish at lunch. Dakota was one of these children, explaining, “I didn’t have any fish, and I didn’t like watching it being gutted”.

Many of the children commented on the soups that were served: turkey and rice was served on Monday, three sisters’ soup was served on Wednesday, and corn soup was served on Friday. In reference to whether he liked the three sisters’ soup, Dakota said, “...I did kind of and I didn’t kind of”. Dakota was disappointed that corn soup was only served on the final day: “I wanted corn soup like everyday or somethin”.

Another dish that the children enjoyed was the yogurt parfaits. Every day of the BLE, one of the groups was assigned to make snacks for the others. Yogurt parfaits were perhaps the most popular of these snacks. Three children specifically mentioned making the parfaits as a favourite activity. Tyler said, “it was fun when we were making the

yogurt”, Dakota exclaimed, “I loved the granola yogurt things”, and Colin said, “I wanna make that berry parfait again...I wanna make that for school, to take it to school”.

**4.6.3 Least favourite part of the BLE.** While many of the children enjoyed the field trip to Skah Nah D’Oht Iroquois village, Dakota said it was his least favourite activity “‘cause... we didn’t see any, like, animals”. Raya’s least favourite part was “...when people talk[ed] a lot about boring stuff”, referring possibly to the dieticians’ presentations throughout the week. In fact, a few of the children mentioned that learning about healthy foods, specifically from the dietician who gave a presentation about the amount of sugar and fat in foods, was their least favourite part. Olivia, for example, said that her least favourite part was “...going to that food thing, and she’s telling us what was healthy and how much sugar on it, and all that”. Olivia further explained that she did not like the dietician’s presentation “‘cause it didn’t feel real comfortable when I eat, it didn’t feel really comfortable”. Jenny also commented that the dietician’s presentation made her feel sick or uncomfortable:

My thing I didn’t like about the camp was, um, learning about healthy and that, ‘cause how much fat was in [a] bottle of, I dunno, something, can of Pepsi or that. That big blob of fat, ‘cause then I’m like ew! I almost puked.

**4.6.4 What to add to the BLE.** When we first asked the children “if you were in charge of the BLE, or a similar program, what would you have added?”, many of them seemed hesitant to answer, or perhaps needed more time to think. Zach, for example, told the RA, “That’s hard. I’m gonna say some... I don’t know actually. I don’t think there’s anything”. However, after a bit of prompting, and reassuring the children that we would not be offended, a plethora of ideas began to trickle out. These ideas are listed below.

**Lacrosse.** Four of the children – three males and one female – discussed adding lacrosse to future camps like the BLE. This idea was not surprising to me, given the interest in lacrosse that I had observed throughout the week.

**Longer camp.** Many of the children thought that the camp should be longer. David, for instance, said, “I’d keep everything the same, but more field trips, and run the camp longer and play lacrosse”. Zach, similarly, said “I would make it longer”, and Marian said, “I’d make it longer, make it bigger”. How long would the children like the BLE to last? According to Zach, “I’d make it, uh, probably a month? Yeah, a month. It would be fun. That’s something I would like to have – a longer experience.” David also said, “How come it was only one week?... It could’ve been three”.

**Overnight component.** Four of the 18 children suggested adding an overnight component to the camp. Jenny said, “you should have us sleep overnight... Like have your own cabin and everything, like boot camp”. Olivia agreed with Jenny, saying “Yeah, overnight camp!” Alexandra liked the idea of staying overnight, but said, “I would only stay overnight for like one night”. Earlier in the week, when I talked to Alexandra about this idea, she said she normally does not like sleeping away from home because she gets homesick and scared. Adding an overnight component to the BLE would suit many of the children’s interests.

**Girls’ and boys’ activities.** A few of the children suggested separating the boys and girls in the BLE. Olivia, for example, said “next year you should just make a girl’s camp”, and Dakota added, “and a guy’s camp”. I think that many of the children would be interested in separating the boys and girls for certain activities, if not for the entire length of the camp (i.e., have a separate camp for boys and girls).

***Traditional components.*** Some of the children expressed an interest in learning more about their culture through camps such as the BLE. Zach, for example, said “One thing I would add too is I would add kinda like more guest speakers... To teach us about our culture, and how it’s affected. Like [have] more guest speakers speak.”

***Other additions.*** Other suggestions to improve or add to the BLE included adding different forms of art, such as finger painting, as well as adding trampolines and more activities outside. Zach and Darian also suggested adding a greater variety of options throughout the day, rather than all of the children doing the same activity at once. Darian expressed this idea to her group, saying: “say if you didn’t want to play a game with somebody, then there’s like another station you can go to and do something else, because you don’t have to just sit out of the game”.

**4.6.5 What the children learned at the BLE.** When we asked the children “what was one of the most interesting things you learned?”, many of them talked about healthy foods. Tyler said he learned about “fruits, vegetables, and being healthy”, Amanda said she learned about “eating healthy stuff”, and Colin said he learned “to not eat junk food... like chips and all that”. Moreover, many of the children referenced the dietician’s presentation as a source of knowledge at the BLE. Shane said he learned “...how many sugar things are in coke”, Dakota said, “the most interesting thing I learned was that pop had more sugar in it than the chocolate bar”, and Jenny explained, “I didn’t know [that] chocolate milk was like a liquid chocolate bar”.

In addition to learning about healthy foods, nine of the 18 children said that learning about traditional medicines was one of the most interesting things they learned. Alexandra mentioned “I learned a lot from the people telling me about the medicines”;

more specifically, she learned “what cedar can do for you, like it helps you breath”.

Hayley, similarly, said, “[I learned] that there was different medicines to help you feel better. Like if you are really sick, you can find all the stuff you need in your backyard”.

Hayley offered an example, saying “...if you get a really bad tummy ache, you can use a special leaf and make it into a tea and it will help you”. In addition, three of the children mentioned learning about jewelweed. As Zach explained, “I learned that jewelweed is a cure to poison ivy and itchiness, and I can specify what it looks like”.

In addition to learning about healthy foods and medicines at the BLE, one child said that she learned about “... the soapstones. I didn’t know how long they took. I thought they took like a day to make ‘em, but they actually take like a half an hour, or two hours” (Jenny). Another child, Shane, said he learned “how to smudge”. This was particularly surprising to me, given that on of the first day of the BLE, it appeared as though all of the children knew how to smudge.

**4.6.6 Evaluation questions.** As mentioned previously, four evaluation questions were provided by two team members from SOAHAC. The first question, “do you feel that you’ve increased your knowledge of healthy eating practices?”, did not generate much discussion; most of the children simply raised their hand to vote yes or no.

However, the second question, ‘Do you feel that your physical activity has increased as part of the program?’, generated a bit more discussion by a few of the children. The BLE was perceived by most of the children as a healthy place to be. When asked whether her physical activity had increased, for example, Sara replied, “it’s like the same!”. She then went on to say, “when I go to camp I’m physical I guess” (Sara). Dakota was one of the children who agreed that his physical activity had increased at the BLE, explaining that

when he is at camp, he is more active than when he is at home, due to the fact that “there’s a lot more kids here... than in my complex”. Having more people to play with contributes to Dakota’s perception that camp is a healthy place to be, unlike his home where “... I usually just play videogames”.

The final two evaluation questions, which asked the children about traditional foods and medicines, generated a small amount of discussion. This discussion was captured in the previous section (5.5: What I Learned at the BLE). All four evaluation questions, as well as the children’s answers, are provided in Tables 2 to 5. Please note that in all of the tables, N/A is short for ‘not available’, meaning the child not did respond and/or was not asked this question.

Table 2

*Question 1: Do You Feel That You've Increased Your Knowledge of Healthy Eating Practices?*

Group number	Yes	No	N/A
1	5	0	0
2	3	0	2
3	1	2	0
4	5	0	0
Total	14	2	2

Table 3

*Question 2: Do You Feel That Your Physical Activity Has Increased as Part of the Program?*

Group number	Yes	No	N/A
1	4	1	0
2	3	1	1
3	3	0	0
4	1	4	0
Total	11	6	1

*Note.* All of the children who answered 'no' commented that their physical activity levels had neither increased nor decreased, but stayed the same.



