

**Experiences of Anishinaabe Kweok (Anishinaabe Women) Accessing Health Care and
Dreams for the Future**

by

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Abstract

The experiences that Indigenous people have with health are impacted by their cultures and the consequences of colonization. The thesis project aims to communicate the experiences that Northern Anishinaabe kweok (Anishinaabe women) are having accessing health care, what health means to them and their dreams for the future of health. The study took place in Sudbury, Ontario. Through storytelling sessions, seven Northern Anishinaabe kweok shared their experiences. Rooted in an Anishinaabe paradigm, hermeneutic phenomenology and thematic analysis were used to understand the stories shared during the storytelling sessions. Storytellers described their conceptions of health, their experiences accessing health care, and their dreams for the future of health care. Experiences accessing health care were defined by interactions with health care providers, outcomes and the environment in which in the interactions took place. The conceptions of health described by the storytellers were influenced by the examples of health they had around them, such as observing their parents. Health was defined by cultural factors, including holism. The storytellers shared two major ways the health care system can be improved; how health care is approached and more education about culturally safe health care for providers and policy makers, as well as more education about the health and the health care system for Indigenous people and community members. The stories support the need to improve health care access and treatment for not only Anishinaabe kweok, but Indigenous people in general.

Keywords: Indigenous, Anishinaabe kweok health, Northern, storytelling, access-to-care, culturally appropriate care

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The Experiences of Anishinaabe Kweok (Indigenous Women) Accessing Health Care and Dreams for the Future

The first step in anything we do as Anishinabek¹ is introduce ourselves, to provide a point of connection. Ophelia nindizhnikaaz, Noodin Kwe ndaya. Mshiikenh mndoodem, Chalk River, Algonquin territory, nindoonjiba, Atikameksheng Anishinaabeg nindaa. My name is Ophelia, and my spirit name is Wind Woman. I am Turtle Clan, which I get from my mom. My reserve community is Henvey Inlet First Nation. I grew up in Chalk River, and currently live in Sudbury on the traditional territory of Atikameksheng Anishinaabeg. My dad is of mixed Irish and Polish descent. I was extremely privileged to grow up practicing both of my parents' cultures and religions. My parents always made sure we had access to the land and water; my mom held her culture close, and my sister and I were raised going through both Ojibwe and Catholic traditions. This shaped my duality; a Two-Eyed Seeing approach is how I was raised (Marshall, et al., 2018). I have, through one eye, an Ojibwe lens, philosophy, and way of life: through the other eye, a Westernized view.

¹ The words used to describe Indigenous people in Canada have changed throughout time. For this thesis, the author/listener will use the term Anishinabek (plural) to describe her people, and the term Indigenous to describe the broader First Nations, Métis and Inuit population in Canada. The word kwe is the Anishinaabemowin word for woman, while the plural form is kweg. However, the terminology used by researchers in their studies is used in this thesis when describing their research.

As an Anishinaabe Kwe I have the loving responsibility (McGregor, 2015) to make decisions that care for the next generations. My part in caring for the next seven generations is to use my studies to improve health outcomes for Anishinabek.

The first song I learned in my culture was, 'The Water Song (Nibi Wabo)', an Algonquin song; the Algonquin share a language family with the Ojibwe and some similar beliefs and ways of life. This song is sung by those that carry the water, life givers. This song means, "The Water is the life blood of Mother Earth. The Water that I carry is the blood of Mother Earth, The Water is the life blood of our bodies," (Betancourt, 2018). The song is sung four times, once in each direction.

Water teaches us about loving responsibility, it teaches us about life, and is intricately connected with women's health. As we hear in the song Nibi Wabo, in the Anishinaabe worldview, my view, water is life. The water we have now is in many ways the water our ancestors interacted with, like our future generations will (McGregor, 2015). The future generations will need this life source. Therefore, the decisions that we make now need to consider the generations to come after us. The water holds us accountable to these responsibilities.

This thesis is deeply rooted in an Anishinaabe paradigm. By nature, it is also two-eyed, recognizing the cultural interactions of Anishnaabe research and Westernized academia. Central to this thesis is honouring my people through research, and to this end, ceremony, language and an Anishinaabe world view are central to the entire thesis approach. This world view, such as the connection between women, the land and the water, philosophies rooted in the world around us and research as a way of connecting to the past, present and future may be foreign concepts to some, yet these ways of being and knowing have existed with my people since time immemorial.

Scope of the Study

The purpose of this research is to better understand Anishinaabe kweok (Anishinaabe women's) conceptions of health, their experiences accessing health care and their dreams for the future of health care access to contribute to a better understanding of these topics that may aid in closing the gap in health disparities of Indigenous people². Understanding this cultural perspective can contribute to developing forms of mental health services and health promotion that respond appropriately to the dilemmas created by this complex histories and social contexts. The literature calls for a better understanding of the racialized experiences of Indigenous people (Allen & Smylie, 2015). Authors of a heart health study (Fontain, Wood, Forbes & Schultz, 2019) call for more research about the 'alternate ways of knowing to inform health-care decisions and policies', (p. 8). In addition, in an early study by Kirmayer, Brass and Tait (2009), the authors concluded that a cultural perspective in both mental health services and health promotion would address the challenges stemming from the complex histories of Indigenous people. Moreover, Kurtz, Turner, Nyberg and Moar (2014), have called for research that not only examines issues in health care reform, but that also includes vision for the future, providing solutions from those that are most affected. Therefore, a better understanding of the experiences Anishinaabe kweok are having while accessing health care as well as an understanding of what health means, will contribute to connecting the understanding between health care providers and Indigenous women seeking health care.

² Indigenous is an umbrella term referring to First Nations, Métis and Inuit people in Canada.

Starting with a literature review, the current state of Indigenous health will be looked at by first establishing how colonialism has historically impacted Indigenous health and identity, as well as how the legacy continues. To get a sense of the experiences that Indigenous people have accessing health care, studies from across Canada, with some specific to the unique barriers Indigenous women have accessing health care, will be reviewed. The calls to action, reflected in the literature, for improving health care through education requires an understanding of what health means to Indigenous people, the experiences they are having accessing health care and their dreams for the future of health care access. This research focuses specifically on the experiences of Anishinaabe kweok. The research methodology will be presented, with an emphasis on respectful research methodology rooted in an Anishinaabe paradigm. Putting together the results of the storytelling sessions with the literature review, the discussion will communicate the main takeaways of what was learned, while suggesting research implications that will illustrate what can be done with this knowledge.

The State of Indigenous Health and Health Care

Anishinaabe kweok face unique challenges accessing health care which have been influenced by settler colonialism, setting up determinants of health that influence how Indigenous women experience health care. Indigenous people have ideas of what it means to be healthy separate from the mainstream view of health (Craft & Lebihan, 2021). Despite difficulties and negative experiences accessing health care, Indigenous women dream of a future where health care access is more equitable (Kurtz et al., 2014). In this section, literature illustrating settler colonial impacts on Indigenous health are reviewed, along with previous

literature on Indigenous views of health, and experiences of health care access for Indigenous people, especially Indigenous women; the section will end with various calls to action for improved access to health care for Indigenous people.

Colonial Impacts on Indigenous Health

The current state of Indigenous health in Canada must be understood within the context of colonialism, both past and ongoing (Allan & Smylie, 2015). Western legislation and child welfare systems are two major points of colonialism that have shaped the landscape of Anishinaabe health (Waldram, Herring & Young, 2006). In this section, Anishinaabe governance will be discussed to add more context to the impact of colonial legislation and how the colonial legislation has fashioned and influenced Anishinaabe health and health care access, will be reviewed.

Anishinaabe Governance

Anishinaabek have sophisticated systems of governance that continue to be passed down. The Algonquin people have the Pike Constitution (Moko, 2022). Across Turtle Island, many nations use a clan system. A clan system is a foundations governance structure rooted in kinship, balance and responsibility shared by all members. In the Ojibwe nation, the Odoidaymi'wan (clan system) has seven cardinal clans the Crane, Loon, Fish, Bear, Martin, Deer and Bird (Benton-Banai, 1988). Each clan has a distinctive role in governance, community and social organization (Benton-Banai, 1988). The distribution of roles built in a distinct system of accountability, reflecting interdependence and collaborative decision making. Of great importance, the clan system has decentralized leadership, decisions made through consensus and ways to address disputes with each other.

Legislation

The 1493 Doctrine of Discovery, Royal Proclamation of 1763, and the 1876 Indian Act are all early pieces of legislation that impacted Anishinaabe access to land. The Doctrine of Discovery, Royal Proclamation and early versions of the Indian Act established that in the eyes of settlers, Indigenous people were subhuman beings not deserving of the same rights as settlers. Indigenous people still live under the Indian Act. This prejudiced view persists today and is apparent in the way Indigenous people are treated when accessing health care services (Browne, Fiske & Thomas, 2001; King, Smith & Gracey, 2009; Allen & Smylie, 2015; Bartlett & Boyer, 2017). These pieces of legislation set the legal groundwork for assimilation and ongoing colonial practice.

In 1493 the Doctrine of Discovery (Pope Alexander VI, 1493) was influenced by Catholicism and implemented through a series of Papal Bulls issued by the Vatican; the doctrine provided a framework for Christian exploitation of Indigenous people and their lands (Fonseca, 2020). The Doctrine stated that if land was owned by non-Christians, it was considered available land (Fonseca, 2020) free to be owned and used by the wider community, including Christians. In this way, the Doctrine disrespected and undermined existing government structures and treaties among Indigenous people and has had devastating effects on Indigenous rights and racial equity (Fonseca, 2020). On the other hand, the Royal Proclamation of 1763 (1985) served as a piece of legislation that recognized the Indigenous people as having some land rights. This Royal Proclamation declared that treaties shall be used to negotiate land. However, Europeans maintained most of the power, resulting in their governing and controlling of the land. When the Canadian Confederation was declared in 1867 (The British North America Act, 1867), Indigenous people, during this time, were suffering greatly due to poverty, famine and the spread

of illness brought by settlers. Under these circumstances, treaties were signed (Waldram et al, 2006) reducing the amount of land and resources Indigenous people had access to.

The 1876 Indian Act is a piece of legislation that seeks to control and assimilate Indigenous people as Canadian citizens (Fonseca, 2020). The Indian Act of 1876 set forth the definition of a ‘status-Indian’ in the eyes of the government (Fonseca, 2020). Consequently, anyone that was declared a status-Indian was not allowed to vote and was forced to live on reservations. The right to vote for First Nations and Inuit people in federal elections was not received until 1960 (Ladner & McCrossan, 2007). This Act served to enable the assimilation of Indigenous people into mainstream society (Fonseca, 2020). For example, the pass system was implemented under the Indian Act in 1882 and was active in some parts of Canada until the 1950s (Barron, 1998). The purpose of the pass system was to restrict the movement and activities of Indigenous people (Allen & Smylie, 2015). To leave the reserve, Indigenous people had to request a pass signed by an Indian agent (King et al., 2009; Barron, 1998). Amendments were made to the pass system to allow passes to be signed more freely (Barron, 1998). This served the purpose of monitoring and restricting the movement of Indigenous people. Restricting the movement of Indigenous people also prevented them from being able to participate in the economy, access Western health care, visit relatives, hold gatherings, inhibited access to Indigenous medicines and healers and for more children into Indian residential schools.

These pieces of legislation established Canada’s legacy of institutional racism, by implementing policies that cemented ideology of Europeans as superior to the Indigenous people of Turtle Island. The policies created a paternalistic relationship between the Canadian government and Indigenous people (Allen & Smylie, 2015). The circumstance of this relationship informs current health systems and the treaty rights to health care (Allen & Smylie,

2015) and impacts access to health services. In summary, legislation shapes the foundation of health care systems and inhibits the self-determination of Anishinabek, while encouraging racism and social exclusion.

Treaties and the Shifting of Health Duties

In the 1880s, the first version of the Department of Indian Affairs was established (Waldram et al., 2006). At this time, Indian Agents were largely responsible for providing either medical services or access to medical care for First Nations people. However, the Agents also often withheld food rations and medical aid (Waldram et al., 2006, p. 188). Health care is a treaty right as written in the numbered treaties which extend from Saskatchewan to the Manitoba-Ontario border (Boyer & Spence, 2016). Specifically, the Medicine Chest Clause in Treaty 6, is interpreted to mean that the First Nations people in that treaty area have the right to medical care provided by the federal government (Craft & Lebihan, 2021). It is now thought that essential food and items were withheld to strategically force Indigenous people off fertile land, away from each other onto reservations (Knott 2020; Fonseca, 2020), and this served to create catastrophic health conditions. It was not until the 1950s that the Canadian government created a branch to aid in the First Nations health crisis (Waldram et al., 2006). The government wing that controls funding for First Nations and Inuit. (status as such is determined by the Canadian government) has faced many reorganizations. These organizations have undergone name changes, turnover in directors, and variations in the extent to which various levels of the government are financially responsible for Indigenous health. Currently, national level services for First Nations, Inuit and Métis are the responsibility of Indigenous Services Canada (ISC) (Government of Canada, 2022). ISC controls the Non-Insured Health Benefits program (NHIB) (Government of Canada, 2022). NHIB can only be accessed by First Nations people, defined as Status Indians in the

Indian Act, and Inuit people that are ‘recognized by an Inuit land claim organization...’ (“Who is eligible for the non-insured health benefits program,” 2023, para. 2). Some of the major concerns of NHIB are that it excludes Métis and non-Status First Nations; constant changes have led to confusion and disorganization, barriers to service access, and the current approval processes for things such as reimbursements, are tedious (Allen & Smylie, 2015). Treaties and the shifting of health duties have created pervasive issues with adequate funding, and other systemic barriers (e.g. systems navigation and culturally safe access to health care) to accessing health and social access to services.

Binoojünyik (The Children)

Residential Schools

During the 1880s residential schools became increasingly recognized and implemented by the government across Canada (Hanson et al., 2002). The purpose of residential schools was to assimilate Indigenous children into Canadian society (Hanson et al., 2002). Under the Indian Act, attendance of residential school by Indigenous children became mandatory (Hanson et al., 2002). In fact, attendance in any other schooling system was illegal (Hanson et al., 2002).

Although legislation requiring students to attend residential schools changed throughout the years, the last residential school did not close until 1996 (Hanson et al., 2002). Living conditions in residential schools were abhorrent (Hanson et al., 2002). With the purpose of assimilation, Anishinaabe students were punished for speaking their languages (Hanson et al., 2002).

Residential schools were also rife with emotional, physical and sexual abuse (Hanson et al., 2002; Waldram et al., 2006). Further, some schools used students for manual labor (Hanson et al., 2002). During the period between 1942 and 1952 Canadian researchers, in conjunction with various levels of governments, performed nutritional studies on Indigenous people within their

communities and residential schools (Mosby, 2013). This research did more for the careers of the researchers than it did for the communities of the people that were experimented on (Mosby, 2013).

In 1907, Dr. Peter Bryce, the premier medical officer for the Department of Indian Affairs, wrote a report documenting the health conditions of residential schools. Bryce estimated that at least 25% of children that attended residential schools died, often due to tuberculosis, amplified by poor sanitation conditions and starvation (Waldram et al., 2006; Mosby, 2013). This figure does not include students that were sent home and then died. Bryce estimated that anywhere from 27- 75% of children discharged from residential school died (Hanson et al., 2002). Bryce advocated for Indian Day Schools; indeed, there was an increasing number of Day Schools. The difference between Indian Day Schools and residential schools is that children that attended day schools often stayed in their communities and went home in the evening. However, the Indian Day Schools were still rife with abuse and served the purpose of assimilating Indigenous children (Raptis, 2016). In 2002-2003, a study showed that about 20% of on-reserve First Nations adults reported attending residential school (Reading & Wien, 2009). About half of those respondents believe that attending residential school negatively impacted their health (Reading & Wien, 2009). The most cited events that happened in residential schools that contributed negatively to health were, isolation from family, abuse, harsh discipline, loss of cultural identity, separation from community, witnessing abuse, and loss of language (Reading & Wien, 2009).