Table 4

*Question 3: Did You Learn More About Traditional Foods and Medicines?*

Group number	Yes	No	N/A
1	5	0	0
2	2	0	3
3	3	0	0
4	5	0	0
Total	15	0	3

Table 5

*Question 4: Did You Learn More About How Traditional Medicines are Used and Prepared?*

Group number	Yes	No	N/A
1	5	0	0
2	0	0	5
3	3	0	0
4	5	0	0
Total	13	0	5

## **4.7 Conclusion**

The children in this study associated various occupations with being healthy, most of which centered around eating healthy foods and being active. While the children had experience participating in a number of cultural occupations, and seemed to enjoy discussing these occupations, they did not initially connect these to health. All of the occupations that the children described occurred at certain places, and with certain people, concepts which were explored in the second and third themes of this chapter. When talking about health, the children largely fixated on the physical aspects, rarely making reference to mental, emotional, or spiritual well-being. However, a few of the children made connections between health and emotions, such as being happy or being sad, and these were discussed in the fourth theme of this chapter. Moreover, many of the children discussed what a healthy and unhealthy body looks like, and the diseases associated with poor health; both of these concepts were also explored within the fourth theme. Finally, this chapter highlighted the results from the final sharing circles, and examined children's perceptions of the BLE, including what they liked, did not like, and what they learned. In the next chapter of this thesis I will discuss the results in more detail, in relation to four main discussion points. Within this discussion I will highlight the significance of the various findings, make suggestions for additional research, and provide recommendations for future health programs aimed at First Nations children.

## Chapter 5

### 5 Discussion

In the previous chapter of this thesis, the findings of the present study were presented according to five main themes. The first theme, ‘Enhancing Health Through Engaging in Occupations’, examined the two types of occupations that the children discussed: occupations associated with caring for the body (such as eating healthy foods and being active), as well as those associated specifically with their culture (such as dancing in ceremonies or hunting for deer). While cultural symbols, such as the medicine wheel and the wampum belt, appeared in some of the children’s paintings, the children rarely spoke about their culture unless specifically asked. The second theme, ‘The Importance of Place in Children’s Occupations’, and the third theme, ‘The Importance of Learning and Doing with Others’, examined the physical and social environments that the children associated with their occupations. Most of the occupations that the children explored were described as occurring outside, and with family members or friends. Parents appeared to play a prominent role in teaching their children about health, whereas grandparents taught their grandchildren about the customs and traditions of being First Nations. The fourth theme, ‘Healthy Bodies and Healthy Minds’, examined how the children primarily focused on the physical aspects of health, but occasionally connected emotions to health. Common discussion points within this theme included how people can maintain health, and the diseases associated with poor health. Finally, the fifth theme, ‘Evaluating Our Experience’, examined the children’s perceptions of the BLE, including their favourite and least favourite activities, and the knowledge that they gained throughout the week.

In the final chapter of this thesis I interpret these main findings in relation to four prominent discussion points that will help illuminate the significance of the research findings, including how our findings relate to studies discussed in the literature review. These discussion points enable us to make connections to the discipline of occupational science, provide suggestions for future research, and offer recommendations for future health programs involving First Nations children.

The first discussion point explores the importance of strong relationships within the community-based participatory research (CBPR) process, and how relationships with family members and friends influenced children's perceptions of health. The second point acknowledges the importance of place, and the connections the children made between being outside and being healthy. Learning through doing is the third topic of discussion, which was viewed as an essential pedagogical approach by our research team and the children. Finally, the fourth point locates First Nations children between two distinct worlds, and explores how Western and Indigenous notions of health influenced the children's perceptions.

Following these four discussion points, I will summarize the recommendations for future health programs that emerged from this project, as well as the strengths and limitations of the present study. I will then conclude by reflecting on my own 'learning through doing' process as a member of this CBPR project, and the lessons I have learned through conducting research with the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) and the children in this study.

## **5.1 The Centrality of Relationships to our Research and to Health**

This discussion begins with a focus on relationships, not only because relationships emerged as an important concept within the findings (under the theme ‘The Importance of Learning and Doing with Others’), but also because the present study would not have been possible without them. CBPR studies, such as the present study, “... demand collaborative partnerships with Aboriginal communities based on respectful, equitable relationships” (Greenwood & de Leeuw, 2012, p. 27). Good, strong relationships formed the basis of the present study and were primarily responsible for its success. While my co-supervisor Dr. Richmond had worked with SOAHAC previously, every meeting with our research team provided an additional opportunity to get to know each other and to share stories about life in general. I also made an effort to attend non-research specific events in order to strengthen these relationships and to learn more about the communities with whom I was working. I attended a Pow Wow in London, for example, as well as a medicine workshop at SOAHAC and a sweat lodge ceremony with members of our research team, including our four Research Assistants (RAs). These opportunities allowed me to develop stronger relationships with a few members of our research team and to observe, first-hand, the importance of relationships within SOAHAC and the broader First Nations community.

The importance of relationships was again brought to my attention in the process of planning the BLE with our four RAs. Most of the Elders, guest speakers, and volunteers who helped out at the BLE were related to one of the RAs, as well as children at the camp and/or various staff at SOAHAC. For example, one of the RAs had a niece attend the camp and a cousin who worked at SOAHAC. Midway through the week, the

RA's mother and grandmother came to give a presentation, and were thus reacquainted with various members of their immediate and distant family. In addition, two of the other RAs had mothers involved in the BLE; one was involved in the research throughout, while the other cooked lunches for all of the children. The existence of these intertwining relationships helped to create a sense of community at the BLE. The BLE was thus an holistic program, not only because it addressed the four quadrants of the medicine wheel, including physical, mental, emotional, and spiritual health, but because it involved families and community members from every generation. Even on the final day of the BLE, I overheard children rediscovering ways in which their families were connected. While I cannot speak for everyone, I, at least, felt a great sense of community and belonging in the process of creating and taking part in the BLE.

In addition to the relationships that were already in place, and perhaps re-established throughout the week of the BLE, the BLE also provided a place and space for children to create such relationships. All of the children were close in age, and from First Nation communities in Southwestern Ontario. The children were thus able to develop friendships with their peers, based on similar backgrounds and cultural interests. Research has shown that the formation of friendships between members of the same culture can positively influence cultural identity, thereby promoting overall health (Belanger, Barron, McKay-Turnbull, & Mills, 2003; King, Smith, & Gracey, 2009). The following sections will describe how relationships are a key component of holistic health, and the ways in which relationships influenced the children's perceptions of health in the present study.

### **5.1.1 Relationships are a key component of First Nations children's health.**

The idea that relationships are important to health is demonstrated in a variety of Western health models, such as the social-ecological model of health, which, according to Dahlberg and Krug (2002) “considers the complex interplay between individual, relationship, community, and societal factors” (as cited by the Centres for Disease Control and Prevention, 2013, para. 1). Of greater importance to this thesis, however, is the centrality of relationships in Indigenous conceptualizations of health (King et al., 2009; Little Bear, 2000; Wilson, 2003). According to Little Bear (2000), children are born into “... a large circle of relatives and friends” (p. 81); as children grow up and find their place in the world, they are supported by this circle through love, teachings, and resources. In turn, children reciprocate this love and contribute to their communities by sharing resources and offering support (Little Bear, 2000). The Public Health Agency of Canada (2013) has also recognized this circle of belonging in which First Nations children exist, calling it a circle of connectedness: “the circle of connectedness sees the child at the centre, surrounded by his or her parents, who are in turn surrounded by their community” (para. 4). As a result of this circle, many First Nations people “have an idea of the person that can be characterized as community-centred” (King et al., 2009, p. 77). A person's identity, and their overall health, is partly determined by the relationships they maintain with the people around them (King et al., 2009). According to the Public Health Agency of Canada (2013), “[this] is particularly true for Aboriginal children's healthy development since community and belonging are such important parts of their cultures' belief systems” (para. 4).

Social networks, including relationships with one's family and community, are viewed as a social determinant of First Nations children's health (Smylie & Adomako, 2009; Starkes & Baydala, 2014). Children learn values and behaviours from others in their community, including parents, Elders, and other children (Blackstock, Bruyere, and Moreau, 2006). In fact, "all community members have a responsibility to help children learn to live in ways that promote their health" (Blackstock et al., 2006, p. 7). The following section will explore the ways in which relationships emerged in the results of this study, and how we can use this information to create effective health programs for First Nations children.

**5.1.2 Relationships influenced children's perceptions of health.** Within the results chapter of this thesis, the importance of relationships was explored primarily under the second theme, 'The Importance of Learning and Doing with Others'. The children's perceptions of health were largely influenced by their relationships with other people; the children discussed health in terms of who taught them how to be healthy, or with whom they engage in healthy and/or unhealthy occupations. Social occupations – those that involve more than one person – were often described by the children as healthy. Unhealthy occupations, in comparison, were often described as occurring alone, such as playing videogames or watching television.

Family members, including parents, siblings, cousins, aunts, uncles and grandparents, emerged in this study as common social influences on children's perceptions of health. Similarly, in a study by Pigford, Willows, Holt, Newton, and Ball (2012), First Nations children aged 8 to 12 years "... indicated that the majority of their experiences around food and activities involved family members" (p. 989). In the present



study, parents or caregivers were described as important companions in everyday activities, as well as role models who teach their children about health. Children indicated that their own decisions, in relation to being active and eating healthy foods, are often influenced by the decisions of their parents or caregivers. Blackstock et al. (2006) have similarly highlighted the importance of role models on Indigenous children's health: "[Indigenous] children learn healthy behaviours through role models, including family members, and other adults in their communities, elders, and even other children" (p. 7). Moreover, within the present study, some of the children shared stories from their parents that reinforced or helped to shape their own perceptions of health. Jenny, for example, said that when her mother was pregnant for the first time, she only ate junk food and the baby was born small and weak. When the mother was pregnant with her other children, however, she ate healthier foods and the babies all came out strong. Jenny's mother's history helped to reinforce Jenny's belief that junk food is not a healthy choice.

In addition to parents or caregivers, the children in this study described siblings, cousins, and friends as people with whom they spend their time and participate in a variety of healthy occupations. Many of the occupations related to caring for the body, such as eating healthy foods and being active, involved siblings, cousins, and friends. The children said that playing with their friends was a healthy occupation, as was swimming with them and going for walks. In relation to their culture, the children described additional occupations in which their siblings, cousins, and friends were involved, including going to Pow Wows, or playing lacrosse. Moreover, according to the children, if siblings, cousins and/or friends were not available and/or uninterested in doing

something healthy, like playing outside, then the children themselves were less likely to pursue a healthy occupation, and more likely to play videogames or watch television.

In general, the children did not speak about grandparents or other relatives until the end of the sharing circles, when we asked them specifically about occupations related to their culture. In First Nation communities, cultural knowledge is often gained through observation and experience (Richmond, 2014); as Little Bear (2000) has said, “teaching through actual experience is done by relatives: for example, aunts teaching girls and uncles teaching boys” (p. 81). Within the sharing circles, only a few of the boys talked about going hunting and fishing with their uncles. However, within the greater BLE, I heard many of the children talk about their aunts and uncles, and the knowledge that they had gained through engaging in these relationships. Clearly, aunts and uncles played a prominent role in the lives of many of these children.

Grandparents, on the other hand, were repeatedly brought up by the children in the sharing circles, even more so than parents when discussing cultural occupations. Many of the children appeared to have close relationships with one or more of their grandparents, describing them as important sources of traditional knowledge who taught them how to hunt, dance, or speak their language. Grandparents and Elders are often important keepers and transmitters of IK in Indigenous cultures. Other studies with Indigenous children and youth have found that these roles are acknowledged and respected. Pigford et al. (2012), for example, found that:

In relation to traditional foods and cultural events, parents, grandparents, and elders were identified by children as sources of information about healthy foods

and activities, and often “Mom” or “kokum” [grandmother] or both were identified as primary sources. (p. 989)

While the children in this study did not use the term ‘Elder’, most Elders are also grandparents (Varcoe, Bottorff, Carey, Sullivan, & Williams, 2010). Whenever an Elder spoke at the BLE, the children were quiet, attentive and respectful. Moreover, during the final sharing circles, many of the children made reference to the knowledge they had gained from Ernestine, the Elder who conducted the medicine walk. The children’s ability to recall this information demonstrates the benefits of connecting Elders with First Nations children; Elders have a lot to teach, and the children are willing to listen. Past research has demonstrated that First Nations children reach out to Elders for IK, as they are perceived by the children to hold more knowledge than any other generation (Kral, 2011; Royal Commission on Aboriginal Peoples (RCAP), 1996). Children who are in contact with an Elder are also more likely to participate in cultural occupations (Smith, Findlay, & Crompton, 2010), which is important to identity and overall health (Kenyon & Carter, 2011; Kral, 2012; RCAP, 1996).

The significance of relationships within children’s perceptions of health demonstrates the need in occupational science to expand beyond the study of individual occupations to consider the implications, to health and well-being, of occupations done collectively with others. While Western notions of health were shown to influence the children’s perceptions (see section 5.4), Indigenous values, such as collectivism and balance, were apparent in their ideas as well. Colin, for example, explained that when he goes hunting with his grandfather, they lay down tobacco after shooting a deer. According to Colin, laying down tobacco allows them to give back to nature and

maintain balance with the ecosystem. In contrast to an independent view of the self, which is prevalent in Western society, Colin exhibited an interdependent view, seeing himself as part of a larger collective, and as someone who can influence, and be influenced by, other living things (Little Bear, 2000). A further discussion about how Indigenous and Western ways of knowing influenced the children's perceptions of health is provided in section 5.4 of this chapter.

Other children within this study demonstrated similar understandings, recognizing that the occupations they associate with their health and/or their culture are influenced by their social and physical environments. Their understandings of health were dependent upon the greater cultural surround, and the values and beliefs of their parents, grandparents, and friends. As Asaba (2008) has explained in the occupational science literature, "If the sense of self is inseparable from the whole, then a discussion of participation in occupation... is likely inseparable from collective relationships and social context" (p. 76). Future research within occupational science should further examine how collective occupations, such as dancing in ceremonies, produce shared meaning among First Nations children, and contribute to their sense of cultural connectedness and/or cultural identity.

The findings from this study demonstrated that family members and friends play a significant role in children's perceptions of health. For the most part, children gain knowledge about their health and culture through the relationships they retain with their parents and grandparents. Children's perceptions of health, and their consequent health behaviours, are therefore influenced by the people around them. The following section

will address the importance of these relationships in developing effective health programs for First Nations children.

**5.1.3 A community-centered approach to health promotion programs.** The results of this study demonstrate that family members, including parents, siblings, and grandparents, were viewed by the children as primary sources of knowledge about their health and their culture. Children discussed most of their occupations in terms of doing them and learning them with others. Since family, friends, and the larger community play a role in First Nations children's perceptions of health, then they too should be involved in strategies to address their health (Blackstock et al., 2006; Pigford et al., 2012).

Research has shown that health promotion strategies aimed at the individual do not work well in First Nation communities, largely because the individual plays only a small part in determining their own health status, and because an individual's sense of self is largely influenced by their family and community (Greenwood & de Leeuw, 2012; King et al., 2009). As a result, programs aimed at First Nations children should involve family members and the larger community whenever possible. As Blackstock et al. (2006) have explained "[successful] interventions would involve not only the child, but also their family and community to ensure everyone had the knowledge, wellness, and strength to support the child in achieving and maintaining holistic health" (p. 5). Moreover, due to the fact that Elders are traditionally responsible for passing down IK to younger generations, and due to the success of bringing Elders into the BLE and other culture camps across Canada (RCAP, 1996), future health programs for First Nations children should incorporate Elders as teachers.

## **5.2 The Importance of Place in the BLE and Children's Perceptions of Health**

Just as relationships between people are important, so are relationships between people and the land. According to Wilson (2003), “Aboriginal people contend that the relationship they have with the land shapes all aspects of their lives: the cultural, spiritual, emotional, physical and social” (p. 87). As a result, “land, as place, is an integral part of First Nation peoples’ identity and health” (Wilson, 2003, p. 83). The connections between place, identity, and health are complex and multi-faceted (Wilson, 2003). An essential aspect of these inter-connections is that health is achieved through maintaining balance between the physical, mental, emotional, and spiritual aspects, and Mother Earth provides individuals with the means of achieving such balance (Wilson, 2003). In return, First Nations children are taught to respect Mother Earth, and to “relat[e] in a sustainable way with the resources of the lands, airs and waters of their local ecosystem” (Richmond, 2014, p. 4).

Within occupational science, a growing body of literature has examined the inter-relationships between people, the natural environment, and participation in occupation. A number of occupational scientists, including De Rozario (1997) and Frank (2011), have challenged the notion that humans are independent of the environment, arguing instead that humans shape, and are shaped by, the environments in which they live. Persson and Erlandsson (2014) further addressed this connection through examining “the relationship between the human occupations of today and their consequences for tomorrow” (p. 13). Persson and Erlandsson (2014) introduced the concept of ‘ecopation’, defined as eco-friendly and sustainable occupations, and argued that “humans have to, and are able to... reach a more sustainable way of living that has the potential to bring well-being and

wealth to an increasing proportion of the world's inhabitants" (p. 20). Capon (2014) agreed with the need to pursue sustainable occupations, arguing that "... future human health, well-being and survival is entirely dependent on the health of planetary systems" (p. 10).

A few articles within the Journal of Occupational Science have addressed the unique relationship between Indigenous people and the natural ecosystem. Darnell (2009) has pointed out that "the interdependence of place and human occupation is obvious to most First Nations people and hard to express within specialized vocabularies of mainstream science and public discourse" (p. 7). She further argued that "the simultaneous attention to health and well-being and to the environment highlight the inseparability of these domains in Anishinaabeg thought" (Darnell, 2009, p. 7). Frank (2011) summarized a number of presentations from the sixth annual research conference of the Society for the Study of Occupation (SSO:USA), all of which focused on the occupations of Native American tribes in the American Southwest. In her article, Frank (2011) explored the relationships between tribal people and their land, and examined how colonial legislation has severed or disrupted a number of these relationships. It is important to note, however, that the voices of First Nations and American Indian people were absent from these articles.