The long-term impacts of residential and Indian Day Schools have been deeply damaging to Indigenous people and communities. These institutions left a legacy of trauma, with survivors reporting negative impacts on their wellbeing, due to the abuse, neglect and cultural erasure they

endured. The assimilationist policies enforced through harsh discipline, punishment for speaking their languages, and separation from their families and communities, resulted in widespread loss of cultural identity and intergenerational trauma. Though Indian Day Schools were seen as less harmful to Dr. Peter Bryce, they also contributed to the loss of Indigenous knowledge and community structures. The findings from the 2002-2003 study demonstrate these lasting effects, with many reporting ongoing health issues directly related to their experiences in residential schools.

60s Scoop

In the 1950s as the height of residential schools lessened, state apprehension of Anishinaabe binoojiinyik (Indigenous children) sharply increased. This era became known as the 60s scoop. This period lasted about two decades (Allen & Smylie, 2015). At this time, about 1 in 3 Anishinaabe children were apprehended. The majority of children were placed in non-Indigenous homes or institutions and denied their culture, resulting in the loss of language for many (Hanson, 2020). Physical and sexual abuse in these homes and institutions “was uncommon” (Hanson, 2020, para. 10). The children that were victims of the 60s scoop likely experienced psychological and emotional problems (Hanson, 2020), which contributes to the poor health status of Indigenous people (Allen & Smylie, 2015).

Sterilization Efforts

A study done by Karen Stote (2015) confirmed what the Indigenous community knew all along; thousands of Indigenous women were subjected to forced, uninformed or otherwise coerced sterilization in the 1970s (Stote 2015, as cited by Arsenault, 2015). Stote, as cited by Arsenault (2015) reported that in some cases practitioners championed the sterilization of Anishinaabe Kweok to reduce the Anishinaabe population. For example, in 1979, when she was

just 14 years old, Anishinaabe kwe Morningstar Mercredi had a tubal ligation performed on her during a c-section (Ore, 2018). She did not find out about the sterilization procedure until decades later, when she and her partner wanted to have children. This news led to a severe decline in Mercredi's mental health (Ore, 2018). Unfortunately, sterilization by force or coercion still happens in the modern era (Standing Senate Committee on Human Rights, 2021). A report produced by the Canadian Senate's Standing Committee on Human Rights, published in 2021, featured a case of such sterilization that happened in 2018. Canada's history of sterilization demonstrates threats to Indigenous women's autonomy, the right to parent, and the paternalistic relationship between Indigenous nations and the Canadian government. Stories and experiences of sterilization have resulted in the mistrust of health care practitioners on the part of Indigenous people (Bartlett & Boyer, 2017; Ore, 2018).

Ongoing issues with Child Welfare

The overrepresentation and monitoring of Indigenous birth-givers in the Child Welfare system has continued into the modern era (Allen & Smylie, 2015). Despite making up about 4% of the Canadian population, Indigenous children account for 48% of children in government care (Allen & Smylie, 2015). A key factor in the overrepresentation of Indigenous children in the Child Welfare system poverty due to the history of colonialism and continuing discriminatory policies (Quinn et al., 2022). First Nations, Inuit and Métis children and families are subjected to a Child Welfare system that undermines cultural and community standards of care, limiting preventative care (Quinn et al., 2022). With community and culture providing a solid foundation for the development of a healthy Identity, Child Welfare interventions need to shift their focus to community health and invest in culturally sound ways to improve the state of Child Welfare (Quinn et al., 2022).

Colonial Events, Identity and Indigenous Health

Demonstrating the impact of colonial events on the health of Indigenous people, authors King, Smith and Gracey (2009) provided a review examining the health disparities, and the factors that enable them, between Indigenous and non-Indigenous people. The authors asserted that the ever-changing identity of Indigenous people through the eyes of society has impacted how Indigenous people can see themselves (King et al., 2009). Further, it was found that traditional teachings and knowledge can support the development of a healthy identity (Smylie et al., 2007; King et al., 2009). Central to these teachings and dispersion of knowledge is the engagement of Elders. Language was identified as an essential part of identity, and language revitalization was regarded as a strategy to improve health (Smylie et al., 2007; King et al., 2009). The loss of identity, coupled with cultural changes and disregard for the autonomy of Indigenous people, has been linked to poor mental health outcomes such as high rates of depression, alcoholism, suicide and violence, with an added impact on youth (Waldram et al., 2006). Continuing with cultural shifts is the urbanization of Indigenous populations. This urbanization contributes to the destruction of traditional family units and community supports, largely affecting Indigenous women who are lone-parents and of low income (King et al., 2009). Aspects of urbanization such as residential instability contribute to social difficulties, which in turn impact health (King et al., 2009; Reading & Wien, 2009). A consequence of the urbanization of Indigenous people is the tendency to pan-Indigenize, with Indigenous services not being tribal-specific (King et al., 2009).

Loss of land and the destruction of the environment also negatively impact Indigenous people (Waldram et al.; King et al., 2009). In fact, Indigenous people share a deep connection

with land, and liken the destruction and exploitation of land to physical assault (King et al., 2009; Craft & Lebihan, 2021). Connected with the land is the ability for a person to acquire their own foods. Being removed from the process of hunting, fishing, gathering and sharing community food negatively impacts Indigenous people's health, especially in the mental and spiritual realms (King et al., 2009). Within Indigenous societies, there are Elders and the elderly. Elders have an important role, passing on traditions, providing consultation for leadership, and generally providing insight and guidance for community members. Many, if not all, Elders have been impacted by consequences of colonial policy such as residential schools, the removal of children and loss of culture (Waldram et al., 2006; King et al., 2009; Reading & Wien, 2009). Those consequences disabled many from being able to go through the traditional training one undergoes to be an Elder, further dismantling traditional structures and therefore having negative health impacts (King et al., 2009). In summary, colonialism has had determinantal and long-term impact on the health of Indigenous people.

Conclusion

At the beginning of this section there was a brief description of some Anishinaabe governance systems. Settler colonialism disrupted many aspects of Anishinaabe and Indigenous ways of life. Some of the major events of settler colonialism were discussed such as early legislation, the creation of treaties and subsequent shifting of health duties, as well as the apprehension and state control of childcare. The impacts of these events are vast, from the literature, it was described that these events created a generational trauma effect which has left Indigenous people more susceptible to violence, substance abuse, and health and mental health issues. The issues created by colonial legislation become compounded when culturally safe care is inaccessible. These events resulted in major losses of Indigenous health practices, culture and

language (Waldram et al., 2006), negatively impacting the health of the community and individuals (Waldram et al., 2006; King et al., 2009).

What Does it Mean to be Healthy? Indigenous Conceptions of Health

Indigenous people, including myself, are frequently not authors of our own stories in health spaces, with stories of health often being narrated by non-Indigenous people (Allen & Smylie, 2015). This lack of control of the narrative lends itself to the characterization of Indigenous health being shadowed by racist stereotypes and images (Browne, 2001), and impacting health care delivery (Wylie and McConkey, 2019). The idea that Indigenous people are subhuman and characterization of Indigenous people as ‘savage’ have existed since early colonialism is apparent in the legislation section of the literature review. Hill (2014) describes a holistic Aboriginal framework for individual healing. In this framework, the path to healing is based on Aboriginal views of health and of wellness (Hill, 2014). Hill (2014) asserts that healing for Indigenous people must be congruent with their worldviews, and understandings of health. Therefore, to understand the experiences Anishinaabe kweok are having in health care, and how they want to experience health care, we must understand their ideas of health first.

To begin, ideas of health by Indigenous people are broadly rooted in holism, with an understanding of how the realms of mental, emotional, spiritual and physical health are interconnected (Craft & Lebihan, 2021). In addition, this holistic view of health is deeply tied to cultural practices, community and the natural environment (Craft & Lebihan, 2021). Below is an exploration of literature that relays ideas of health as conceived by Indigenous people.

Issak and Marchessault (2008), examined understandings of health by members of a Cree First Nation in Manitoba. There were 29 youth that participated in focus groups and 10 adults that participated in in-depth one-on-one interviews. The older youth and adults all referenced the

medicine wheel to understand the different facets of health. The younger youth did not mention the medicine wheel by name but discussed the four aspects of health contained in the medicine wheel: mental, spiritual, emotional and physical. Both groups indicated the importance of having positive role models for youth. Both age groups said that having traditional practices could contribute to better spiritual health. Further, both age groups related that traditional activities are important in day-to-day life and overall health and discussed diet and physical activity as contributing to health. Interestingly, both age groups identified technology as something that negatively impacts levels of physical activity. Lifestyle education and making good choices were identified by both groups as pathways to health. All in all, both the youth and adult groups identified physical, mental, spiritual and emotional dimensions as essential components of health.

In a study done by Fontaine, Wood, Forbes and Schultz (2019), ideas of heart health, *mité achimowin* in the Cree language, were expanded upon through digital storytelling and learning circles with six Cree women from Manitoba, Canada. To begin, one of the authors, Fontaine, shared her cultural knowledge about heart health through a Cree lens, as learned from her relatives. The maintenance of heart health was integral to the Cree traditional life through caring for the “physical, emotional and spiritual needs of the individuals, community and family” (p. 1). Relationships between people and the land were also emphasized as contributing to personal health and wellbeing. The researchers identified six main themes related to how the women discussed the heart: heart health and caring for their heart, changes to diet, changes to lifestyle, related health conditions, experiences with the health care system, residential schools, and relationships with children and grandchildren. The women identified that changes to the diet caused by colonial-imposed interference impact the *mité* (health) of Indigenous people, such as

access to traditional food and the increase of the presence of foreign foods with lots of sugar. Changes to lifestyle included a shift from traditional activities that keep the body healthy, such as older siblings taking care of younger siblings, traveling by canoe, and the gathering of food and water. These activities were also reported to contribute to sustaining connections with others, drawing on themes of a holistic view of health. Related conditions such as smoking and diabetes were discussed in relation to heart health. Storytellers discussed how residential schools impacted their heart health, including the breaking up of families, especially through the loss of language, loss of culture and traditional caring practices. Engaging with children and grandchildren positively impacted the women's heart health, both through physical activity and connections with family.

Traditional medicines are essential to the maintenance of holistic health. In a study conducted by Manitowabi and Shawande (2011), 43 people participated in semi-structured interviews aimed at understanding the strengths and weaknesses of a traditional medicine program based out of Manitoulin Island. Results focused on ideas of traditional medicine, the impact historical events had on them, and how their programming can continue to grow. Ideas of traditional medicine were impacted by historical events. Participants spoke about the impacts of residential schools, Christianity and biomedicine, all of which suppressed traditional medicine. Traditional medicines were described as holistic and having a spiritual aspect. Whether directly or indirectly, all participants mentioned holism in relation to traditional healing, including understandings of balance. Spirituality was linked to traditional medicine and healing. Participants talked about the interaction of traditional and biomedical medicine, stating that both are beneficial.

Despite many attempts to erase Indigenous people and culture, Indigenous ideas about health have still been passed down. The Cree, Anishinaabe, and other Indigenous groups in the literature expressed holistic views of health that encompass emotion, mental, physical and spiritual domains of health and are inseparable from land, culture and the community. These studies affirm the need to center Indigenous voices in health care reform. By listening understanding an Indigenous view on health, the health care system can be better designed to help Indigenous people- though that would also mean that health care providers and policy makers would need to have an understanding of Indigenous people and health.

Accessing Health Care as an Indigenous Person

In this section, *Accessing Health Care as an Indigenous Person*, the impact of misconceptions about Indigenous people by health care providers will be expanded on. To heal, there is a need for a holistic approach to health care, deeply rooted in Anishinaabe worldviews. The studies reviewed highlight the importance and interconnectedness of the four elements of health, mental, emotional, spiritual and physical. Crucial to maintaining health are traditional practices, community engagement and connection to the land (Waldram et al., 2006; Issak & Marchessault, 2008; King et al., 2009; Manitowabi & Shawande, 2011; Fontaine et al., 2019) As stated by Hill (2014), a holistic Aboriginal framework for health and healing reflects Anishinaabe ideas of health, and therefore improves Anishinaabe health. Critical to this framework is the implementation of traditional practices, community engagement and connecting to the land. To improve health-care experiences for Indigenous people, it is essential that Indigenous stories are respectfully heard to aid in the understanding of health and the factors that impact Indigenous health.

Accessing health care as an Anishinaabe kwe is complicated by discrimination, stereotyping and power imbalances. Discrimination in health care has a strong relationship with having unmet health needs (Kitching, George and Tiensvoll, 2019). Contributing factors to having unmet health needs, are not having a regular health care provider and poor knowledge of cultural safety in health care delivery (Kitching et al., 2019). The next section provides insight into the experiences that Indigenous people, especially Anishinaabe kweok, have accessing health care.

Browne, Fiske and Thomas (2001) conducted interviews with 10 women from Carrier First Nation and asked them about their encounters with mainstream health care services. The experiences the women had accessing health care were described as invalidating encounters or affirming encounters. Invalidating encounters had themes of being dismissed by health care providers, having to transform oneself, marginalization, negative stereotypes about Aboriginal women, situations of vulnerability, and disregard for personal circumstances. Being dismissed had a subtheme of not being listened to, which resulted in participants not returning for subsequent health care visits. The women shared stories in which they transformed their appearance and behaviour, in an effort to have fair treatment when accessing health care. The women felt vulnerable in situations in which they had to be exposed for physical exams. Feeling vulnerable in these situations was contextualized by previous experiences in residential schools and of being assaulted previously, thus reinforcing the need for culturally appropriate, trauma informed care. Negative stereotypes came about in the way the women were treated. The women were aware that they were ‘judged in stereotypical negative ways and treated accordingly’ (Browne, et al., 2001, p.16). One woman’s daughter was apprehended after an unfamiliar doctor wrongly assumed her child was being harmed. After a call to her regular doctor who ‘set them

straight', her child was returned. Marginalization from the mainstream was marked by cultural incongruity and seeing non-Indigenous women navigate the health care system with ease. Affirming encounters had the themes of actively participating in health care decisions, feeling genuinely cared for, affirmation of personal and cultural identity, and the development of a positive, long-term relationship with a health care provider. Acts of kindness, respect shown towards culture and emotional care all marked feeling genuinely cared for. While having a positive, long-term relationship with health care providers was common in affirming encounters, invalidating or negative experiences resulted in the women not wanting to return for subsequent visits. Affirming encounters were positive, respectful and helped develop relationships between patients and providers. In conclusion, the women that shared their stories had health care encounters that were either affirming or invalidating due to the health care providers' level of knowledge of cultural safety. Further, despite the benefits of having positive, ongoing relationships with providers, there is often a lack of health care options, e.g. within rural settings, such as in the case with Carrier First Nation. With well documented health care encounters and the resulting outcomes from this study done in Carrier First Nation, British Columbia, this thesis will bring a northern Anishinaabe view to the literature.