Of most relevance to this thesis, although not specific to First Nations children, was an article by Manuel (2003) in the Journal of Occupational Science. Manuel (2003) argued that urban environments must include natural spaces, especially for children's use:

In an increasingly urban world, having some wild nature close to home provides places where people, children in particular, can readily learn about the natural

world and develop an appreciation and sensibility that becomes the foundation of environmental citizenship. (p. 31)

Manuel (2003) argued that children develop a spiritual connection to the environment through engaging in nature-based occupations. She used the term ‘topophilia’, which originated from cultural geography, to describe “the sense of belonging and commitment that we develop with our everyday and special environments” (Manuel, 2003, p. 32). In conclusion, Manuel (2003) explained:

Children seek (need?) spaces that are accessible to them, they seek (need?) spaces not subject to an adult agenda, and they seek (need?) spaces that connect them to the shared experiences of natural creation not found in our engineered world. (p. 36)

Manuel’s (2003) arguments have important implications for the children in the present study, given that over half of the children reside in an urban area (the city of London), yet depend on the land for a variety of cultural occupations. Future research within occupational science should explore the types of spaces and places that are conducive to cultural occupations, and therefore supportive of the health and identity of First Nations children.

**5.2.1 Connecting children to the land at the BLE.** Connecting children to the land was considered an important priority of the BLE. The BLE was thus located at the Garden Learning Centre (GLC) at SOAHAC’s Chippewa site. The GLC is surrounded by open fields and gravel roads, and has a large pond in its back property. Although many activities occurred within the GLC, children enjoyed exploring the land and playing outside between activities. It was not uncommon to see two or three of the children



walking around the pond, throwing stones in the water, or looking for frogs and snakes. Moreover, on the second day of camp, we went on a field trip to Skah Nah D'Oht Iroquois village, located within Longwoods Road Conservation Area. During this field trip, the children went on a hike and a medicine walk, and were able to explore the land, trees, and waters of their local environment. Many of the children enjoyed this field trip, and discussed the knowledge they had gained from it within the second set of sharing circles. The following section will further explore how the children in this study connected health with the land.

**5.2.2 Children perceived the outdoors to be a healthy place.** The importance of place, specifically the outdoor environment, was a significant theme in the results of this thesis. Healthy occupations were almost exclusively described as occurring outside, such as swimming, playing with friends or family, running around, dancing in ceremonies, going hunting and fishing, and participating in organized sports such as soccer and lacrosse. Outdoor scenes were also portrayed in a number of the paintings, further pointing to the connection children made between being outside and being healthy.

In the final sharing circles, children expressed their interest in being outside, indicating that future camps should incorporate more outdoor activities and less time spent inside. A few children commented on the fresh air at the GLC, saying that they preferred it to the polluted air within the city of London. However, some of the children noted the lack of trees at the GLC, and said that ideally, the camp would be located in an area surrounded by trees. The following section will summarize the reasons for connecting First Nations children to the land, and provide recommendations for future health programs.

**5.2.3 Connecting children to the land in health promotion programs.** Past research has shown that providing First Nations children with opportunities to be out on the land will help them to develop a strong sense of identity (Richmond, 2014; RCAP, 1996), and to gain IK through learning and practicing important land-based skills (Richmond, 2014). Connecting children to the natural environment is further supported in the occupational science literature; through engaging in nature-based occupations, many of which are also cultural, children will develop a sense of belonging and an increased understanding of their natural environments (Manuel, 2003). The children in this study enjoyed being outside, and expressed an interest in outdoor activities such as an overnight camp. Future health programs aimed at improving or maintaining the health of First Nations children need to build upon the children's interests and create opportunities for being out on the land.

### **5.3 The Importance of Learning Through Doing**

Throughout this project, especially in the initial stages of planning the BLE, our research team drew upon IK, provided by our community partners, to guide the decisions that were made. As discussed previously in the third chapter of this thesis, IK is a unique form of knowledge that is deeply personal and highly dependent upon place (Richmond, 2013). One of the key characteristics of IK is that it is learned through firsthand observation and practical experience; First Nations children acquire such knowledge by watching their Elders, and being out on the land (Richmond, 2014). An important objective of the BLE was to support this type of knowledge translation through connecting children with their Elders and providing opportunities for experiential learning, defined as "...a process whereby concepts are derived from and continuously

modified by experience” (Kolb, 1984, p. 26). The activities that our research team planned throughout the BLE were thus largely hands-on, such as making crafts and going for hikes. While a few activities involved sitting indoors and listening to Elders speak, they were often accompanied by other activities to help advance the children’s understanding and to create meaning through subjective experience.

A key assumption within occupational science is that doing (i.e., engaging in occupation) is central to learning. As Davis, Polatajko, and Ruud (2002) have explained, “...doing is so central to life and development that occupation is considered a basic human need that organizes human behaviour, and is deeply seated in human life” (p. 54). Engaging in occupation is central to children’s development; what children do, and how children learn, is dependent upon the environment, including the cultural environment in which they live (Davis et al., 2002; Wiseman, Davis, & Polatajko, 2005). In examining the occupational science literature, only one study was found that explored the occupations of First Nations children, specifically the occupation of play (Gerlach, Browne, & Suto, 2014). According to Gerlach et al. (2014), children of all backgrounds, including Indigenous and non-Indigenous children, require opportunities for engagement in meaningful play experiences. Play, which is largely characterized as a hands-on experience, is central to health and identity, and allows children to learn about their world through actively engaging in it (Gerlach et al., 2014). However, within Western society, the concept of play “... has been largely defined, categorized, and decontextualized by adults from primarily a White, middle-class, and urban perspective” (Gerlach et al., 2014, p. 6). As a result, play is often defined as ‘child’s work’, and as a means through which children can prepare for the school years by learning about literacy, numeracy, and the

English language; Early development programs and other school-readiness interventions often promote these types of play while overlooking the social, historical, and political factors that have shaped the notion of play (Gerlach et al., 2014). Culturally meaningful forms of play, that promote the identity and health of First Nations children, are often not included in these programs (Gerlach et al., 2014). Gerlach et al. (2014) argue that while literacy and numeracy are certainly important, programs that are geared towards and/or include First Nations children need to acknowledge Indigenous ways of knowing and doing, and provide culturally-appropriate hands-on experiences. Within Canada, several organizations and programs, including Aboriginal Head Start (AHS) and the National Collaborating Centre for Aboriginal Health (NCCAH) have mirrored Gerlach et al.'s (2014) suggestion to include cultural occupations in programs designed for Indigenous children. It is proposed that these occupations will help children to build a strong, positive cultural identity and lead a healthier life (Aboriginal Head Start Association of British Columbia, 2012; NCCAH, 2012). Further discussion on these organizations, and the significance of providing opportunities for hands-on learning, is provided in section 5.3.3. First, I will explore the significance of hands-on learning within the present study, and the potential of this pedagogical approach to enhance children's health through teaching them about their culture.

**5.3.1 Learning through doing at the BLE.** One example of learning through doing occurred every day at the BLE, when one of the four groups was given the opportunity to work with their counselor and create a healthy snack for the rest of the campers. This activity provided the children with a hands-on opportunity to learn. In addition, two dietitians gave presentations throughout the week about nutritious foods

and eating a well-balanced diet. Through listening to the guest speakers, observing their counselors, and learning through doing, the children were able to gain valuable skills, such as how to prepare nutritious snacks and how to handle food safely. Moreover, within the final sharing circles, children expressed a preference for the cooking activity over the dietitian's presentations, suggesting that children prefer hands-on learning to learning from a lecture. However, the findings also suggest that the knowledge gained through hands-on experience may be articulated differently from the knowledge gained through listening to presentations. Within the final sharing circles, the children discussed what they learned from the dietitian's presentations, but did not verbalize the knowledge they gained from the cooking activity.

The medicine walk at Skah Nah D'Oht Iroquois village was another example of a hands-on activity that was conducive to learning. During this walk, children were asked by a local Elder to pace through the woods and gather leaves or branches that caught their eye. When the children returned to share their findings, the Elder provided teachings based on each medicine retrieved. Throughout the gathering, which took place in an open field under a large tree, I observed that the children remained quiet and extremely attentive. One child even took notes about the medicines, in a small pocket book that she carried throughout the day. A few days later, during the final set of sharing circles, many of the children shared their knowledge from the medicine walk, such as the healing power of cedar tea, and the special properties of jewelweed. Bringing the children out on the land and allowing them to experience nature provided a unique opportunity for them to learn through experience and to acquire IK from a knowledgeable Elder. It is also interesting to note that on the same field trip, all of the children watched a twenty minute

documentary on the history of First Nations people. While many of the children discussed the medicine walk in the final sharing circles, none of them mentioned what they learned from this documentary.