Denison, Varcoe and Browne (2013) researched the experiences of Aboriginal women accessing health care when state apprehension of children is being threatened. The authors investigated the intersections between the higher proportion of Aboriginal children in state care than non-Aboriginal women, the poorer health outcomes of Aboriginal women compared to non-Aboriginal women, and barriers to health care access that Aboriginal women face. The authors examined a total of seven interviews from Aboriginal women and health care providers from previous data and conducted

interviews with nine Aboriginal women and eight health care providers. They found that the threat of child apprehension shapes the health status and well being of Aboriginal women and children. While the threat of apprehension did not deter the women from accessing health care services for their children, it did deter them from accessing health care for themselves. Other factors that deterred the women from seeking health care were racism, prejudice and discrimination. The authors concluded that health care providers need education on culturally safe approaches to health care and argued that these approaches will mitigate colonial impacts on the health of Aboriginal people.

In a study done by Kurtz, Turner, Nyberg and Moar (2014), 14 urban First Nations and Métis women living in the Interior of British Columbia participated in a traditional talking circle and shared their stories accessing health care and their ideas for health care reform. The experiences these Indigenous women had were impacted by being Aboriginal and female. The treatment they received had incidences of mistreatment, disrespect and dehumanization. For example, an elder sought health care for an eye injury; despite being sober for over 20 years, the doctor asked her how much she had had to drink. Another woman, who appeared white, noticed that when health care providers read her chart which identified her as being Indigenous, she was treated differently. Another woman described fearing accessing health care with her kids, because she feared that child and family services would be involved. Child and family services involvement with Anishinaabe children has a long history as discussed in the *Binoojiinyik (The Children)* section. This colonial legacy continues to incite fear within Anishinaabe kweok (Denison et al., 2013), impacting how they feel when accessing health care services, fearing that they may be subjected to involvement with child and

family services. Lastly, the women felt like they were not believed, felt unwelcome and had little trust in the health care system, which ultimately discouraged them from seeking health care. In summary, the interactions these women had with health care were marked by mistreatment, disrespect, dehumanization, and racial profiling. In one instance, a woman spoke about the potential involvement of child and family services.

Bartlett and Boyer (2017) conducted interviews with seven Aboriginal women in Saskatoon about their experiences with tubal ligation, coercion after childbirth, and interactions with health care providers involved in their labour and delivery, as well as health care providers that were involved, in some extent, with labor and delivery. The areas of this study relevant to this thesis are the experiences the Aboriginal women had accessing health, specifically their interactions with health staff and the outcome of their experiences. The women shared feelings of being invisible, profiled, and powerless, with many feeling pressure to undergo tubal ligation, often being told it was for their own good. They reported racism, discrimination, and being ignored by staff- one woman noted the nurse only addressed her husband. Coercion included ongoing negative remarks from providers, lack of options, misinformation or lack of information about the procedure's permanence, and pressure to consent. These experiences had lasting effects on the women's self-image, relationships, and health, leading them to avoid health care-even in life-threatening situations.

In a 2019 study, Fontain et al. asked six First Nations women from Northern Manitoba about their experience with heart health. The researchers integrated Indigenous research methodology through digital story telling. All women storytellers

shared their experiences with health care access, either sharing stories about themselves, family members or the health care system more generally. Many of them emphasized a ‘general lack of respect’ between medical staff and Indigenous patients, specifically when the use of traditional medicines and traditions in general were brought up. Interactions that were perceived as being racialized were both direct and indirect. For example, a storyteller shared that her brother was overlooked by emergency nursing staff, who thought his issues were due to alcohol abuse, resulting in his death. In addition, another storyteller shared that while she was working in health care, with mainly non-Indigenous people, she recalled hearing her colleagues make racist comments about Indigenous patients. Other areas of concern were elders being overmedicated and issues navigating the health care system.

A study conducted by Burnett and colleagues (2020) used data from a larger project and aimed to understand the attitudes and beliefs about influenza infection and vaccination held by Indigenous people and care providers. The authors of this study sought to investigate Indigenous choices around health care, specifically accessing vaccinations. Participants were Indigenous community members, health care providers, and sometimes both. Interviews were conducted in both focus group and individual settings. This study took place in northern Ontario. The findings were organized into three types of location, adding context to health care access issues in each location. Most relevant to the scope of this thesis is the location type, “urban-rural spaces”. Though urban-rural cities, such as Thunder Bay are a hub for people in more rural and remote areas, most of the Indigenous people interviewed did not have a long-term health care provider, and instead relied on the emergency department and walk-in

clinics. Impacted by racism and colonialism, it can be hard for positive relationships to form between Indigenous people and health care providers. Further, the authors of this study found that lack of continuity with health care providers could further impede the development of positive relationships. The lack of a positive relationship when attempting to access health care, resulted in Indigenous people not trusting or being comfortable with health care providers. Health care providers acknowledged that if those seeking health care had negative experiences before, they were less likely to attend follow up visits. In summary, those that live in rural-urban areas rely on emergency departments and walk-in clinics for primary care, limiting the chance to form comfortable relationships with health care providers, resulting in negative experiences.

In a small study done by Buchner, Pearson and Burke (2022), five Indigenous women shared their stories through semi-structured interviews about having Ministry of Children and Family Development (MCFD) interventions at the birth of their babies, prior to being discharged. The study took place in British Columbia, Canada. Seven major themes emerged from the stories: the impact of child welfare involvement; a structural power imbalance; addictions; socioeconomic struggles; missed preventative opportunities; the role of advocacy; and the importance of identity, culture and bonding. Relevant to the topic of this thesis, is that the presence of social workers at birth complicates the receiving of health care access. Combined with the legacy of colonial interference in Anishinaabe families and real-life effects such as reported by one of the women in the Browne et al. (2001) study (having her child wrongly apprehended), the presence of social workers when Anishinaabe kweok are giving birth is inappropriate

and marred with colonial surveillance. The women noted the importance of the role of advocacy, whether it comes from themselves or a helper, in receiving appropriate care and support. Trust was central to how comfortable the women felt with contacting and interacting with their social workers within the hospital setting. All of the women also felt a structural power imbalance between them and health care providers marked by feeling powerless, being watched and judged, and navigating foreign health care systems. In summary, accessing health care for the purpose of delivering their children was complicated by the presence of the MCFD. Poor treatment resulted in avoidance of health care, lack of trust and poorer health outcomes.

Overall, four major themes were identified in the literature reviewed regarding accessing health care as an Indigenous person: preparation for a health care visit, management of perceptions, feeling like a stranger and wanting change. Collectively, the review highlights issues of discrimination, stereotyping and power imbalances Anishinaabe kweok face when accessing health care. Poor treatment greatly deterred Anishinaabe kweok from seeking health care and contributed to poor health outcomes. Preparation for a health care visit is highlighted in the study by Browne et al. (2001), with women describing transforming their appearance and behaviour to ensure fair treatment and demonstrating deliberate preparation to counteract perceived biases or negative stereotypes. The study by Burnett et al. (2020), demonstrated that when Indigenous patients are without long-term health care providers, it leads them to depend on emergency or walk in clinics. This type of health care access causes individual to navigate health care spaces unprepared. In the study by Browne et al. (2001) being dismissed and being subject to negative stereotyping reflect how women in clinical settings manage how they are being perceived, similar to feelings of being judged and treated accordingly. Feeling like a stranger was

identified in the Bartlett and Boyer study (2017), when women described feeling invisible and powerless in interactions, being ignored or treated differently, contributing to feelings of isolation in these environments. In the study by Kurtz et al. (2014) a participant noted that once her Indigenous identity was identified by health care professionals, she felt that she was treated differently, and noted that the demeanor of the health care professionals changed, illustrating that perceptions impact interactions. In the Burnett et al. (2020) study, Indigenous patients expressed discomfort and distrust in health care spaces, highlighting feelings of not belonging and feeling like a stranger in the health care system. Wanting change was a major theme explicitly expressed in the studies by Kurtz et al. (2014), Bartlett and Boyer (2017) and Buchner et al. (2022). To move forward towards more affirming encounters, treatment must be respectful and culturally competent, which is essential for improving health care experiences and therefore health outcomes for Anishinaabe kweok.

Calls to Action

The Need for Better Data

Over 60% of the Indigenous population in Ontario live in urban settings, meaning not on reservations (Smylie et al., 2011). The lack of data regarding urban Indigenous people makes it difficult to draw conclusions about the population (Reading & Wien, 2009). Existing data has biased population samples; for example, Indigenous perspectives and context are often left out of data collected about Indigenous people (Smylie et al., 2011). Moreover, research about Indigenous people done by non-Indigenous people often reflects racial stereotypes and is pervasive in the Canadian narrative (Allan & Smylie, 2015; Waldram, Herring & Young, 2006). For example, stating that genetic predetermination is responsible for health inequities often occurs while ignoring the role that social and structural health determinants play (Allan &

Smylie, 2015; Kurtz et al., 2014; Wylie & McConkey, 2019). Large scale surveys often lack enough Indigenous participants to be able to draw conclusions from the data (Smylie et al., 2011). Gathering and publishing data about the urban Indigenous population is imperative; this evidence inform policy changes, the creation of effective services, as well as changes to existing services, resulting in improved health conditions and outcomes for Indigenous people (Smylie et al., 2011). Although advancements have been made in Indigenous peoples' health data collection, there are still gaps in the data. On-reserve Indigenous people are often excluded from data collection, and off-reserve data is often minimal, making it difficult to draw conclusions (Reading & Wien, 2009). For example, First Nations people living on reserve were largely excluded from the census-based surveys pre-2011, including important surveys such as the Canadian Community Health Survey (Allan & Smylie, 2015). This is especially important when the state of Anishinaabe health is being evaluated. Elements such as type of service use, frequency of disease, types of interactions and other defining characteristics of health, health care and health experiences are crucial to understanding and subsequently improving health outcomes and experiences for Anishinabek.

Government, Anishinaabe and Grassroots Responses

To address the racialized issues Indigenous people face when accessing health care, there have been responses at the government level. To begin, the Truth and Reconciliation Commission of Canada's Call to Action, calls for the federal government to 'recognize, respect and address...the distinct health needs of (Indigenous) people' (TRC, 2015, p.3). In the mid 2000s the Ontario Human Rights Commission [OHRC] (2003) responded to a report titled *Paying the Price: The Human Cost of Racial Profiling* by expanding the OHRC policy to encompass racial discrimination that impacts health. The purpose of expanding the OHRC policy

on discrimination is so that people that have experienced discrimination can report it and obtain legal help. Many medical professional and medical training organizations have moved towards establishing policies and curriculum to better support the Indigenous population. As reported by Allen and Smylie (2015), the Society of Obstetricians and Gynaecologists of Canada (SOGC) released a Policy Statement. The Indigenous Physicians Association of Canada and Association of Faculties of Medicines of Canada (2009) updated their curriculum to better educate medical students' about culturally competent care. Additionally, the Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing, and the Canadian Nurses Association jointly implemented cultural safety and competency in nursing education (Wilson et al., 2013, as cited in Allen & Smylie, 2015). Lastly, the Royal College of Physicians and Surgeons of Canada (2013) released a health values and principles statement distinguishing the roles of health care providers in respecting Indigenous health principles through culturally safe care.

After the tragic death of Joyce Echaquan during the fall of 2020, the federal government hosted three national dialogues regarding the state of Indigenous health care (Government of Canada, 2021). During the fall of 2020, an Anishinaabe kwe named Joyce, died in a Quebec hospital. Joyce livestreamed how she was being treated, with the corner's report confirming that the racism and prejudice Joyce faced at the hospital contributed to her death (Nerestant, 2021). The events leading up to Joyce's death clearly demonstrate the devastation of stereotyping and prejudicial treatment. The result of these national dialogues was discussion related to eliminating racism in the health care system, with few concrete actions recommended (Government of Canada, 2021).

Despite many Indigenous people living in urban settings, resources like Statistics Canada often fail to capture this population in public health data (Smylie et al., 2011; Reading & Wien,

2009). Major gaps in the literature about Indigenous health inhibit the ability to create or update programming and policy to best serve Anishinaabek. Indigenous women endure the burden of being disproportionately afflicted with chronic illness, as well as systemic racism in health care settings (Allen & Smylie, 2015). A variety of studies support that Indigenous women are disproportionately afflicted by chronic illness when compared to Indigenous males and non-Indigenous counterparts (Allen & Smylie, 2015).

From the literature reviewed above, there were few studies that addressed calls for action and visions of change. To begin, participants from the study conducted by Manitowabi and Shawande (2011), explained that they wanted to see traditional medicine programming expanded upon to meet the needs of the wider community. Many saw the use of traditional medicines as a path towards healing and recognized it within their own stories (Manitowabi & Shawande, 2011). The expansion of traditional medicine programming was cited as a contributing factor to the rebirth of Indigenous people, especially in the areas of community health and wellbeing (Manitowabi & Shawande, 2011). Denison et al. (2013) called for nurses to have training on the histories of Aboriginal people and how to care in a way that is culturally competent. The authors also called on the government to recognize poverty as a barrier to health care access, and to create policies that address policy as a social determinant of health (Denison et al., 2013). In the study done by Kurtz et al. (2014), the women who shared their stories about accessing health care also shared their ideas for health care reform. The women advocated for culturally safe health care practices and emphasised the need for education (Kurtz et al., 2014). The women also wanted to see Aboriginal people involved in teaching, policy making and health care delivery (Kurtz et al., 2014). Calls for action from the study done by Bartlett and Boyer (2017), included having treatment options that are well-explained, having a helper present during appointments,

and increased education on tubal ligation in accessible languages. The health care providers from this study, called for policies related to tubal ligation to be reviewed, along with reviewing alternatives to having child and family services conduct apprehensions at birth. Additionally, the health care workers called for ‘intensive’ support for Aboriginal women, such as specialised social workers and access to more culturally appropriate health services (Bartlett & Boyer, 2017). Moreover, the health care providers called for more access to information about tubal ligation outside of the hospital and information about consent for Aboriginal women (Bartlett & Boyer, 2017). Lastly, health care workers called for a better system to report inappropriate apprehensions (Bartlett & Boyer, 2017). One woman from the study done by Fontaine et al. (2019) stated that health care professionals need training on Indigenous history, culture and perspectives to alleviate the frequency of stereotyping and racism that Indigenous people are faced with in the health care system. In summary, the calls to action from this report call for the health care system to respect and incorporate Indigenous views of health, especially holism, and ensure that services are culturally appropriate and accessible.

The TRC’s Calls to Action, specifically calls 18 to 24, deal directly with health and call to, ‘recognize, respect and address...the distinct health needs of (Indigenous) people (TRC, 2015). From the literature, it is clear that Indigenous people, especially Anishinaabe kweok, have increased difficulties when trying to access health care. With the governing bodies of many health disciplines calling for Indigenous-specific education to address the health care needs of Indigenous people, there needs to be research that identifies the unique perspectives of what health means to Indigenous people, the current experiences Indigenous people are having when accessing health care, and how they want the health care system to change. Previous research about the experiences Indigenous people are having while accessing health care and in the health

care system largely address the Indigenous population living in British Columbia (Browne et al., 2001; Kurtz et al., 2014; Buchner et al., 2022). There is some research done around Indigenous health care experiences in Manitoba and Saskatoon (Issak & Marchessault, 2008; Fontaine et al., 2019; Bartlett & Boyer, 2017). Research about the experiences Indigenous people are having accessing health care in Ontario are mostly from the East and South. There is limited research that addresses health care access for Indigenous people in Northern Ontario. This intent of this research is to specifically listen to the stories of Anishinaabe kweok in Northern Ontario about accessing health care, what it means to them to be healthy, and their dreams for the future of health care.

In the literature review, three domains were explored and contextualized by historic and current events. Conceptions of health were identified in terms of philosophy (Issak & Marchessault, 2008; Manitowbi & Shawande 2011 & Fontain et al., 2019), however the circumstances around being healthy and the contributing factors to being in good or bad health could be further explored. Three areas of experiences accessing health care were identified in the literature review, including preparation for health care visits and management of perceptions, feeling like a stranger in Westernized health care facilities, and wanting change. These areas are heavily impacted by the historical context of colonialism and modern ideas of Anishinaabe identity. It is important to note that with the many studies calling for change and groups advocating for more education, there is growing trend towards more social accountability. The last section of the literature review discussed calls to action, aimed at improving health care access, experiences and outcomes for Indigenous people. Change must be driven by the people impacted. The research questions were informed by the theoretical domains in the literature review:

1. What are the storytellers' conceptions of health?
2. How is accessing health care influenced by being Anishinaabe Kwe (an Indigenous female)?
3. What are the storytellers' dreams for the future for accessing health care?

Methodology

The methodological approach used for this study is qualitative and inherently rooted within a Two-Eyed Seeing framework (Marshall et al., 2018). In the most basic form, a qualitative approach is used to uncover participants' experiences and the meaning they associate with those experiences (Worthington, 2013). The theoretical framework that best fits this study is Two-Eyed Seeing, in that it is rooted in hermeneutic phenomenology, a Western theoretical approach, complemented by an Anishinaabe (Indigenous) paradigm. A Two-Eyed Seeing framework is situated in both the Anishinaabe and Western worlds (Marshall et al., 2018). This framework is often used in research that combines aspects of Anishinaabe life in the Western context (Day, 2023; Fontaine et al., 2019; Held, 2019).

New Zealand researcher Linda Smith (2012) emphasizes the importance of reflecting the traditional values of the research population as a principle of decolonizing research. Therefore, this research was undertaken using an Anishinaabe paradigm. An Anishinaabe paradigm is reflected in four domains, ontology, epistemology, axiology, and methodology (Held, 2019). Anishinaabe ontology and epistemology are relativist – reality is based on shared experiences and their relationships to one another (Held, 2019). Within the current study, stories were shared, which gave light to the realities that Anishinaabe kweok have accessing health care. Further, by sharing their ideas of what it means to be healthy, a collective understanding of health can be defined, based on experience and mutual understanding. Anishinaabe axiology holds up

Anishinaabe values and is done in a way that benefits the community through respectful and continuous consideration of all relations (Held, 2019). Being mindful of benefit to the greater Anishinaabe community, a plan was put in place to ensure that Anishinaabe communities would be able to access the results. Addressing ownership, control, access and possession, the primary researcher consulted with Maamwizing Indigenous Research Institute (MIRI) at Laurentian University, in Sudbury, Ontario. MIRI agreed to act as steward of the data, be involved with the progress of the project, help First Nations communities and organizations access non-identifying data, and will maintain the project data related to this project. The research agreement with MIRI is in **Appendix A**. Further, the principal investigator consulted with her nation, Henvey Inlet First Nation (HIFN), to review principles of OCAP® and formally solidify a relationship. The acknowledgement of this conversation with HIFN can be seen in **Appendix B**. To show respect to all relations involved in this study, storytellers were treated with care and were invited to smudge together, to share food and drink, and were offered an honorarium. For our relatives and generations to come, this research is meant to incite systemic change within the health care system, improving health care interactions, and hopefully outcomes. Finally, Anishinaabe methodology honors Anishinaabe knowledge systems, which is why the tradition of orality was upheld with storytelling, through one-on-one storytelling visits as a method of data collection (Allan and Smylie, 2015).

In Anishinaabe culture, it is understood that through bizindan (listening with all senses), nsastamookii is reached (an understanding emerges). To capture this understanding, hermeneutic phenomenology was relied on and thematic analysis used to process the data. Hermeneutic phenomenology has been used to interpret legends, stories and historic texts (Patton, 2014). Hermeneutic phenology is concerned with essential meanings- specifically what elements are

essential in understanding a phenomenon (Lindseth & Norberg, 2004; Patton 2014). To understand what is essential the to meaning of the phenomenon, the environment in which the phenomenon takes place must be understood (Patton, 2014). This environment considers social and historical contexts, and lived experience (Standing, 2009). To understand something phenomenologically, the listener must bring themselves to the stories being shared. For this thesis, the stories shared were transcribed. Then a preliminary reading of the transcriptions was done, forming a naive understanding of the stories. This naive understanding is basic, yet some commonalities and differences between the stories begin to be met by the listener. After all the transcriptions were read, parts of the text were highlighted, sometimes sections of sentences or several sentences. These sentences were then condensed into meaning units. These meaning units were reflected on individually, in the context of the individual story and with the other stories, creating part of the hermeneutic circle. Hermeneutic phenomenology is also relational, in that meanings that are essential to describing something are reinforced by each other. This relationality aligns well with Indigenous ontology and epistemology. Meaning units may join to create categories, those categories may join to form subthemes, and those subthemes may join to create main themes (Lindseth & Norberg, 2004).

The use of this approach required the development of a semi-structured interview. Traditional ideas of respectful research and storytelling were reflected in the method of data collection; interviews were viewed through the lens of storytelling, guided by questions during the storytelling visit. Storytelling can be viewed as a way of entering the hermeneutic circle (Patton, 2014). The questions were developed using methods set out by Patton (2014) and modeled after Djivre et al. (2012).

The idea of collective dreaming to explore storytellers' ideas for change comes from Oneida scholar Stephanie Day (2023). Storytelling is a powerful tool for the Anishinabek, especially kweok to 'formulate resistance towards the impact of colonialism' (Posca, 2023, p.68). Recognizing that the sharing of health care stories primarily took place in Westernized settings, sharing these stories is an act of colonial resistance. Storytelling also gives space to dreaming. Dreaming allows for a way of healing related to determining our futures. Dreaming for the future is healing through connection to our past and giving direction to our future, connecting with ancestral and modern knowledge, and aligning positive goals for future generations (Smith, 1999; McGregor 2015; Day, 2023). In addition, collective dreaming towards a better future compliments the Anishinaabe research principle of having a positive impact that encourages healing and development (Smylie & Allen, 2015; Held, 2019).

Participants

Using purposive sampling, seven participants volunteered to share their stories. All seven storytellers were First Nations and between the ages of 22-45 years. All storytellers shared their stories in English, with a few storytellers using some common terms in Anishinaabemowin (Ojibwe language); for example, one of the storytellers spoke about her clan being 'mukwa', which means bear. All storytellers identified as women or kweok (Indigenous woman). To preserve their anonymity, each storyteller was assigned a pseudonym at random.

Procedure

Ethical approval was obtained from Laurentian University's Research Ethics Board (LUREB) and can be found in **Appendix C**. Storytellers were recruited using social media, posters and word of mouth, with individuals interested in the study emailing the author and principal investigator who is described as the listener. The recruitment script can be found in

Appendix D. The listener subsequently sent interested individuals information about the study, including storyteller criteria, the study purpose, and a form for potential participants to indicate their interest in study involvement. The criteria set out for participants was that they must speak English, identify as female or kwe (Indigenous woman), identify as Indigenous or Anishinaabe, and be between the ages of 20-50 years of age. The criteria reflect the main research questions concerned with the intersectionality of gender, race and health experiences. The listener then contacted interested individuals via their indicated contact preference and set up a location and time for the storytelling visit. Potential participants then received an invitation, consent form and encouragement to ask any clarifying questions. Storytelling visits were conducted in-person and virtually. In-person storytelling visits were conducted in the listener's office on the Laurentian University campus, in the Indigenous space on a college campus, and in a local coffee shop. Virtual storytelling visits were conducted with the listener in her secure home office, and the storytellers in their own homes.

Respecting Anishinaabe conversational and storytelling traditions, the storytellers were invited to smudge with the listener. The in-person storytellers were offered tea, coffee, water or juice, as well as light snacks such as a muffin or scone, from a local coffee shop. The virtual storytellers smudged in their own homes, while the listener smudged in her home office; all but one in-person participant smudged, due to the storytelling visit taking place at a local coffee shop. The virtual storytellers were encouraged to have a beverage and snack. At the beginning of the storytelling visit, after the smudge, the study consent form was read to the storytellers as seen in **Appendix E**. Storytellers were reminded of their right to end the storytelling visit and/ or withdraw from the study at any time. At this point, written or verbal consent was obtained. Verbal consent was recorded. As the language that a researcher uses may obscure the

meaning of responses obtained in interviews (Standing, 2009), common terminology was established with participants prior to the interview data collection, as seen in the procedure set out by Djivre et al. (2012) and inspired by van Manen (1990). This was accomplished by asking story-sharers which words they felt most comfortable using and providing definitions for academic or medical terms such as ‘primary care’. Establishing terms ensured that the phenomena was described using terms originating from the respondents.

The second part of the storytelling visit focused on the storytellers’ cultural conceptions of health, and then experiences accessing health care. Guiding questions were organized in order from least to most intrusive (Patton, 2002, as cited in Djivre et al., 2012), and can be found in **Appendix F**. Storytellers were asked to share times in which they felt healthy and unhealthy, as well as what health means to them, they were asked about positive and negative experiences accessing health care and their dreams for the future of health care, with a focus on experience and access. Probes were used by the listener for clarification, elaboration and to emphasize detail (Djivre, 2012). The storytelling visit questions ended by asking the storyteller what their dreams for the future of health care would be. Though storytellers could add additional information or comments throughout the storytelling visit, they were formally asked at the end of the visit if they would like to add to their stories or ask any follow-up questions, as well as give feedback about the story sharing process.

To conclude the storytelling visit, the author read the debriefing script, as seen in **Appendix G**. Storytelling sessions lasted 1.5-3 hours, with the guided question portion lasting about an hour (Buchner, 2011).

The understanding of the storytellers’ experiences and dreams regarding accessing health care was confirmed by participants, using member checking. The understanding was revised

using feedback from the storytellers, upholding Anishinaabe (Indigenous) research values (Held, 2009; Smith 2012). Only two out of the seven storytellers participated in the member checking process.

To ensure that the results of the study were not impacted by the listener's beliefs or assumptions, the author engaged in bracketing throughout the study and kept a reflective journal before and after interviews (Buchner, 2011; Djivre, 2012; Standing, 2009). The process of bracketing also serves the hermeneutic process by allowing the author to have a view of the phenomenon that is not obscured by existing ideas (Posca, 2023).

Hermeneutic understanding was reached through thematic analysis (Lindseth and Norberg, 2004; Patton, 2014; Standing, 2009). Recordings were transcribed verbatim. Upon training in hermeneutic principles and thematic analysis, two research assistants helped with data organization and coding. Codes were assigned qualities that were found to be common or variate to the phenomenon. Qualities that are common or strongly variate across a phenomenon are considered essential themes (Standing, 2009). These themes are postulated to give rise to essences. Essences are the themes (overall common experiences i.e. racialized treatment) and their variations (verbal discrimination, time, discrimination, violence, etc.) relating to the lived experience unique to everyone. A collective lived experience was derived from the essences. The collective lived experiences constructed the narrative of the phenomenon, as seen in the discussion section. The themes resulting in the narrative were verified using member checking. Member checking resulted in changes to one storyteller's quotation to preserve anonymity, and adding to another quotation for clarity. The second storyteller that replied to member checking had no edits and provided supportive feedback. Another storyteller provided a list of additional information about access to health care Indigenous women and their children, before member

checking was sent to storytellers. There were no disputes between the listener and the storytellers during member checking. All the feedback provided by storytellers was incorporated.

Results

The data consists of stories and dreams shared by storytellers. Out of the seven story sharing sessions, six were fully recorded. One story sharing session failed to record due to audio issues. Interviews ranged in length of time, averaging about one hour and ten minutes. All of the storytellers responded to the guiding questions. One participant followed up with additional thoughts via email before member checking was started. Additional information from the storytellers was included. Relating to the three research questions, results were organized into three categories: conceptions of health, experiences accessing health care and dreams for the future.

Conceptions of Health

Storytellers were asked what it meant for them to be healthy, to share times that they felt healthy or unhealthy, and how definitions of health for Anishinaabe kweok may differ from Western conceptions of health. Storytellers shared that the context within which their ideas of health are based shape how and what they know about health. They shared stories about times they felt healthy and unhealthy, and shared attributes of being or feeling healthy and unhealthy. The main themes that emerged from conceptions of health were context, healthy and unhealthy. Main themes were further explored in subthemes, and further divided into categories. The breakdown of these themes, subthemes and categories regarding conceptions of health can be seen in Table 1: Anishinaabe kweok Conceptions of Health.

Table 1

Storytellers' Conceptions of Health

Main Themes	Subtheme	Category
Context	Belief systems	Culture
		Star signs
	Parents	Observation
	Barriers	Recognition
Healthy	Time	Intention
		Time as a Health Resource
		Ongoing Process
	Holism	Physical Ability
		Access to Services, Programming and Resources
		Balance
		Cultural Activities
	Self	Knowledge
		Growth
		Connection
Authenticity		
Unhealthy	Time	Self Care
		Overburdened
		Without Direction
	Self	Activity
		Dismissal
		Negative Self Image
		Lack of Access to Culture
Manifestations of health	Isolation	
	Sensations	

Context. Context represented ideas, situations and events that shaped the understanding of health; this theme had three main subthemes, including belief systems, parents, and barriers. All storytellers contextualised their conceptions of health with Anishinaabe culture by discussing the four facets of health, the medicine wheel, prophecies like the seven hills, or connecting health to land and water. Maya talked about the seven hills as a way of "...looking at everything" when it comes to understanding health, and where we have been and where we are going as Anishinaabek. Ruby said that the "...balance of all your health are within that medicine wheel". One storyteller, Sage, connected her ideas of being in balance in terms of the medicine wheel to her astrological star sign, and said, "I'm also a Libra, so as Libras, we're balanced people". Maya also stated that she understood health by watching when her parents feel most healthy. Summer discussed mental illness and suicide within her family and connected that with her family members being removed from their Ojibwe culture. Storytellers Sage, Lauren, Kai, Ruby and Summer all recognized that Anishinabek people experience unique barriers to accessing health care, such as racial barriers, foreign system navigation and incompatibility. Sage said, "We (Anishinaabe kweok) have a lot of different barriers." All participants recognized how colonial and generational trauma impact the current state of Indigenous health and access to health care. For example, connecting settler colonialism with the loss of land, and limited mobility contributing to the poor health outcomes of Indigenous people.

Healthy. Being healthy was described by the storytellers and had four main subthemes: time, holism, and self and manifestations of health. Time had three categories, including intention, time as a health resource, and that health is an ongoing process. Holism had four categories, including physical ability, access to services, balance and medicine wheel teachings,

and being in ceremony or participating in cultural activities. Self had five categories: knowledge, growth, connection, authenticity, and self-acceptance or being self and taking care of self.

Manifestation of health had one category, feelings and indications of health.