### **5.3.2 Learning through doing as a means to develop knowledge about health.**

Not only was learning through doing an important theme throughout the development of the present study and the activities that were planned, it also emerged as a central concept when the children talked about health. When I began to read through the data from the first set of sharing circles, specifically the data originating from our question about being healthy as a First Nations person, it seemed to me as though the children talked about culture in one of two ways: either by the traditional knowledge that they had gained, or the activities that they had done. To me, at least in the beginning, this distinction between learning and doing made sense. While some of the children talked about specific knowledge related to medicines or their language, others talked more broadly about the cultural occupations in which they took part, such as dancing in ceremonies or fishing with their family. Nevertheless, the more I immersed myself in the transcripts, the more this line between learning and doing began to blur. While the children certainly learned ‘facts’ acquired from sources like books, the media, or school, they also shared how they had learned about what was healthy through doing, particularly doing with others. As Aristotle once said, “for the things we have to learn before we can do them, we learn by doing them” (Nicomachean Ethics, trans. 2007).

What I realized through the process of reading through transcripts and analyzing the data, is that learning and doing are intricately linked; in order to *learn* something, one often must *do*. This is especially the case with IK, which is gained through experience

and by watching others (Richmond, 2014). Many of the occupations that the children discussed were learned through doing, such as hunting and fishing, dancing and smudging. When asked to describe why these occupations are healthy, the children mostly discussed the process of doing the occupation, and the physical benefits it had on their health. However, some of the children described the process of learning these occupations, saying that the knowledge they gained through engaging in occupations is important to their health as well. For example, knowledge of traditions and knowledge of one's language were described by two children as important to health. Thus, not only was the process of *doing* cultural occupations considered by the children to be healthy, so was the process of *learning* them. More often than not, these processes occurred together; children learned to dance, learned to hunt, and learned to clean a fish through watching their Elders and trying it themselves.

The findings from this study support the idea that First Nations children learn meaningful knowledge through experience, and will gain IK through exposure to Elders and engagement in cultural occupations (Kenyon & Carter, 2011; King et al., 2009; Kral, 2012; RCAP, 1996). The children in this study demonstrated a sincere interest in their culture, not only within the sharing circles, but in informal conversations as well. The children were constantly sharing stories about their culture, comparing the number of dreamcatchers or lacrosse sticks they owned, the different types of dances they knew, and the various community Pow Wows they had attended. The following section will explore the importance of incorporating hands-on learning into future health programs for First Nations children.

### **5.3.3 The significance of incorporating hands-on learning into health**

**promotion programs.** As mentioned throughout this thesis, cultural identity of First Nations children is enhanced through exposure to traditional teachings, which are largely passed down through Elders, and engagement in cultural occupations (King et al., 2009; RCAP, 1996). The children in this study enjoyed listening to their Elders and learning about their culture through participating in occupations such as drum making and playing lacrosse. Health promotion strategies should build upon the children's interests (Blackstock et al., 2006), and promote the thirst for cultural knowledge that was so evident throughout the BLE.

Within Canada, several organizations have demonstrated the need to develop urban-based and on-reserve cultural programs, where First Nations children can listen to their Elders and learn through doing. In 1995, the federally funded Aboriginal Head Start (AHS) program was developed in Canada to support the learning and developmental needs of children living in Indigenous communities (Health Canada, 2011). One of AHS' priority areas was – and continues to be - to provide Indigenous children with cultural opportunities that foster the development of a strong, positive cultural identity (Health Canada, 2011; Aboriginal Head Start Association of British Columbia, 2012). Moreover, in 1996, RCAP released a report recommending that all levels of government in Canada (provincial, territorial, and federal) provide funding to community initiatives in order to create youth camps that promote a healthy lifestyle, provide opportunities for cultural activities, and bring Elders and youth together. More recently, the Health Council of Canada (2011) has recommended that health promotion interventions for First Nations children incorporate IK and cultural practices:



Traditional knowledge and cultural practices play a fundamental role in rebuilding and strengthening the Aboriginal spirit, thereby addressing health-related problems, such as chronic disease, addiction, and violence, which arise from a broken spirit, mind, and body. (p. 24)

In addition to those mentioned above, other organizations, including the Public Health Agency of Canada (2013) and the National Collaborating Centre for Aboriginal Health (2012), have advocated for the inclusion of cultural occupations in programs aimed at Indigenous children and youth. While some programs have already been developed in Canada, most are not community-driven, and are thus founded upon Western values rather than IK (Blackstock et al., 2006). In the following section I will explore how programs need to bring together Western and Indigenous knowledge systems, in order to create programs for First Nations children who are walking between these worlds.

#### **5.4 Honouring Cultural Values While Living in a Western World**

First Nations children, like most other children in Canada, “have access to and participate in multiple cultures” (Kirmayer, Simpson, & Cargo, 2003, p. S19). The cultures in which First Nations children participate, however, often promote contrasting values and distinctive beliefs about concepts such as health. Indigenous cultures, for example, promote collectivism and holistic health, whereas Western cultures are often entrenched in individualistic values and the biomedical model of health (Kirmayer et al., 2003; Little Bear, 2000). The values and beliefs of the various cultures in which First Nations children exist are thought to influence their individual perceptions and the ways they think about the world.

Within the field of occupational science, a few studies have examined the occupational implications of living within and/or between two cultures in Canada; however, these studies have largely focused on the situation of newly arrived immigrants, or the children of immigrants. Connor Schisler and Polatajko (2002) examined the occupational change, in relation to self-care, productivity, and leisure, experienced by Burundian refugees living in Canada. The majority of the refugees' occupations were found to have been altered or abandoned, "... due to environmental [physical, psychological, cultural, social, spiritual, political, etc.] factors, as responded to by the individual" (Connor Schisler and Polatajko, 2002, p. 90). Similarly, Lencucha, Davis, and Polatajko (2013) examined the occupational change of children whose parents immigrated to Canada. The children and parents in this study were "...beginning the process of bringing together their heritage culture with the cultures of their receiving country" (Lencucha et al., 2013, p. 185). Since moving to Canada, the children and parents engaged in a variety of new occupations, such as learning how to swim, but attempted to maintain key values and traditions from their heritage culture. Moreover, the children often helped to navigate their parents through the Canadian culture, engaging in "cultural-interpretation" (Lencucha et al., 2013, p. 186). While the immigrant children in Lencucha et al.'s (2013) study are similar to First Nations children in that they are living between two worlds, there are a plethora of differences between these populations. The families of First Nations children were the descendants of the original inhabitants of North America; their culture has existed in this country for far longer than any other immigrant child. It is interesting to note that while studies have examined the occupational experiences of immigrants and their children in relation to cultural change,

no studies within occupational science have examined the situation of First Nations children. Future research could examine the occupational experiences of First Nations children today, and how generations before them have balanced Indigenous and Western cultures. The following section will explore how the children's perceptions within this study reflected contemporary and cultural notions of health.

**5.4.1 Children's perceptions of health are influenced by two different cultures.** At first glance, the children's paintings appeared to incorporate both contemporary and cultural symbols of health. Contemporary symbols refer to symbols used in Western society to promote health through physical activity and healthy eating habits. Examples of these symbols that were present in the children's paintings included fruits, vegetables, picnic baskets, and playgrounds. Cultural symbols, on the other hand, have been traditionally used in First Nation communities and, in accordance with our definition of culture, represent the "beliefs, values, customs, and traditions that are transmitted from generation to generation through teachings, ecological knowledge, and time-honoured land-based practices" (McIvor, Napoleon, & Dickie, 2009, p. 7). Examples of cultural symbols that appeared in the children's paintings included the medicine wheel, the wampum belt, and the three sisters. Moreover, some symbols may be considered contemporary, cultural, or both, depending on who created it and/or the reason why it was created. The lacrosse stick is an example of a symbol used in mainstream society as well as in First Nation communities. While the lacrosse stick may symbolize physical health, it may also symbolize healing and pride, as two of the children pointed out. Discussions with SOAHAC helped me to understand which symbols could be cultural, contemporary, or both in the children's paintings.

Despite the presence of cultural symbols within the children's paintings, most of the children did not expand upon their significance when discussing health in the sharing circles. The two children who painted the medicine wheel spoke briefly of its relevance, one more in depth than the other. As for the four children who painted the wampum belt, only two described why they drew it, and that was after a bit of prompting. Olivia said she painted the wampum belt because it represents her nation. David, on the other hand, said it represents friendship, and he painted the belt because he has friends from different nations. Neither Olivia nor David made a verbal connection between the wampum belt and health. Nevertheless, due to the fact that Olivia, David, and two other children painted this particular symbol when we asked them to think about health, it may be that they inherently made this connection but were unable to verbalize it. Finally, in describing his painting, Shane said that he painted the three sisters, a cultural reference to corn, beans, and squash. Shane, however, did not describe why he chose to paint the three sisters specifically, except that vegetables are healthy.