Time. Storytellers Maya, Sage, Lauren and Kai all talked about the role of intention in their conception of being healthy, such as having purpose, direction or routine. Maya said "...knowing where you're going, what you're doing, what's going on, generally, to me, that is being healthy". On reframing her ADHD, Lauren felt like she had a purpose and said, "Yeah so I thought that was really cool, and it made me feel like we all have different gifts, and things like that. So, it felt like that was my gift, we have different roles and responsibilities". Kai said, "I think everybody kind of needs a purpose to move forward and for me I'm a medical student". Lauren said she felt healthy when she had enough time as a resource to maintain health, "I felt balanced. I didn't have too much on my plate, I still had a lot but um, just enough so I could go to Powwows and take my daughter there". Storytellers Maya, Sage and Summer expressed that maintaining health is an ongoing process. Sage said, "Yeah, it's an ongoing process because sometimes it's easy to just like not want to take care of yourself and sleep in bed all day".

Holism. Holistic contributions to health had the four categories of physical ability, such as being able to exercise or move, especially in nature; accessing both traditional and mainstream services, programming and resources; being in balance; and being in ceremony or other cultural activities. Storytellers Sage, Lauren, Kai, Ruby and Summer all talked about feeling healthy when engaging in some sort of movement. Sage spoke about feeling healthy when she had access to sports and other movement such as 'taking care of the sugar bush'. At a time when she felt healthy Lauren said, "...we used to go to the gym together and we'd always be out rollerblading, or jogging, biking". Kai said, "When I was growing up, if you're having a hard time, just go for a

walk in the bush and you are able to think about what's happened, relax, kind of get more in touch with nature and kind of feel more like yourself" and that she felt, "particularly healthy, usually right after a workout... Or the last time when I was with my kid, we were able to finally go for a walk". On being on the land and hiking, Summer, said "like there's ceremony that's involved. There's thought and intention and care and nurturing that's involved".

Storytellers Sage and Lauren stated that accessing services, programming and resources helped them feel healthy. Sage said, "So I recently connected with people at the Friendship Centre, and it's been about a year since I've been going to their programming and I can't tell you these people- I feel so connected to these people there, the workers. There I can be myself around them". Sage spoke about being able to access ceremony and culture through her education institute as something that makes her feel healthy. Both Sage and Lauren mentioned accessing services via a mental health professional. Lauren said she felt healthy when she was able to meet with psychiatrist and take care of her mental health.

All storytellers spoke about being in balance, and the four traditional facets of health or the medicine wheel. Sage said, "So I think for me to be healthy is that I have values of living a well-balanced lifestyle and that means living by the medicine wheel teachings...I need to take care of my physical, mental, emotional and spiritual health. On a regular basis". Maya said "...having balance would be healthy". Clover identified health as being more than physical health by saying that health is "...is more than our human body". Kai said that health, "...would be a good balance in your life, whether it be mental, physical, emotional or spiritual health". Ruby said, "I really think spiritual health and the balance of all your health are within that medicine wheel".

All storytellers said that they felt healthy when they were in ceremony or partaking in other cultural activities such as a language camp, as discussed by Maya. Sage said she feels healthy when she is, "...praying and just always accessing the land and putting up my tobacco, smudging". Lauren said she feels, "...really healthy when I take her (daughter) to like ceremonies, powwows, when we smudge in the morning. It makes my heart feel healthy and my spirit I guess". Kai said that when she doesn't have time to practice her culture then, "...it's stressful and it feels unhealthy". Ruby said "Yeah so being on the sugarbush makes me feel healthy and I think it's because it hits all the aspects of health. It hits my physical, it's hitting my spiritual, it's hitting my emotional, and I just feel very well" and "we did a ceremony at the top of the hill, there was a lot of eye opening experiences during that time where I feel like since then, it's improved my family's spiritual health". Summer said "...I remember the feeling when I was really sick and just smudging".

Self. Conceptions of being or feeling healthy were connected to self and had the categories of knowledge, growth, connection, authenticity, and self-acceptance or being and taking care of themselves. Storytellers Maya, Sage, Lauren, Ruby and Summer all related feeling or being healthy to knowledge, whether giving or receiving. Maya said, "...I just think it's important to be a healthy role model," and "Taking care of myself and getting my education," makes her feel healthy. Maya felt healthy when she was able to, 'carry a sweat lodge', something she had been learning and training to do 'for years'. Lauren said "(it helps my spirit) to know that I am calmly and positively encouraging my daughter's life too". Ruby said, "I feel like healthy for me is also accessing cultural knowledge" and "the more I learn, the healthier I am". Summer said that, "My education has really given me a lot in terms of how I treat myself". Summer also discussed 'feeling well' knowing that her family member was learning their language.

Storytellers Sage, Lauren, Ruby and Summer all felt that growth contributed to their health, whether it be personal, or community-based, such as advocacy work. Sage said that she feels healthy when she is practising her boundaries. Lauren said, “I’m thinking some generations down the line like I wanna help that way and it’s like by me holding down my spirit now and holding these boundaries so hopefully people... my great-great-great-grandkids, seven generations down the line, won’t ever have to worry about this because I stopped it now”. Ruby said, “just that experience showed me what happiness is” when she tried new things. Summer said, “Engaging in ceremony, working on my issues with my family, I was honoring myself, my name and this elder at the same time, and I felt really, really, really great”.

Connection, especially to the land and to other people, was a category expressed by Sage, Lauren, Ruby, Clover and Summer. Sage said, “I feel so connected to the land and feel more connected in the world” and “I was just thinking of it as a web you feel so connected”. Lauren said on the importance of spending time outside or in the bush “...just like being situated and grounded and being able to breath...I think we all come from the land”. Ruby said, “I think of Indigenous health, versus non-First Nations health, I think it's the spirit, it's the interconnectedness”. Clover identified that being in community and around “good people” helped her feel healthy. Summer said, “...nurture all of my connections that relate to myself and the people around me”.

Storytellers Maya, Sage, Clover stated that they feel healthy when they are able to be authentic. Maya said, “...being myself, that's what makes me feel healthy”. Sage said, “Talking my truth is healthy”. Clover said, “Being myself” makes her feel healthy.

Maya, Kai and Ruby identified that they feel healthy when they can take care of themselves. Maya said, “What makes me feel healthy? Is when I can take care of myself”. Kai

said, "Just managing the stresses of life with managing the stresses of my individual health". Ruby said, "I feel like right now more than ever, I feel healthy because I know how to come back, I know how to balance myself".

Unhealthy. Storytellers described being unhealthy. This theme contains three main subthemes: time, self and manifestations of health. Within time are the categories of not having enough time and feeling overburdened, a lack of life-direction, and a lack of activity or being able to move. Self had four categories, including being dismissed or otherwise overlooked, negative self image, not being able to engage in culture, and being isolated. Manifestations of health had one category: feelings and indications of health.

Time. Storytellers Maya, Sage, Kai, Ruby and Clover all discussed feeling unhealthy when they felt overburdened. Maya said, "Too much office work... we are not meant to be that busy". Sage said, "I was kinda like trying to take care of everyone else where that wasn't healthy". Kai said, "Too much stress (laughs)...if I go too long without working out...eating poorly or not being able to spend time with my kid or family, or not being able to do cultural things...so then when I don't have a good life balance where I don't have time to do that stuff and it stresses me out... when it goes off balance like that, then it uh stresses me out and then I think I feel unhealthy". Ruby said, "It was just so overwhelming that the best way to deal was to numb everything, that's what alcohol does". Clover said, "having a lot on my plate".

When Maya, Clover and Summer felt that they were without direction, they felt unhealthy. Maya said, "there was no point to like, so like, there was no direction anywhere". Clover said an unhealthy time for her was while figuring out what to do post grad. Summer said, "I couldn't find like real direction".

Storytellers Maya, Lauren and Ruby felt unhealthy when they couldn't or weren't participating in physical activities. Maya spoke about a time she felt particularly unhealthy: "I had no sports". Lauren said, "I can't move and it's just like I have no energy to even lift up my arm". Ruby said, "If I go a week without walking my dog, I feel unhealthy," and "this year we didn't tap our sugar bush and I feel ick".

Self. Being dismissed or otherwise overlooked contributed to storytellers Sage, Lauren, Kai and Ruby feeling unhealthy. Sage said, "I went to this [church] they were saying the culture is bad, it's evil and I'm like I can't live my life like this". Lauren said, "Um so, while I was feeling unhealthy it felt like, honestly it felt like my spirit was like so hurt and I was taking so much disrespect from everyone and everything and it's just like my spirit was really damaged and hurt...I feel like not being heard was the issue". Kai said, "It was extremely stressful because it was harmful in what happened, and then the school did not react appropriately". Ruby spoke on her dental visit focusing more on the cultural education of the doctor: "I felt like the visit wasn't about my teeth".

Having a negative self-image contributed to Sage not accessing health-related activities and services, contributing to her not knowing how to be healthy. She said, "I always believed that other people deserve to have an education, to have connection, to have a healthy lifestyle, to go hiking" (and not herself).

Summer felt unhealthy when she was not able to participate in cultural activities. She said, "Like culturally, I felt unhealthy in that way because I felt like I wasn't honoring different parts of myself". This was also reflected by Sage who said that "Winter time is hard cause there's not many ceremonies in the winter..".

Maya felt unhealthy when she felt isolated or not connecting with others. She said, "...I felt like I had nobody in my life...I was like very alone".

Manifestations of Health. Storytellers Maya, Sage, Kai and Ruby all identified physical sensations of being unwell. Maya said, "...it's like the spirit of depression or spirit of anxiety". Sage said, "...for a long time in my life there was like this weight on my chest," when describing the impact of being in poor emotional and spiritual health. Kai said, "Because after that, then you get all sorts of other issues and you'll get sore stomach aches or your headaches or all these other physical symptoms come after you get too much stress". Ruby said, "When I felt the most unhealthy, I had the most pain inside".

The conceptions of health shared by the Anisinhaabe kweok storytellers reflect a nuanced and culturally grounded understanding influenced by context, personal experiences, and tradition. Health is seen as holistic with dimensions of physical, mental, emotional and spiritual wellbeing. Shaping their perspectives, storytellers shared how belief systems, parental influences and barriers such as colonial trauma contributed to their conceptions of health. Balance, intentionality and connection to culture through ceremony and the land were key components to being healthy. For example, engaging in cultural activities, having a sense of purpose and being able to access support contributed to their sense of wellness.

Contrarily, storytellers identified the state of being unhealthy with being imbalanced, disconnected and having unmet needs. Storytellers spoke of challenges that contributed to feeling unhealthy such as overburdened schedules, negative self-image, and lack of cultural engagement. Hindering their ability to engage in holistic health practices were time constraints and isolation. Manifestations of healing presented as both emotional and physical elements.

Experiences Accessing Health care

Storytellers shared their experiences accessing health care, both positive and negative experiences. The stories told about accessing health care had three main components: interactions, environment and outcome. In Table 2: Experiences Accessing Health Care, each theme, subtheme and category related to experiences accessing health care are broken down.

Interactions. The interactions that the storytellers had accessing health care shaped their experiences. Interactions had the subthemes of self, and outside of self. Self had three categories, preparation, self-determination and advocacy, and feeling vulnerable. Outside of self had five categories: time, level of acceptance, professionalism, and kindness or truth.

Self. Sage, Lauren, Ruby and Clover all prepare themselves for a health care visit. Sage said, "I told them put on my file not to mess around with me, put it in big friggin' letters". Lauren said, "I feel like I go in to prepare myself to defend myself". Ruby said, "I'll take my earrings out because I feel like they're the one thing that helps identify me. It's weird to say, but I wanna look as white as possible". Ruby also said, "That's why I find that these situations are very... I pick and choose when I want to identify as Native because I really get scared on some of the assumptions. Or some of the... not lazy work, just discriminating work that people might do". Summer also reflected trying to look less 'nish' (meaning looking First Nations) when she seeks health care, especially in emergency departments. Clover said she, "Prepare(s) to hear bad news".

Table 2

Experiences Accessing Health care as Anishinaabe Kwe

Main Themes	Subtheme	Category
		Preparation
	Self	Advocacy Self- Determination
Interactions		Vulnerability
	Outside of Self	Racialization Time Level of Acceptance Professionalism Truth and Kindness
Environment	Cultural Adjacency	Options
	People	Familiarity & Allyship
	Setting	Feeling Westernized or Indigenous
	Lasting impressions	Action Hope Hesitancy
Outcome	Direction	Understanding Options Complaints Process
	Cost	Cross-Provincial Care & Reimbursement

Advocacy was involved when accessing health care for storytellers Sage, Kai, Ruby, Clover and Summer. Sage said, “I’ve seen a family member going in and I had to be an advocate for her” and “I knew the right people to connect with and how to get an apology”. Kai said, "Of

course I was, I was in BioMed. So, like, looking up all the options and you can get a necessary medical procedure...So I tried to convince the doctor to like, please get me this referral so that I can get fixed". Ruby spoke on educating her endodontist: "It makes the whole experience exhausting when I get help like that because then I leave, and I think about that. And that's fine but I just feel like my health is not necessarily the main thing". Clover said, "...it felt like I had no choice but to give in and just accept the disrespect". Summer said, "I'm really grateful, my mom is a nurse and will come with me to make sure I've been taken care of".

Lauren, Ruby, Clover and Summer identified feeling vulnerable when accessing health care. Lauren on being treated by a massage therapist that she had been on a date with, which he brought up while she was on the table, "I'm face down in a vulnerable position. So, I was really uncomfortable with it". Ruby said, "I waited until the whole process was done. To me, I felt like if I would've said anything during the (dental) procedure, you'd put yourself at risk for like him doing a shitty ass job" when sharing her story. Clover spoke about how she avoids male doctors. Summer said, "I know that (the photos are) for medical purposes. But like, there's pictures of myself and I, I don't like that...I feel vulnerable".

Outside of Self. Lauren, Kai, Ruby and Summer shared stories in which they had directly racialized interactions. Lauren said, "They show they don't care where your safety is priority versus where it's not and how that differs with the colour of your skin and your background". Kai said, "They, they must have assumed I was just because I was brown, that I wanted drugs or that I was taking too many drugs". Ruby said on the quality of her care, "That depends if I disclose if I'm Native or not" and "I find my experience depending on whether or not they find out, or if I'm willing to tell will change how the experience is". Summer said, "...I know that I

don't look visibly nish...I noticed a difference when I would dress more nish, I would kind of get rushed around fast or I would kind of not be taken as seriously”.

Maya, Lauren, Kai, Clover, and Summer all felt disregarded through forms of being rushed, neglected, ignored, or overlooked during their negative interactions. Maya said, "...it was really uncomfortable that he didn't believe me when every other interaction I had had up until that point with doctors was like no they believed what I said", and spoke about the time she went to the hospital for a concussion, and the doctor would only talk to her boyfriend of two months. Lauren said, “the secretary made me feel shitty about it when she’s like ‘oh, he can’t even bring you a towel?’ Then, for them to just ignore it again when I went in the third time”. Kai said, "I felt neglected. I felt like I was less than human. I felt that I was ignored. That, I was wasting their time. That, they just didn't want me there”. Summer said, "Specifically in the Western institutions, it's like band aids and you get out. We gotta get the next person in and I do get that. I understand that there's so many people who are needing access to these services, but at the same time, it's like, how am I ever supposed to get better and be informed about my health?". Clover said, "...well it didn't feel like a welcoming service, kinda just the next person on the list to go through... and it felt like they didn't care about me”.