Other than the children who briefly described the cultural symbols in their paintings, most of the participants did not talk about their culture when we asked them questions about health. Instead, more consistent with a biomedical model, most of the children discussed health in terms of the foods they eat and the physical activities they do. For example, the children talked about fruits, vegetables, and milk as healthy foods, and listed running around, swimming, and playing outdoors as healthy occupations. Moreover, despite our best efforts to keep the discussions positive, through only asking questions about what it means to be healthy rather than ill, the children often discussed health in a negative light, describing what an unhealthy person looks like and/or the

diseases an unhealthy person might have. Interestingly, and without any prompting, the children described a number of lifestyle diseases, such as obesity, diabetes, heart disease and cancer, that are increasingly endemic in First Nation populations. The children's perceptions of health, which centered around food and activities as well as illness and disease, were largely influenced by Western beliefs about health; the children tended to focus on physical aspects, which are central to Western health models, while largely ignoring the mental, emotional, and spiritual aspects that together represent an holistic, First Nations view.

As explained previously, cultural occupations did not immediately come to mind when we asked the children about health. When we asked our final question about what it means to be healthy as a First Nations person, some of the children began describing these occupations, while others appeared confused by the question and gave similar answers to the questions asked before. A few of the children discussed specific cultural traditions that were related to health and followed at certain events, such as smudging at the birth of a child, and laying down tobacco after killing a deer. Others discussed a variety of cultural occupations in which they take part, such as dancing in ceremonies, hunting with family members and making crafts such as dreamcatchers and drums. When we asked the children to connect these occupations to health, they largely focused on physical health, saying that engagement in these occupations allowed them to be more active. In a similar study with First Nations youth aged 12 to 19 years, Isaak and Marchessault (2008) found that “most of the younger youth interviewed spoke mainly of the physical aspects of health” (p. 117); when discussing cultural activities, they talked about “the positive effect on health due to the physical effort involved” (p. 118). While

the children in the present study focused primarily on physical health, it is important to recognize that the children may have viewed health holistically, but did not have the words to articulate how. The children, after all, were only 10 to 12 years of age, and may not be able to orally describe abstract concepts, such as mental health (Natapoff, 1978).

The amount of time that First Nations children spend in Western institutions is one possible reason why physical health was so dominant in their perceptions, and why the children seemed to separate their knowledge of health from their knowledge about culture. While we cannot dismiss the ongoing impact of residential schools on the lives of First Nations children, I focus here on the present-day institutions in which all of Canada's children are a part. Children today are spending more and more time in schools, after-school programs, camps and other establishments, and consequently, significantly less time at home (Christensen & Prout, 2005). The increasing trend of institutionalization is "suspected of creating and sustaining generational divisions in society, and, in particular, of creating a gap between children and their parents" (Christensen & Prout, 2005, p. 52). The knowledge that children gain at home and through their families is thus kept separate from the knowledge they gain in institutions such as school.

Moreover, with a few exceptions, such as Hillside School on Kettle and Stony Point First Nation (<http://www.hillsideschool.ca/>), the majority of Canada's educational institutions are not built upon, or conducive to, Indigenous ways of knowing (Battiste, 2002; Singh & Reyhner, 2013). As a result, the knowledge that First Nations children gain about health, at least through their schools, is based upon Western perceptions. Nevertheless, within this study, only a few of the children brought up their teachers as

important sources of health information. This finding was echoed in a study by Pigford et al. (2012), who found that "...participants did not highlight teachers and school administrators as primary sources of health information, which suggests that children tended to rely on adults family members and experiential learning to form their understandings about health" (p. 992). Future research should further explore where children learn about health, and the impact that Western institutions have on First Nations children's perceptions of health.

**5.4.2 The worth of incorporating contemporary and cultural notions of health.** Overall, the children's perceptions of health centered around healthy foods and activities and were influenced by contemporary and cultural notions of health. For the most part, children focused on physical health and the effects or repercussions of not being healthy. The children's fixation on illness and disease is reflective of the biomedical model of health that has dominated Western health care for over a century (Engel, 1977). In the last decade, the World Health Organization (WHO), and several such institutions, have redefined health to include not only physical, but mental and social aspects as well (WHO, 2003). Nevertheless, it is our belief that the children in this study, and likely other children too, are still receiving the message that health is primarily physical, and is achieved through eating healthy foods and obtaining adequate amounts of exercise. While some of the children incorporated cultural symbols into their paintings, and spoke of cultural occupations at the end of the sharing circles, they struggled to verbalize how and why these were related to health. Moreover, only one child spoke about health holistically, which is especially significant given that "the philosophical foundation of traditional knowledge revolves around a holistic model that recognizes the

intimate connectedness between the person, the food they eat, their environment, health and healing, and the impact of lifestyle choices” (National Aboriginal Health Organization, 2011, para. 1). Given that children’s perceptions are influenced by both Western and First Nations values and beliefs, it is extremely important that we find ways to bring these knowledge systems together (Pigford et al., 2012). After all, as Greenwood and de Leeuw (2012) have stated, “recognizing multiple ways of knowing and being in the world is fundamental to effective research and effective health care practice with and for Aboriginal peoples” (p. 7) .

## **5.5 Contributions and Strengths of the Study**

Overall, the present study acknowledged a number of important gaps in research with First Nations children. While a number of studies have explored children’s health from an adult or caregiver’s point of view, very few studies have looked at health through the eyes of First Nations children. Moreover, the methods used throughout this study have rarely been employed with First Nations children. Sharing circles, for instance, have only been used in one other study with First Nations children aged 12 years or younger, and were not found to work in that specific situation (Watson et al., 2008). The combination of paintings and sharing circles generated rich results within this study, and proved to be a useful and innovative method in research with First Nations children.

Moreover, within the field of occupational science, very few studies have explored occupation from an Indigenous perspective, and the ways in which occupations contribute to holistic health. The few studies that have been done have failed to incorporate the voices of Indigenous people, making it difficult to comprehend whose opinion is being heard. Furthermore, no research within occupational science has



explored occupation through the eyes of First Nations children. This study was the first of its kind to explore the occupations that First Nations children associate with health, and the ways in which these children connect occupation, health, and culture.

**5.5.1 Insights regarding the use of multiple methods with children.** The painting activity and the sharing circles were two distinct yet complimentary methods that allowed us to approach the topic of health in a child-friendly way. The paintings allowed the children to play with the idea of health and to be creative in expressing what health meant to them. The children were given time to think and reflect, and were therefore able “to craft a more complete depiction [of health], which is more difficult to achieve linguistically in a brief interview or survey” (Literat, 2013, p. 88). In addition, the children were able to incorporate cultural symbols and IK into their paintings without the prior or future constraint of having to explain them. The wampum belt, for instance, appeared in five of the 18 paintings, but was only discussed in the sharing circles by two of the children who drew it. While the other three children did not verbalize their knowledge, it is important to realize that the way children express knowledge is multifaceted; just because they could not – or chose not – to articulate something verbally, does not mean that they did not have the knowledge. The paintings provided a different vehicle through which to express this knowledge, and allowed for “subjective, emotional, and co-constructed ways of knowing” (Literat, 2013, p. 12), which were important considerations of the present study, and key characteristics of IK (Richmond, 2014) and critical constructivism (Guba & Lincoln, 1994).

Bringing the paintings into the sharing circles gave each child a starting point from which to further talk about health. The sharing circles themselves allowed children

to share ideas and to express verbally what they could not express on paper; for those children who were less skilled and/or less comfortable with the painting activity, the sharing circles allowed for a verbal form of expression. While the paintings were an individual activity, where we urged children to work independently and not copy from their friends, the sharing circles were a group activity, allowing for dialogue, discussion, agreement, and dispute. The paintings added depth to the sharing circle discussions, while the sharing circles added meaning to what the children first drew (Pridmore & Bendelow, 1995). For example, many of the children incorporated picnic baskets into their paintings, which led to a discussion about picnics within the sharing circles. Moreover, by discussing the elements that made picnics healthy, such as being outside and being with people, the sharing circles added meaning to what the children had painted. It is also my belief that the paintings and the sharing circles allowed for different findings to emerge. As Darbyshire, Macdougall, and Schiller (2005) have stated, “a range of methodological strategies ... capture a broader and deeper range of children’s perceptions and experiences than a reliance on a single technique” (p. 423). The wampum belt, for example, appeared in a number of the children’s paintings, but was only discussed at the beginning of the circles, when the children described what they painted. Had the painting activity not occurred, the wampum belt might never have been mentioned. Similarly, had we not conducted the sharing circles, a number of cultural occupations may never have been discussed. While several of the children discussed dancing, for instance, as a healthy, cultural occupation, none of the children incorporated this idea into their paintings. Using multiple methods allowed for unique and insightful findings to emerge, and was thus an important component of the present research study.