On the other side, Maya, Kai, Clover, and Summer identified being validated as positive components to their health care experiences. Maya said "I feel like respected and cared for, not like I am bothering her (the nurse practitioner)”. Kai said, “And then she immediately gave me a referral to oncologist and blood work...Because she believed me and she sent me to the surgeon right away, we were able to get it out right away, so it didn't turn into cancer”. Clover said, "Yeah so that was a good experience. It was really quick”. Summer said, “Being taken seriously...that was the first positive experience I had (in getting a diagnosis)”.

Maya, Lauren, Clover and Summer all felt like they were being invalidated during their negative experiences. Maya said, "...probably othered, yeah. I don't know if they believed me or not," on sharing with her doctor that ceremony helped her ongoing health issues". Lauren said, "Yeah for them to like to believe, or if they're going to write me off like a typical 'rez' person". Clover said that she, "felt ashamed" after interacting with a doctor about having diabetes. Summer said, "But then I like, I also see the side eye and like. I see that there are microaggressions".

Lauren, Clover and Summer shared stories in which health care practitioners acted unprofessionally. Lauren said, "And he's still massaging me, and I went from having a professional massaging me while face down to having a tinder date who I ghosted with his hands on me while I'm face down in a vulnerable position. So, I was really uncomfortable with it". Clover spoke about when the doctor had said something sexually explicit when treating her mother. Summer spoke about when the doctor dismissed her concerns and said he would tell his daughter the same thing, "That was very unprofessional of him".

Sage and Lauren valued authentic interactions with health care practitioners that indicated truthfulness and kindness. Sage said, "They are so welcoming...They are so respectful, what a big difference" when talking about the Indigenous clinic. Lauren said, "...they are just straight up. The nurse...she's really real. I like her. She's always just listening to me".

Environment. The environment in which the storytellers accessed health care shaped their experiences. Environment had three subthemes: cultural adjacency, people and setting. Cultural adjacency had the category of treatment options. People had the category of familiarity and allyship. Setting had the category of feeling Westernized or Indigenous.

Cultural Adjacency. Storytellers Maya and Sage felt cared for when they were offered traditional health options. Kai noted liking having traditional health options and programming "...if you want a healer, you can actually get it. There are cultural activities," she also noted, for which you are limited to the territory, for example, having Mohawk services on Mohawk territory and "needing to be okay with that". Lauren didn't like being referred to an Indigenous counsellor before she understood her and her people's history saying, "I'm a human being, just help me.... now I see that we do have a lot of intergenerational trauma that like they would get, but I hated being compartmentalised into a typical, othered".

People. Maya, Sage, Lauren, Clover and Summer all identified being familiar with people or being able to identify allies contributed to a positive health care experience. Maya said, "I felt okay, it was the same room (as always)", in reference to an experience with a nurse practitioner: "She's known me my whole life, so she's really good". Sage said, "I've known him since I was a little kid...they're amazing how they treat me there, like they don't treat me disrespectfully at all". Lauren said, "he knows people's names," when talking about her pharmacist. Clover spoke on how she likes her paediatric doctor because the doctor was familiar to her and had been in the (Indigenous) community for a while. Summer spoke of feeling comfortable seeing her mother's doctor because it was someone familiar.

Setting. Sage and Clover had positive experiences accessing health care through native health clinics. Sage said, "There is an Indigenous clinic. Amazing to me. The people make me feel so good when I am there". Clover said, "So she did a good job of believing me" in regards to the workers at the native health care clinic. Summer felt conflicted about having a negative experience in a native health clinic. Summer said, "I should feel more comfortable in that space...and when that doesn't happen that's uncomfortable". Sage spoke directly about not liking

being in a hospital setting. Sage said, "I don't like being in those spaces. I don't want to be there. You...can feel like these people don't want me here. They don't like me".

Outcome. Outcome had three subthemes, including lasting impressions, direction and cost. Lasting impressions had the categories of direct action, hope or wanting to go back, and not wanting to go back or avoidance. Direction had categories of feeling provided for and the complaints process. Cost had one category: the cross-provincial care and reimbursement.

Lasting Impressions. After having negative interactions, storytellers Kai and Ruby wanted to take direct action. Kai spoke of wanting to become a doctor and going to medical school. Ruby said, "I'm more of an advocate".

After having positive experiences storytellers Maya and Kai were left hopeful and wanting to go back. Maya said, "I feel hopeful after I go see her (nurse practitioner), because she gives me options", and "Makes me more apt to go see her whenever anything's going on". Kai said, "Gives me hope. Umm, because then you know some they can do well when people try; that you can have good experiences when people are working together towards, patient health".

Maya, Lauren, Kai, Ruby and Clover did not want to go back or avoided health care after having negative experiences. Maya said, "Now I really don't wanna go anytime", and "I'm like they're gonna look at me like I'm silly". Lauren said, "I haven't went back since". Kai said, "I don't want to be a patient, ever. I avoid going to the doctor as much as I can". Ruby said, "It just didn't make me feel great about going back". Clover spoke of how she avoids walk-in clinics because of unfamiliar people.

Direction. Understanding options or what to do after their health care visits contributed to whether a storyteller felt provided for. Sage liked being given options; she said "Do you want some (traditional) medicines? Do you want me to...refer you to counselling?" Maya, Kai and

Summer felt like they were missing a follow up or some instructions. Maya said, "they didn't even tell me to like relax or do anything that people with concussion do". Kai said, "So they didn't ask me if there's anything they could do with me. I never actually seen a doctor that whole time". Summer said, "She didn't follow up with anything, she didn't ask me questions". Ruby felt provided for when she had a follow up: "I feel like I was provided for because he finished the cleaning, he called me twice just to make sure everything was fine and it was healing okay". Lauren and Clover felt provided for when they were understood. Lauren said, "That they are open to what I need" when talking about her pharmacy. Clover spoke on how she feels provided for when able to fully express herself.

Sage, Ruby, Clover and Summer all pursued a complaints route. Sage said, "Next time you do this to me, I am going to the media". Ruby said, "I have emailed patient relations so many times that they know me quite well". Clover said, "I tried making a google review on their thing" and "I spoke out about my experience and still wasn't heard. Now, I couldn't get that health care". Kai also spoke about the possible consequences of pursuing the complaints process, "... because if you report your MD, I don't know if your name is attached to there but, then who are you going to see? So, then you get no medical care". Summer said, "And I do hope that you know something was done with this investigation, but I never heard from it and that no one followed up with my case since it's been about a year since I made that complaint". The complaints process has consequences as expressed by Kai and Clover. Kai acknowledged that reporting a medical doctor could lead to not having any options when in a rural setting. On the consequences of reporting, Clover said, "it's either you stay silent, take the shitty behaviour, just get what you can, or you speak up, defend yourself, protect your spirit and then possibly get the shit end of the stick".

Cost. Maya had a unique experience getting cross-provincial care and navigating the reimbursement process. Maya said, “yeah and everyone was like Canada, universal health care, and I'm like yeah no,” when sharing a story about accessing health care in Ontario as a Quebec citizen, and having to pay first to be reimbursed at a later date.

Storytellers shared positive, negative and neutral experiences accessing health care which brought to light the impact of interactions, environments and outcomes. Interactions included themes of self-preparation, vulnerability, advocacy and external factors such as racialization, disregard and professionalism. Some preparation involved preparing to be on the defence, while others involved altering their appearance to mitigate discrimination. Feelings of validation arose from respectful treatment, though many stories highlighted neglect, invalidation and unprofessional behaviour contributing to the feeling of vulnerability in the health care system. Positive interactions, such as familiarity with health care providers and being treated in an authentic way came out as exceptions rather than the standard of care.

The environment also played a key role, with storytellers valuing culturally adjacent care and familiar settings. Though it was not true for everyone, native health clinics often provided a sense of belonging. Outcomes further highlighted systemic challenges. Negative experiences frequently led to avoidance or hesitancy to seek care, while positive interactions contributed to hope and trust. Stories were shared about the complexities of navigating the health care system, specifically the complaints process and coping with the consequences of advocacy – particularly in rural areas with limited health care options.

Dreams for the Future

Storytellers shared their dreams for the future of the health of themselves and others, and access to health care. Storytellers were asked to share their dreams for the future of access to

health care for Anishinaabe kweok and Anishinaabek. Dreams for the future included changes to the way health care is approached, and increased education for providers, policy makers, people and community knowledge. The main themes of approach to health care and education were further broken down into subthemes and categories which can be seen in Table 3: Dreams for the Future.

Approach. Approach had five main subthemes, including equitable, truly holistic, self-determined and safe. Equitable had three categories: receiving care not based on income status, race or appearance (inclusive care); accessing care and proximity of care; and cost. Truly holistic had two categories, including health as culture and food. Self-determined had two categories, understanding of options (informed choice) and individualised care. Safe had five categories: culturally appropriate; compassionate (kind, gentle and respectful care); child welfare; fear; and accountability. Other included the category of transportation.

Table 3

Dreams for the Future of Health care

Main Themes	Subtheme	Category
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Approach to Health care	Equitable	Inclusive
		Access
	Truly Holistic	Cost
		Culture
	Self-Determined	Food
		Informed Choice
	Safe	Individual Need
		Culturally Appropriate
	Other	Compassionate
		Child Welfare
Education	Providers and Policy Makers	Fear
		Accountability
	Indigenous People and Community	Transportation
		Culturally Appropriate, Trauma Informed Care
	Navigation	Understanding
		Community Knowledge

Equitable. Sage, Kai, Ruby and Clover had dreams of health care that was inclusive, and free of being othered based on income status, race or appearance. Sage said, "and I'm like motherfucker. Do they call after us? No. They don't give a shit," when a non-Indigenous patient

received a follow up call and she did not. Kai said, “It needs to be a cultural shift of less seeing people as money”. Ruby said, "For women, it's having a baby and not being afraid of it being taken away because of what your knowledge is, or background, or family history, whatever it might be”.

Kai, Ruby and Summer all identified transportation as a barrier to accessing health care. Sage, Kai and Ruby shared dreams of easing health care access. For example, storyteller Kai shared a story about the consequences of not having access to care because of being so far north. She noted that having closer proximity to care or better access to transportation services could prevent deaths or the worsening of health conditions. Ruby said, "this eutopia of health care is, like it's always accessible”.

Sage noted cost as a barrier and shared her dream to have that alleviated. Sage said, "I wish that health care was free”, and "I wish that they (women) would have access to medical services and expenses to help them take care of their families”.

Truly Holistic. Maya, Sage, Lauren, Kai, Ruby and Clover all expressed culture as an important component of health care and wanted to either integrate traditional care with Westernised care or to have Indigenous health spaces. Maya said, "...the dream is that you can use both (Western and traditional methods) and treat the person in your own every single way possible...each side has their merit”. Sage spoke about [an], "Indigenous maternity centre, so women can be able to have traditional access to having children”. Lauren said, “...a native health care building. I feel like I'd be more in a safe spot and more understood" and "I think there should be more space for two spirit people”. Kai said, "What I want are for people to have access to the resources that they need, for holistic health”. Ruby said, "having a space, and a space that supports culture”. Clover mentioned "to have a traditional space”.

Sage and Ruby identified food as a route to health. Sage said, "A lot of our women have trouble accessing services to food so that they can make sure that their kids are healthy" and "Women need a healthy, like, cooking program in their communities". Ruby said, "I think it could impact health in a way that gives people more confidence...you're talking about people growing their own food".

Self-Determined. Sage, Kai, Ruby and Clover all expressed that health care should have informed choice. Sage said, "...they should have access to services that will be transparent, that will be to (work with them to receive) the care that they need". Kai said, "...the idea is that they should have a choice". Ruby said, "not everyone's gonna wanna learn their culture". Clover spoke on "leaving with clear instructions".

Maya, Sage, Lauren, Kai and Ruby all expressed that care should be based on an individual's needs and that Indigenous health care should be guided by Indigenous standards. Maya said, "...they would go and actually get solutions that fit what they actually want". Sage said, "We have to respect and honour what people's definition of health means to them...giving them their sense of dignity". Lauren said, "Yeah, the whole point of the health care is to help individuals. And it's not to provide a specific narrow path of helping this person, you're there to help them in whatever way that is". Kai said, "...something that I want to bring to my practice later, is to make sure that I listen to my patients and try and figure out what's wrong from their point of view... to treat what the actual issue is". Kai said, "Yeah. Indigenous people believe in a holistic approach. Why is that not reflected in our health coverage?" Ruby said, "We need everyone to get what they need, not just the same thing" and "we really have to start thinking long term...First Nations need to make their own standards".

Safe. Maya, Sage and Ruby all expressed wanting more culturally appropriate services. Maya said, "...like the dream is that there would be like cultural supports there that you can refer to them..." Sage said, "Being able to access, like, health care services in a more traditional manner". Ruby said, "I think that access to certain cultural services that foster the spirit".

Sage, Lauren, Kai and Clover want care that is delivered in a way that is compassionate. Sage said, "Why do we have to sit there and fight for nice treatment? Why do we have to fight for that? I don't get it, it's always a fight like why couldn't we just receive compassionate services?" Lauren said, "... there needs to be that gentleness". Kai said, "We need to be able to undo that trauma by treating people gentler". Clover said, "To leave in a good way".

Sage expressed wanting mothers to feel safe. Sage said, "...women having to let their children go (to seek health care outside of remote communities). You don't see a lot of our non-Indigenous people doing stuff like, like, right, and that's traumatising".

Sage and Ruby expressed wanting to feel safe or not scared. Sage said, "I just want women to be able to feel safe and protected and to feel a sense of dignity and a sense of hope when they're receiving health care services at all times". Ruby said, "It's not being scared within a health care system".

Storytellers Lauren and Kai want more accountability. Lauren said, "I think first they need to introduce themselves to show that they're a safe person. To let them into your circle of care and your community". Kai said, "...the repercussions for improper treatment of a patient are minimal in rural areas because people don't litigate. So. There needs to be a way for people to report... If you were to promote that. Then they would make them more accountable".

Education. Education had two subthemes, providers and policy makers; and Indigenous people and community. Providers and policy makers had the category of culturally appropriate,

trauma informed care and understanding. Indigenous people and community had the categories of building community knowledge, building personal health knowledge, and navigation.

Providers and Policy Makers. Maya recognized where stereotypical ideas of Indigenous people may come from: " I think people will need to experience it because what the ideas of non-Indigenous doctors and who is non-Indigenous here is what they see on TV probably. Right. That would be their main idea of it. Or maybe they read a book about it probably written by a non-Indigenous person who has this really warped view". All participants agreed that some level of education is needed for health care professionals. Clover wants health practitioners to "be healthy in (their) own work," and feels this can be done through education. Sage, Lauren, Kai and Ruby also had calls for more education for health care practitioners around culturally appropriate, trauma-based care. Sage said, "People need to be educated". Lauren said, "There needs to be so much more awareness about consent, and I feel like there needs to be thorough and continuous training on it". Kai said, "they just say being Indigenous is a, is a negative health determinant when it's not actually just being Indigenous, it's just racism like systemic racism that's causing it". Ruby said, "Imagine what that would mean across the board, everyone has to take it because it's a health, and accessibility issue".

Indigenous People and Community. Maya, Sage, Lauren and Kai all have dreams for building community knowledge and care. Maya said, "I think that's what it looks like is teaching people when they're young and having access to it, knowing maybe people in the community go around and ask like, we're going to have an information session on this thing". Sage said, "And I think that it's going to have to be the community, have to start doing the caring for and start being creative. When it comes to providing health care to our own people, we have the knowledge of our ancestors and our (people) from a long time ago and if we get connected to

that, we can gain that knowledge and it's just about helping another in the community". Lauren said, "So, it's like our stories have science within them...We've been able to keep things going for as long as we have because we don't take what we don't need because we know it needs to last and to care for the next seven generations". Kai said, "So then when you take a step back by talking to people, you can see a better way to approach it. So I would want to have more community involvement, more people talking to each other" and "So like there needs to be more community education on, on how to litigate and how to complain and where these complaints should go".

Maya and Ruby dream of building personal health knowledge. Maya said, "...if you don't have that background knowledge, then you're very fearful" and "I think it starts in schools". Ruby said, "So I feel like we're going in the right direction but for my past family, I wonder if they knew more about their spirit, their family, about all that pride, if they would've went down these directions let's say".

Sage, Kai and Ruby all brought up issues with navigating non-insured health benefits. Sage said, "Why is the government pulling out and taking away our services from us?" On accessing Non-Insured Health Benefits (NIHB), Kai said "they're not allowed to access them because they don't have the status card. So. That's, that hurts them when they're challenged, when they have to challenge their own identity just to get help". Ruby said, "The funding is confusing because we get federal funding and provincial funding and it's just...to me, there needs to be one, almost universal organization that can triage to the appropriate places". Ruby wants to have better health care navigation, stating, "Those are all great (variety of services) but they're all in different places".

The storytellers conveyed their dreams for improving health care access and the experiences Anishinaabe kweok and Anishinaabek have accessing health care. Key themes highlighted health care approaches and education. For health care, storytellers envisioned health care that is equitable, truly holistic, self-determined, and safe. Equity was emphasized by suggestions to remove barriers related to income, race, geographical location and affordability. The desire for holistic care included integrating Anishinaabe practices, cultural health spaces and access to nutritious food. Self-determination highlighted informed choice and individualized care, guided by Anishinaabe standards. Safety focused on culturally appropriate, compassionate and trauma-informed services with a priority on accountability.

Education for providers, policy makers, patients and community members were an important component to a better future. Providers and policymakers were called to adopt culturally appropriate, trauma-informed care practices and to actively challenge stereotypes. Storytellers highlighted the need for community education, the development of personal health knowledge, and more effective and efficient navigation of health care systems.

Discussion

In this study, 7 northern Anishinaabe kweok shared their stories in one-on-one storytelling sessions. The storytellers shared stories about times they felt health and unhealthy, positive and negative experiences accessing health care and their dreams for the future of health care access. Their responses were categorized into three major sections: conceptions of health, experiences accessing health care, and dreams for the future. Each section was main themes, subthemes, and categories.

Conceptions of Health

The scope of this research went beyond basic understandings of health by exploring the context in which the story sharers felt healthy and unhealthy. All participants recognized that colonial and intergenerational trauma have impacted the current state of Anishinaabe health. To this end, positive formation of identity and involvement in culture assisted in a path towards being in good health.

Similar to the findings of Manitowbi and Shawande (2011) and Issak and Marchessault (2008), all kweok made direct or indirect references to a traditional holistic view of health, and the four aspects of health being mental, emotional, physical and spiritual. Consistent with the literature, balance of the elements of health were also important in health maintenance. Additionally, the connection of individual health was closely related to the health of the land and water (King et al., 2009; Fontaine et al., 2019). Storytellers all expressed the importance of being on the land, and expressed health as being beyond the physical. Even things that are seen as physical, such as going for a walk in the bush, were underscored with a connection to the natural world, such as connecting with animals and surroundings, with being on the land ceremony in itself. This relationship with the land is consistent with the literature from Fontaine et al., (2019), and Manitowbi and Shawande (2011).

Related to balance and the life-course perspective (Reading & Wien, 2009), is the importance of time to Anishinaabe health. There is the concept of mino-bimaadiziwin, which translates closely to living in a good way, or on a good path (Bedard, 2008). Living in mino-bimaadizin also means to live in a way that is fulfilling (Debassige, 2010). Living in mino-bimaadizin connects to the categories within the theme of time of having purpose, direction or routine. Combining ideas of balance and mino-bimaadiziwin is the ongoing maintenance of health and being in balance.

Manitowabi and Shawande (2011) identified traditional medicine as a path towards health and healing. This is reflected in the storytellers' conceptions of health, as all kweok spoke about feeling healthy when they were in ceremony and partaking in other cultural activities. For example, stories about being in the sugar bush had elements of physical activity, cultural connectedness and connection with family. Being in the sugar bush is a great example of land-based healing. Embedded in cultural tradition and ceremony is connecting with family and community.

Self was a major theme in health, which is closely linked to identity. In the literature review, loss of identity was a result of the fallout of colonial events and has contributed to the poor health of Anishinabek (Waldram et al., 2006; King et al., 2009). Identity and positive ideas about self contributed to the storytellers' health because it gave them the confidence to try new things, allowed them to be positive role models, take care of themselves and to learn new things. A new finding, not reflected in the literature is that the storytellers felt healthy when they could be themselves and live their truth. Consequently, when the storytellers felt dismissed or unheard, they felt unhealthy, and that treatment did damage to their spirit. For example, one of the storytellers discussed feeling like the people around her were not listening to her or acknowledging their actions, resulting in her spirit being hurt. Additionally, the storytellers shared manifestations of health, which also is not reflected in the literature. Feeling the spirit of anxiety and depression was explained by one kwe, which related to another that felt unhealthy when she was carrying pain 'inside'. Stress was also connected to creating physical pain.

In sum, ideas of health from the literature such as holism, balance and connections with others and the land (King et al., 2009; Manitowabi & Shawande, 2011; Craft & Lebihan, 2021) were discussed by the storytellers. The intersection between identity and health was also

discussed. Novel ideas, not previously reported in the literature are the impacts on health and wellbeing that arise from how a person is treated. This exploration of conceptions of health highlights the importance of integrating culturally relevant frameworks and addressing systemic barriers in the health care system.

Experiences

The literature review spanned over 20 years, and Anishinaabe kweok are still having the same issues accessing health care as they did in 2001. The first major theme was interactions, which emerged from asking storytellers to share stories about health care visits, which had the subthemes of self and outside of self. Preparing to defend oneself or to hear bad news was not seen in the literature review. However, two of the storytellers reflected transforming themselves in terms of appearance, as seen in the study by Browne and Fiske (2001). Both of these participants discussed purposely not wearing Indigenous clothing and jewelry, as well as not self-identifying as Indigenous (Waldram et al., 2006). Two storytellers related looking less Anishinaabe to receiving better treatment by health care providers and support staff, similar to the women in the study by Browne and Fiske (2001), in which women explained they transformed their appearance and behavior. In addition, in the study done by Kurtz et al., (2024) the women shared that they felt they were treated differently if their health care providers knew they were Aboriginal. Not reflected in the literature is preparing to hear bad news. Two of the storytellers shared that they prepare to defend themselves when accessing health care, which was also not seen in the previous literature. These kweok also described experiences in which they were not believed, which will be discussed later. Most of the storytellers shared times in which they had to advocate for themselves or family members, embodying self-determination. Self determination was expressed through storytellers educating themselves so they could advocate

for themselves and others, as well as acting as educators to health care providers. Having to advocate for yourself is linked to not being believed. Some of the storytellers shared feeling vulnerable, or powerless when accessing health care, which is seen throughout the literature (Browne & Fiske, 2001; Bartlett & Boyer, 2017; Buchner et al., 2022).

A major part of the literature review was racial profile and racialized interactions, as well as the poor treatment that was associated with it. Four of the storytellers' experiences included directly racialized interactions, with three of those situations being found in the literature: assumptions of substance use, being treated differently based on being Anishinaabe and stereotyping (Browne et al., 2001; Kurtz et al., 2014; Bartlett & Boyer, 2017 & Fontaine et al., 2019). Inequitable and unfair treatment were highlighted many times throughout the literature review, underscoring the fact Anishinaabe women are still having negative experiences, marked by being undervalued and unaccepted, not being listened to or believed, and with unprofessional treatment. Two storytellers shared that they felt like they were just another patient that the providers had to get through; one of them attributed this characteristic to Westernized institutions. Not being believed or ignored can have serious consequences, which was highlighted in Kai's story – having her pain being believed result in early intervention, preventing cancer. Unsurprisingly, but importantly, positive interactions were the opposite; storytellers reflected on the importance of being listened to, which results in receiving health care. Two of the storytellers shared stories that were positive, in which the interactions were rooted in kindness and truth.

The loss of culture impacted health (King et al., 2009) and traditional knowledge, as well as access to traditional ways of healing being identified as improving health (Issak & Marchessault, 2008; Manitowabi & Shawande, 2011; Fontaine et al., 2019). The stories in which women felt

provided for when they were offered traditional health options and access to cultural programming, speaks to the need for traditional knowledge and cultural programming to be available in health care. However, it is important to note that traditional programming is usually reflective of the territory it is hosted on. For example, programming within Sudbury reflects Anishinaabe (specifically Ojibwe) philosophies, ceremony and general approach to programming. As discussed in the literature review, programming and health care can be subject to pan-Indigenizing, when resources are present as Indigenous and not specific. This was reflected by Kai, who noted that where she is located the traditional programming and health care services are Mohawk, which still provided her a safe place to seek health care. Lastly, one of the kweok did not appreciate being directed to an Indigenous counselor, but also recognized the value and importance of Indigenous care providers later in her journey.

Being comfortable with health care providers or having a sense of familiarity was found in the literature review (Browne et al., 2001; Burnett, 2020). This finding is upheld in the current study, with the majority of kweok sharing that having a positive experience involves having a familiar health care provider.

A level of cultural congruency and the importance of access to culturally appropriate care has been discussed throughout. However, one kweok shared her story about having a negative experience in an Indigenous health care facility and was uncomfortable, and felt conflicted about that experience.

The final defining element of health care experiences was the outcome. Similar to the women in the heart health study (Fontaine et al., 2019), two kweok shared that their negative experiences drove them to be the change, with one changing her course to go to medical school and the other being an advocate. As seen in the literature, negative experiences accessing health care resulted

in patients not wanting to go back to the service (Browne et al., 2001; Denison et al., 2013; Kurtz et al., 2014; Bartlett & Boyer, 2017; Burnett et al., 2020). This was reflected in the results of the current study with most of the kweok sharing that having negative experiences impacted their choice to seek out health care, or resulted in them avoiding health care overall. In this study, the kweok that had positive experiences resulted in them feeling hopeful and wanting to go back. This is an important piece to preventative health care, as well as building trust between health care providers and Anishinaabe kweok.

In the study on tubal ligation, Bartlett and Boyer (2017) recommended that treatment options need to be well-explained. In the current study, not being given options, or having unclear next steps contributed to a negative health experience. On the other hand, storytellers felt provided for when they were understood and able to express themselves. Over half of the storytellers filed complaints, however two of the storytellers did explain the possible consequences of going through the complaints process. For example, there are few doctors in rural settings, and there may not be another one to go to, or it may result in poor treatment. These stories highlight the need for culturally safe, inclusive, and responsive health care practices.

Dreams for the Future

Dreams connect us to the past as well as the future. Indeed, the Anishinaabe kweok that came before us were heavily impacted by legislation and child welfare, continuing to the present day. The storytellers called for change in two major areas, approach and education. Firstly, health care access must be equitable. This means that access to health care and the treatment received, cannot be based on income, status, race or appearance. Part of equitable health care access is the unique transportation needs of those living in northern communities, similar to the findings of Burnett et al. (2020). Cost related issues were mentioned by one storyteller and should be

expanded on in future studies. The study done by Manitowabi and Shawande (2011), supports the need to expand traditional programming, which was reflected by almost all of the participants expressing that culture is an important component to health care access. Further, having the opportunity to access cultural health care supports the need for self-determination when seeking health care. Some storytellers cared about the need for specific places within health care settings in which Anishinabek can feel safe. Food in relation to health came up twice during the literature review (King et al., 2009; Fontaine et al., 2019). Food as a route to health was expressed in concepts of health, as well as two of the storytellers underlining the need for food programming. Next, health care must uplift self-determination and be based on an individual's needs. Health care reflecting the needs of the individual was one of the dreams for the future of health care. As reflected by King et al. (2009), health care for Anishinabek must reflect Anishinaabe values. Lastly, health care must be safe. The stories shared resulted in untreated conditions, and some of the stories shared about others, death. Health care must be kind, gentle and respectful, and Anishinaabe kweok should not feel fear when trying to access health care. Two of the storytellers relayed the importance of accountability within the health care system. Moving forward, recommendations for education were made for health care providers, policy makers, Anishinabek and their communities. This education must include Anishinabek and Anishinaabe kweok perspectives, as well as be continuous. Educating health care providers can close the gap of understanding between them and their Anishinaabek patients, as well as for policy makers, so that they can better understand the histories that shaped the current health care systems and the issues that need to be addressed. Education for the Anishinaabek community is rooted in traditionalism, in which the community holds the knowledge needed to help each other (McGuire, 2013).

Dreams reflected needing to increase community knowledge of health care, and personal knowledges in health care. This increase in knowledge can also help substantiate sovereignty over our health and related policies. In addition, Anishinabek need more education on health systems navigation and how to litigate or approach the complaints process. This navigation needs to be done in a way that supports Anishinabek in the health care system, with institutions that are truly trying to improve their health care delivery – otherwise the complaints process is meaningless regardless of how accessible it is. These dreams highlight the need for the commitment to health care that honors Anishinaabe values, fosters respect, and empowers individuals and communities.

Summary of Findings

Storyteller's conceptions of health were rooted in an Anishinaabek view, with aspects of holism and balance. Connecting with the land and water, as well as family and community played an important role in the maintenance of health.

The experiences that Anishinaabe kweok are having accessing health care are defined by interactions, environment and outcome. Negative experiences had elements of discrimination, stereotyping and power imbalance. Positive experiences had elements of honesty, familiarity, and feeling provided for. How a person was treated while accessing health care impacted their decision to seek health care in the future.

The storytellers' dreams for the future included education for Anishinabek and communities, as well as health care providers and policy makers. Other areas of change are the ways in which health care is approached.

Research Implications

The purpose of this research was to understand concepts of health as explained by Anishinaabe kweok, the experiences these kweok have accessing health care and their dreams for the future of health care access, so that health care providers and policy makers can support and develop health care programming for Anishinabek that is rooted in an Anishinaabe framework, allowing for healing of Anishinabek to be determined by Anishinabek (Hill, 2014). In this study, several Anishinaabe kweok expressed that having negative experiences accessing health care impacted subsequent visits, which sometimes resulted in worsening conditions, delays in receiving a diagnosis, and hesitancy to access future health care. This finding clearly supports the need to improve the experiences Anishinaabe kweok are having accessing health care in Westernized institutions, which in turn can lead to better health outcomes and quicker treatment. The approach or framework used to improve these experiences, and interactions when Anishinaabe kweok access health care, must reflect Anishinaabe conceptions of health to effectively deliver health care that aligns with needs of Anishinaabe kweok. The vision for how health care would be ideally delivered was clearly outlined by the kweok that shared their stories. Health care must be equitable, holistic, self-determined and safe. The changes that can contribute to this ideal access to health care services are education for health care providers and policymakers, as well as Anishinabek people and community. Central to the education needs of providers and policymakers is how to offer care that is culturally appropriate, and trauma based, and is delivered continuously or in an on-going model. For the Anishinabek people and community, education needs to be centered on building community knowledge, especially in terms of health care to support one another. In addition, Anishinabek people need ways to gain more knowledge in health care navigation.