Finally, my own observations as well as those of the counselors and assistants helped to add richness to the findings, which was especially important given the short answers that most of the children provided. The observations helped me to recall the challenges, limitations, and triumphs of the research activities and the larger BLE. Through observing the children and listening to their conversations, I was able to better understand how the children in this study thought about health, and the occupations they associated with maintaining health and with being First Nations. The relationships that were developed between myself, the counselors, and the children at the BLE allowed for greater insight into the children's personal worlds, which furthered my understanding of their everyday activities and their individual interests. One of the children, for example, told me about her interest in traditional medicines, and revealed her diary in which she wrote about these medicines. This particular child's interest in the land and its medicines helped me to better understand the importance of IK and its prevailing significance in the lives of First Nations children.

**5.5.2 Insights about cultural occupations.** Within this study, certain assumptions were made as to what did and did not constitute a cultural occupation. For the most part, the occupations that were deemed 'cultural' by our team were those that fit with our definition of culture and were thus "transmitted from generation to generation through teachings, ecological knowledge, and time-honoured land-based practices" (McIvor et al., 2009, p. 7). Examples of such occupations included smudging, dancing in ceremonies, and making drums. On the other hand, occupations such as running and swimming were not considered to be cultural, as children from all cultures may engage in these activities. However, in analyzing the data and writing up this thesis I have come to

question my own assumptions about culture, and the occupations that define it. Within occupational science, occupation and culture are considered interconnected; all occupations are created within the context of a culture, and are thus, in a way, cultural (Bonder, 2007; Yerxa, Clark, Jackson, Pierce, & Zemke, 1990). Moreover, culture, and the occupations that define it, are constantly evolving (Bonder, 2007; Hocking, Wright-St. Clair, & Bunrayong, 2002), and are dependent upon person and place (Kirmayer et al., 2003). According to Hocking et al. (2002), “traditions may be modified, extended or rejected. They may change gradually over time, or parts may be preserved while others change” (p. 118). As discussed throughout this thesis, the children in this study appeared to be influenced by two different cultures: their heritage, First Nations culture, and the culture of Western society. Since occupations are tied to culture, and culture is constantly evolving, then the occupations that the children considered ‘cultural’ may be different from the views of older generations. Running and swimming, for example, were not viewed as cultural by our research team, but they may be considered cultural by the children in this study. Of relevance to occupational science, future research should aim to understand how First Nations children define culture, and how the dynamic nature of culture may mean that what are experienced and considered ‘cultural’ occupations may change over time and perhaps generations. It would also be interesting to examine whether children view their First Nations culture as separate from Western culture, as our research team did, or if they view it simply as one.

## **5.6 Limitations of the Study and Opportunities for Future Research**

The present study aimed to generate knowledge with a small group (n = 20) of First Nations children, in order to inform community-specific programs at SOAHAC.

The methods used within this study were developed in collaboration with SOAHAC, to meet the needs and interests of the local participants. Likewise, the activities and teachings that occurred at the BLE were based upon local knowledge. Thus, while the methods and activities within the current study generated rich, informative results, they might not be effective and/or appreciated in other First Nation communities. As a result, the specific details of the findings from the present study are not considered to be generalizable to other First Nations children living in different communities. Nevertheless, the findings raise important insights regarding First Nations children's perceptions of health that may be relevant to other Indigenous health centres. Moreover, the BLE provides a model that can be adopted and modified to fit the needs and contexts of other communities.

In addition, while this study generated important knowledge about children's perceptions of health, we did not make comparisons between males and females or children of different ages. In creating the BLE and the various research activities, our team did not find it necessary to make such comparisons, as we wanted a broader understanding of how children think about health. At most, the children were two years apart, and were thus believed to be close enough in age to have similar experiences and therefore comparable ideas about health. Future research could explore the differences in how First Nation males and females think about health, and how age and other individual or family factors (e.g., whether the children live in close proximity to grandparents) impacts their individual perceptions. Finally, it is important to point out that although some of our participants came from urban areas, i.e. the city of London, while others lived on reserve, we did not separate the findings based on where the children resided.

Oftentimes, Indigenous families with young children move back and forth between cities and their home community (King et al., 2009); within this study, we did not feel it was important to ask the children where they had previously lived, and for how long. Moreover, many of the programs that SOAHAC creates are designed for all First Nations children, whether they live in rural, urban, or on-reserve communities; it was therefore not a priority of the present research study to separate the findings based on where the children lived. Future research could certainly look into these differences if they are relevant to a particular organization or locality.

## **5.7 Summary of Recommendations for Future Health Programs**

According to Greenwood and de Leeuw (2012), “... children are our future: they are the next generation of parents and leaders” (p. 381). The health of future First Nation communities is thereby dependent upon the health of First Nations children today (Greenwood & de Leeuw, 2012). Nevertheless, compared to other children in Canada, First Nations children fare far worse on many indicators of health and well-being, including higher rates of diabetes, obesity, tuberculosis, injuries, youth suicide, dental caries, and middle-ear infections (Assembly of First Nations (AFN), 2008; Greenwood & de Leeuw, 2012; Smylie & Adomako, 2009). While the statistics on First Nations children’s health have been well researched and documented, they often “perpetuate a deficit-oriented and de-contextualized discourse” (Gerlach et al., 2014, p. 4), placing families and individuals at the root of the problem while ignoring the broader social, political, and historical determinants (Greenwood & de Leeuw, 2012). To better understand the health of First Nations children, research needs to “... consider both the contexts in which disparities exist and the most innovative and culturally appropriate

means of rectifying those inequities” (Greenwood & de Leeuw, 2012, p. 381). The present study aimed to acknowledge the social determinants of health, using Loppie-Reading and Wien’s (2009) framework, and to recognize IK as central way of knowing and doing. This study also aimed to not only incorporate the voices of First Nations children, which have largely been absent from health research in Canada (Isaak & Marchessault, 2008), but to use their voices to inform and enact change – to create meaningful, relevant, and beneficial programs for First Nations children in the local community.

Within the context of the BLE, our research team was able to talk with the children and to learn alongside them. Through these conversations and observations, four important recommendations emerged. These recommendations may be used by SOAHAC, and possibly other Indigenous health centres, to develop practical and effective health programs for First Nations children. First of all, because children emphasized relationships as important sources of knowledge, future health programs should involve the entire community, including children’s families and local Elders, in the design and delivery of these programs. As Little Bear (2000) has said, “anyone can participate in educating a child because education is a collective responsibility” (p. 81). Secondly, programs should foster children’s interest in the outdoors by providing opportunities to be out on the land. These opportunities will allow children to further develop their identity and to gain IK through practicing land-based skills (Richmond, 2014). Third, programs should provide opportunities for learning through doing, as IK is largely gained this way (Richmond, 2014), and the children demonstrated a preference for hands-on activities within the BLE. Finally, due to the influence of both Western and

Indigenous values on children's perceptions of health, future health programs should find ways to acknowledge and incorporate both Western and Indigenous ways of knowing.

## **5.8 Conclusion**

I would like to end this chapter, and essentially this thesis, with a few reflections on my own 'learning through doing' process as part of this CBPR study. When I began working on this project, I had just completed my undergraduate program and had a better understanding of chi-squared tests than the process of conducting sharing circles or even working an audio recorder. I knew little about qualitative research, and even less about community-based methodologies. Yet despite my lack of research experience, and the anxiety that accompanied starting something new, I was able to engage and learn from this process. I was able to gain an appreciation of Indigenous Knowledge systems, and to learn, through doing, about CBPR. I was able to move beyond my linear, biomedical way of thinking and acknowledge the importance of holistic perceptions of health. I was able to learn about the significance of sharing circles, and to apply this knowledge in the development of a successful health-promoting children's camp. And, in the end, I was able to learn from the children, and to observe, first-hand, the success of the BLE, including the friendships that were developed, the knowledge that was gained, and the memories that were created. As Tuhiwai Smith (2012), a Maori researcher from New Zealand, has explained: "In many projects, the process is far more important than the outcome" (p. 128). In a few years, when I look back on this project, I might not remember our five emergent themes, or the symbols on the paintings that the children created, but I will remember the process. I will remember the hard work that went into this study, and the satisfaction of having it all come to light. I will remember the meetings



at SOAHAC, and the conversations we shared in developing this project. And last but not least, I will remember the children, for without their smiles, spontaneity, and positive reflections, the BLE would not have been a success.

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## Appendix A: Schedule of the Bimaadiziwin Learning Experience

Mon 8/19		Tue 8/20		Wed 8/21		Thur 8/22		Fri 8/23	
8	Shuttle Leaves London	8	Shuttle Leaves London 9am	8	Shuttle Leaves London 9am	8	Shuttle Leaves London 9am	8	Shuttle Leaves
9	Registration 9am Opening Ceremony 9:30	9	Morning Ceremony (Ojibway) 9:30am	9	Morning Ceremony (Lenape) 9:30am	9	Morning Ceremony (Oneida) 9:30 am	9	Morning Ceremony 9:30 am
	Read Camp rules		Bus leaves to Skah- nah-doht		Sharing Circle #2		Station Rotation 10am		Teaching on gender roles
10	Med. Wheel Intro	10	Tour of Park	10	Emotional Health	10	Rotations: Archery	10	Obstacle course
	<b>Snack</b>		<b>Snack</b>		<b>Snack- Food Prep</b>		<b>Snack-Food Prep</b>		<b>Snack</b>
11	Painting	11	Story Telling	11	Group Game	11	Rotations: Teepee making	11	Group Game
			Scavenger Hunt		<b>Lunch</b>		Rotations: Dream catcher		
12	<b>Lunch 12:30</b>	12	<b>Lunch</b>	12	Soap Stone	12	<b>Lunch-teaching ceremony and</b>	12	<b>Feast/Social All Afternoon</b>
	Group Game		Capture the feather		Soap Stone		Pouch Making		
1	Sharing Circle #1	1		1	Soap Stone	1	Drum Making	1	Learn songs and dances
	Group Activity		Medicine Walk				Drum Making		
2	<b>Snack-Mental Health</b>	2	Snack -Quantum Integration	2	Snack- Food & Mood	2	Snack	2	Tree Planting
	Med. Wheel Teach		Pick cedar and drum stick		Self-esteem lesson/activity		Drumstick Making		Sharing Circle #3
3	Receive Sweet grass	3	Bus departs Ska-Nah-Doht 3pm	3	Add sage to bundle	3	Add tobacco to bundle	3	
	3:30pm home time		3:30pm home time		3:30pm home time		3:30pm home time		3:30pm home time
4	Shuttle arrives in	4	Shuttle arrives in London 4pm	4	Shuttle arrives in	4	Shuttle arrives in	4	Shuttle arrives in

*Note.* This was the final schedule I received from the Research Assistants who created it. While most of the above activities occurred during the BLE, they may not have occurred in the designated order or at the designated time.

## **Appendix B:** Question Guide for Sharing Circle A (Monday's Sharing Circles)

1. Please tell us your name and something that you like to do.

2. Please tell us about your painting.

Prompts/Reminders for Research Assistants (RAs):

- i. Focus on details & always ask 'why'
- ii. Does your painting have a name?
- iii. What does that mean to you?
- iv. How does that make you feel?
- v. How does that make you healthy?
- vi. Anything else that you would like to share?

3. What does the word 'healthy' mean to you?

Prompts:

- i. What makes a person healthy? Unhealthy? Why?
- ii. Is being healthy important? Why?
- iii. Is it important for your family to be healthy? Why?
- iv. What activities are healthy? Unhealthy? Why?

4. As a First Nations person, what does it mean to be healthy?

Prompts:

- i. Have you heard of any traditional activities that are healthy? What makes them healthy?
- ii. Have you heard of any traditional activities that are unhealthy? What makes them unhealthy?
- iii. Do you like to do these things?

### **Appendix C: Question Guide for Sharing Circle B (Friday's Sharing Circles)**

1. What was your favourite part of the Bimaadiziwin Learning Experience?
2. What was your least favourite part of the Bimaadiziwin Learning Experience?
3. What was one of the most interesting things you learned from the Experience?
4. If you were in charge of the Bimaadiziwin Learning Experience, or a similar program, what would you have added?
5. If you were in charge of the Bimaadiziwin Learning Experience, or a similar program, what would you have removed?
6. Show of hands: Do you feel that you've increased your knowledge of healthy eating practices?
7. Show of hands: Do you feel that your physical activity has increased as part of the program?
8. Now think about the medicine walk at Skah N'ah D'Oht. Did you learn more about traditional foods and medicines ?
9. Did you learn more about how traditional medicines are prepared and used?

## Appendix D: Ethics Approval Notice



Western  
Research

Research Ethics

### Use of Human Participants - Ethics Approval Notice

Principal Investigator: Chantelle Richmond  
File Number: 103955  
Review Level: Full Board  
Approved Local Adult Participants: 20  
Approved Local Minor Participants: 0  
Protocol Title: Niiba Bidoda Anishinaabeg Bimaadiziwin: Let us bring back a good way of life  
Department & Institution: Social Science/Geography, Western University  
Sponsor:  
Ethics Approval Date: August 02, 2013 Expiry Date: July 01, 2016

#### Documents Reviewed & Approved & Documents Received for Information:

Document Name	Comments	Version Date
Instruments	Appendix E3	2013/06/05
Instruments	Appendix D3	2013/06/05
Letter of Information	Appendix D1	2013/06/05
Instruments	Appendix C3	2013/06/05
Instruments	Appendix B3	2013/06/05
Other	Appendix G	2013/06/04
Advertisement	Appendix F1	2013/06/12
Advertisement	Appendix F3	2013/06/12
Other	Appendix F4	2013/06/12
Western University Protocol		2013/06/12
Letter of Information	Appendix A1 - Revised July 15	2013/07/15
Revised Letter of Information & Consent	Appendix A2 - Revised July 15	2013/07/15
Revised Caregiver Letter of Information & Consent	Appendix B1 - Revised July 15	2013/07/15
Instruments	Appendix A3 - Revised July 15	2013/07/15
Revised Letter of Information & Consent	Appendix B2 - Revised July 15	2013/07/15
Revised Letter of Information & Consent	Appendix C1 - Revised July 15	2013/07/15
Revised Letter of Information & Consent	Appendix C2 - Revised July 15	2013/07/15
Revised Letter of Information & Consent	Appendix D2 - Revised July 15	2013/07/15
Revised Letter of Information & Consent	Appendix E1 - Revised July 15	2013/07/15
Revised Letter of Information & Consent	Appendix E2 - Revised July 15	2013/07/15
Other	Appendix F2 - Revised July 15	2013/07/15

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 named research study 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.

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

The Chair of the NMREB is Dr. Riley Hinson. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Signature

#### Ethics Officer to Contact for Further Information

<input checked="" type="checkbox"/> Grace Kelly (grace.kelly@uwo.ca)	<input type="checkbox"/> Vikki Tran (vikki.tran@uwo.ca)	<input type="checkbox"/> Shantel Walcott (swalcott@uwo.ca)
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This is an official document. Please retain the original in your files.

Western University, Research, Support Services Bldg., Ste. 5150  
London, ON, Canada N6A 3K7 t. 519.661.3036 f. 519.850.2466 www.uwo.ca/research/services/ethics

## **Curriculum Vitae**

### **KYLA ENGLISH**

#### **Education**

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2012 – 2014

MSc. Health & Rehabilitation Sciences, Field of Occupational Science

Western University, London ON

Thesis title: Through the eyes of children: First Nations children's perceptions of health

Co-supervisors: Dr. Debbie Rudman & Dr. Chantelle A.M. Richmond

2008 – 2012

Honours BSc. Health Studies, Minor in Gerontology

University of Waterloo, Waterloo ON

#### **Scholarships and Awards**

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Population and Public Health Student Award – Master's Level, \$300

Sponsoring organizations: Canadian Public Health Association & Canadian Institutes of Health Research

Awarded: May 2014

Ontario Graduate Scholarship, \$15,000

Awarded: April 2013

#### **Research and Work-Related Experience**

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Research Assistant - Geography Department

Western University, London ON

May 2014 – August 2014

Research Assistant – Faculty of Health Science  
Western University, London ON  
January 2014 – April 2014

Teaching Assistant - Faculty of Health Science  
Western University, London ON  
January 2013 - April 2013

Research Assistant - Geography Department  
Western University, London ON  
September 2012 - December 2012

### **Service to the Academic Community**

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Indigenous Health and Well-Being Graduate Student Advisory Committee  
September 2013 – August 2014  
Western University, London ON

Occupational Science Student Representative  
January 2013 – April 2014  
Western University, London ON

### **Conferences and Invited Lectures**

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**Student and Early Career Researcher's Forum – Podium Presentation.** *Through the eyes of children: First Nations children's perceptions of health.* May 26, 2014. Toronto, ON.

Sponsoring organizations: Canadian Public Health Association, Canadian Institutes of Health Research – Institute of Population and Public Health, Association of Schools of Public Health in the European Region



**Public Health 2014 – Podium Presentation.** *Through the eyes of children: First Nations children's perceptions of health.* May 29, 2014. Toronto, ON.

Sponsoring organization: Canadian Public Health Association

**'Moving forward with your research': Student panel on graduate research (HS 9516) – Invited Speaker.** November 28, 2013. Western University, London ON.

**Occupation and Education – Poster Presentation.** *Understanding interdisciplinarity in Occupational Science.* October 17, 2013. Lexington, KY, USA.

Sponsoring organization: Society for the Study of Occupation: USA

### **Participation in Workshops/Summer Schools**

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**Indigenous Health and Well-being Initiative Summer School.** June 2013. Western University, London ON.

**Public Health Case Simulation on Seniors Access to Safe Transportation.** February 2013. Western University, London ON.

**Indigenous Health and Well-being Initiative Summer School.** June 2012. Western University, London ON.