Recommendations

Based on the findings of this study, there are four areas of proposed recommendations: health system, clinical practice, policy and programs, and community. The first recommendation for the health system is to integrate Anishinaabe conceptions of health into service design. For example, developing models of care rooted in holism that value the connection between Indigenous people and the land through land-based health interventions. Next is for the health system to support cultural continuity and identity in care. This can be done by having specific cultural programming. The last recommendation for the health system is to support safe and equitable environments. This can be done by training health care professionals in cultural safety, including Indigenous values in policy, and creating Indigenous-specific spaces in the hospital setting. Indigenous specific spaces may include a space to smudge, or access cultural medicines. Clinical recommendations start with respectful interactions and clear communication. For example, using cultural safety training, health care providers can avoid assumptions based on race, appearance or Indigeneity. Communication with Indigenous patients, especially around options, next steps, and possible outcomes must be clear. A process needs to be in place where people can complain and compliment their experiences, creating real-time feedback. Lastly, more primary health care providers may assist in building relationship between Indigenous people and their health care provider. Policy and program recommendations include increasing funding for cultural healing programs and Indigenous health system navigators. Policy must be reviewed and revised to support self-determination in health. Lastly, those that make policy-level decisions must have training on Indigenous history and cultural safety. Community recommendations include strengthening community health knowledge and empowering youth and families. Community health knowledge can be strengthened through health education

workshops, and community-led resources for health care navigation, patient advocacy and filing complaints. Indigenous youth can be empowered by mentorship opportunities in the health care field, which could also increase the number of Indigenous health care professions. Families can be involved in care to reinforce community-based healing models. Within the health system, clinical practice, policy and programs, and community, there are many recommendations that can support Indigenous health moving forward.

Study Limitations and Strengths

For this study, only two of the seven participants participated in the member checking process. Though the small sample size allowed for long storytelling sessions, a larger research team could support more storytellers and therefore increase the number of participants. A better approach could be using participant-based research techniques, such as ongoing check-ins, which could enhance the quality of participant narratives and improve the relationship between the researcher and the participant (Chase, 2017). Due to geographical proximity and limited funds, some storytelling sessions we held virtually. Virtual sessions were subject to technical difficulties. In addition, virtual sessions lacked the opportunity to connect with storytellers through casual conversation, smudging and sharing food.

This study could be improved on by focusing on specific intersections of identity. For example, narrowing the study criteria to Indigenous women with children and their experiences accessing health care for themselves and their children. Another intersection that could be explored are Indigenous women living off-reserve in a different territory, for example a Cree woman living in a city in Ojibwe territory. Lastly, this study could be replicated with Indigenous men.

There are a few strengths in this study worth mentioning. First, as a graduate student it is important to remember why I do research. This research is close to me, starting with the stories of health and healthcare within my own family. Throughout the thesis process, the stories shared by the storytellers were treated like medicine, they were cared for and respected. Next, the methodology that was used included storytelling, an Anishinaabe approach to research and tradition that should continue to be valued. Lastly, bracketing was an essential component to utilizing hermeneutic phenomenology, making the listener aware of her own potential biases.

Conclusion

As stated by Smylie and Allen (2015), not only is it important to share stories, but we must share stories of change, so we become the authors of our own stories and the makers of our own change. Too often, negative depictions of Anishinabek overshadow our truth, which impacts health care delivery.

Ceremony, language and cultural approach was at the forefront of the research methodology. Seven powerful Anishinaabe kweok shared their stories accessing health care for this study. Their stories primarily took place in Westernized institutions. Adding context, these women also shared what health means to them and their dreams for health care access. Using a research approach that is strongly situated in an Anishinaabe paradigm, ceremony, language and a cultural approach was at the forefront of the methodology. The bottom line is that Anishinaabe kweok, despite some improvement in policy and access to culturally appropriate health centres, are still having negative experiences accessing health care, contributing to negative experiences and in some cases contributing to worsening conditions, delays in diagnosis, and hesitancy to seek future health care. Lessons from positive interactions and listening to how Anishaabe kweok

envision the future of access to health care need to be implemented to improve health care for Anishinaabe kweok, and all our relations.

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APPENDICES

Appendix A

Maamwizing Indigenous Research Institute Letter of Support

June 15, 2023

To whom it may concern,

Re: Support for Master's Thesis

As Proposed by: Ophelia O'Donnell

This letter confirms that Maamwizing Indigenous Research Institute (MIRI) supports Ophelia O'Donnell's thesis project titled, *The Experiences of Anishinaabe Kweok (Indigenous Women) Accessing Health Care in Northern Ontario: A Phenomenological Study*.

After meeting with Miss. O'Donnell, a discussion of OCAP Principles ensued, resulting in the following:

1. Ownership
 - a. Though the data for this project will be stored on Laurentian University servers, MIRI will act as a steward over the data. This includes management and oversight.
2. Control
 - a. Maamwizing has been and will continue to be heavily involved in the progress of this project. This includes, but is not limited to, evaluating research techniques, reading over drafts and making recommendations consistent with an Anishinaabe research outlook and principles.
3. Access
 - a. First Nations' communities and organizations have the right to access data about themselves. To this end, other First Nations' communities and organizations may access the research data for their own use through application with MIRI.
4. Possession
 - a. MIRI asserts their right to control the data resulting from this study. Through this mechanism ownership of the data can be asserted and protected, as well as shared with the appropriate parties.

Regards,



Nicole Wemigwans, PhD Candidate, MSW RSW

Maamwizing Co-Director

Appendix B

Henvey Inlet First Nation Letter of Support

May 15, 2023

To Whom It May Concern,

Re: Support for Master's Thesis

As Proposed by: Ophelia O'Donnell

This letter will confirm that Henvey Inlet First Nation approves of and fully supports the Master's Thesis project entitled, The Experiences of Anishinaabe Kweok (Indigenous Women) Accessing Health Care in Northern Ontario: A Phenomenological Study.

It is understood that this project will be guided by the following principles: ownership, control, access and possession (OCAP) as set out by the First Nations Information Governance Centre (<https://fnigc.ca/ocap-training/>) as well as, utility, self-voicing, access and inter-relatedness (USAI) as set out by the Ontario Federation of Indigenous Friendship Centres (<https://ofifc.org/research/>).

Furthermore, it is understood that this researcher will send project updates to HIFN for feedback and revisions, if required. And, that HIFN will have access to non-identifying data to use and inform our First Nation Health Care programming. And, that the results of this project can inform our First Nation regarding issues related to women accessing health care and how women want to improve this access.

It is also understood that this project is based on the voice of Anishinaabe kwe and that these stories are intended to provide grassroots solutions to Westernized institutions and to improve other initiatives.

HIFN is also willing to read drafts of this project to ensure that it is reflective of Anishinaabe kwe from this area. Finally, HIFN has agreed to provide financial support for this project as discussed between Miss. O'Donnell and the HIFN Education Counsellor.

Genevieve Solomon Dubois
HIFN Education Counsellor

Appendix C
Ethical Approval



APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

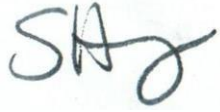
TYPE OF APPROVAL / New x / Modifications to project / Time extension	
Name of Principal Investigator and school/department	Ophelia O'Donnell (Graduate Student, Psychology), Dr. Elizabeth Levin (supervisor) Dr. Joey-Lynn Wabie (Co-Investigator), Diana Urajnik (Co-Investigator)
Title of Project	The Experiences of Anishinaabe Kweg (Indigenous Women) Accessing Health Care in Northern Ontario: A Phenomenological Study
REB file number	6021385
Date of original approval of project	Oct 31, 2023
Date of approval of project modifications or extension (if applicable)	
Final/Interim report due on: (You may request an extension)	Oct 31, 2024
Conditions placed on project	

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your

research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.

A handwritten signature in black ink, appearing to read 'SHoy', is positioned above the typed name.

Sandra Hoy, PHD, Chair, *Laurentian University Research Ethics Board*

Appendix D

Recruitment Script

Aanii (Hello),

My name is Ophelia, I am a Master's student at Laurentian and a member of Henvey Inlet First Nation. I am looking for Anishinaabe kweok (Indigenous women), that live in Northern Ontario, to share their stories about accessing health, what it means to them to be healthy and dreams for the future of health care access. You will be asked to participate in a storytelling visit, guided by questions. The storytelling visit is expected to last 1-2 hours.

If you would like to participate in this study or if you have any questions, please email me, Ophelia O'Donnell bodonnell1@laurentian.ca.

Appendix C

Informed Consent to Participate in a Research Study

Full Study Title: The Experiences of Anishinaabe Kweok (Indigenous Women) Accessing Health Care in Northern Ontario and Dreams for the Future: A Phenomenological Study

Principal Investigator: [Ophelia O'Donnell](#)

Supervisor: Dr. Elizabeth Levin

Contact Information: 1-705-675-1151 ext. 4242 (Laurentian University has a toll-free number: 1-800-461-4030)

Email: bodonnell1@laurentian.ca

Partners: Henvey Inlet First Nation, Maamwizing Indigenous Research Institute

Informed Consent

You are being asked to consider participating in a research study. This form explains the purpose of this research study, provides information about the study procedures, possible risks and benefits, and your rights as a participant.

Please read this form carefully and ask any questions you may have. The researcher will explain this form and all information concerning the study to you verbally.

Participating in this study is your choice (voluntary). You have the right to choose not to participate, and you have the right to withdraw from the study and stop your participation at any time. You may notify the researcher if you wish to stop participating in the study by telling the researcher you would like to stop. If you say you would like to stop, the researcher will confirm with you by asking, "Would you like to withdraw?". If you indicate yes, we will immediately stop. If you decide to stop participating, your data will be removed and there will be no penalty to you.

INTRODUCTION

You are being asked to consider participating in this study because you are an Indigenous woman, living in Northern Ontario and are between the ages of 25 and 50.

WHY IS THIS STUDY BEING DONE?

The purpose of this study is to understand Anishinaabe kweok conceptions of health, their experiences accessing health care and dreams for the future of health care access for Anishinaabe kweok.

WHAT WILL HAPPEN DURING THIS STUDY?

You will be asked to: Participate in a one-on-one story telling visit and follow up. During the story telling visit, you will be asked to share things related to what it means to be healthy, your experiences accessing health care and what you would like to see change in terms of access to health care. The purpose of the follow up is to make sure that you feel like your story is accurately reflected, and will be changed according to your suggestions. The storytelling visit will take approximately one and a half hours to complete and will be audio recorded.

WHAT ARE THE RISKS OR HARMS OF PARTICIPATING IN THIS STUDY?

There is a risk of: discomfort while participating in this study.

If you experience a side effect or complication after participating such as discomfort or sadness, please contact indigenoushealth@hsnsudbury.ca or Nogdawinamin at 1 (800) 465 0999.

There are no medical risks to you from participating in this study, but it is possible that a question we ask may be stressful for you or make you uncomfortable. You do not need to answer questions that make you uncomfortable or that you do not want to answer.

WHAT ARE THE POTENTIAL BENEFITS?

You may not benefit directly from participating in this study. By participating you will have the chance to share your experiences, which will add to the understanding of Anishinaabe health and contribute to shaping policy related to Anishinaabe health.

ARE STUDY PARTICIPANTS PAID TO PARTICIPATE IN THIS STUDY?

You will be paid \$50 in the form of an honorarium, even if you decide to withdraw from the study.

HOW WILL MY INFORMATION BE KEPT CONFIDENTIAL?

All information that is collected, used, or disclosed for this study will be handled in a confidential manner. Anything that you say or do in the study will not be linked to you personally. Non-identifying data may be accessed by Henvey Inlet First Nation to inform programming. Additionally, with respect to Indigenous research protocols, Maamwizing Indigenous Research Institute will act as a steward over the data, including management and oversight. Anything that we find out about you that could identify you will not be published or told to anyone else unless we get your permission. Reports based on the gathered data will not contain information that might link you with a particular quote, unless your permission has been given. The information obtained will be stored in Laurentian University's secure cloud, which will be accessible to the investigator, supervisor and the committee members guiding this research. The data will be password protected. The file in which the interview audio, demographic information and transcripts will also be held in Laurentian University's secure cloud. The information (raw data) will be kept for five years, then deleted using a digital file shredder.

WHAT ARE THE RIGHTS OF PARTICIPANTS IN A RESEARCH STUDY?

You have the right to receive all information that could help you make a decision about participating in this study. You also have the right to ask questions about this study and your rights as a research participant, and to have them answered to your satisfaction, before you make any decision. You also have the right to ask questions and to receive answers throughout this study.

If you have any questions about this study, you may contact the person in charge of this study, Dr. Elizabeth Levin, elevin@laurentian.ca

If you have questions about your rights as a research participant or any ethical issues related to this study that you wish to discuss with someone not directly involved with the study, you may call **Research Ethics Officer, Laurentian University Research Office**, telephone: 705-675-1151 ext. 3681, 2436 or toll free at 1-800-461-4030 or email ethics@laurentian.ca

DOCUMENTATION OF INFORMED CONSENT

You will be given a copy of this informed consent form after it has been signed and dated by you and the study staff.

Full Study Title: The Experiences of Anishinaabe Kweok (Indigenous Women) Accessing Health Care in Northern Ontario and Dreams for the Future: A Phenomenological Study

Name of Participant: _____

Participant/Substitute Decision-Maker (*only if relevant*)

By signing this form, I confirm that:

- This research study has been fully explained to me and all of my questions answered to my satisfaction
- I understand the requirements of participating in this research study
- I have been informed of the risks and benefits, if any, of participating in this research study
- I have been informed of any alternatives to participating in this research study
- I have been informed of the rights of research participants
- I have read each page of this form
- I have agreed, or agree to allow the person I am responsible for (*only if relevant*), to participate in this research study
- I agree to be audio or video recorded. (*Include only if appropriate to the study design*)
- I would like to receive a summary of the research findings

_____	_____	_____
Name of Participant (print)	Signature	Date

Contact email for summary of results _____

_____	_____	_____
Name of Person Administering (print)	Signature	Date

it means to be healthy.

Can you tell me what it means to you to be healthy?

Can you tell me more about this?

Can clarify what this means?

Why do you think this?

Is there anything else you would like to add?

Can you tell me what makes you feel healthy?

- Can you tell me what makes you feel unhealthy?

Can you tell me about a time you felt particularly healthy?

- Unhealthy?

Can you explain this more?

Can you clarify this?

Can you give me an example?

How do definitions of health differ for Anishinaabe kweok than other people?

Why do you think this is? Why is this important?

Can you give me an example?

Is there anything you would like to add about what it means to you to be healthy as an Anishinaabe kwe?

“Now, I am going to ask about some of your experiences accessing health care. You can share any experiences you want to. “

Providing starting point

Do you usually have a positive or negative experience when you access health care?

The participant’s story about accessing health care.

Can you share a negative/positive (based on answer above) experience you had accessing health care for yourself?

Can you give me an example?

- How did you feel in that space?
- Who was involved?
Can you describe the interaction with them to me?
How did they behave towards you/ people you were with?

Can you tell me more about this?

How did this make you feel?

How did you feel when this happened?

- How did you feel after?
- How does that experience impact you now?
- Do you feel like you were provided for?
- Is there anything else you would like to add?

Why do you think this happened?

Is there another positive/ negative (same as above) experience you would like to share with me?

- Same follow up questions as above.

Can you share a negative/positive (based on answer above) experience you had accessing health care for yourself?

- How did you feel in that space?
- Who was involved?
Can you describe the interaction to me?
How did they behave towards you/ the people you were with?
- How did you feel after?

Can you give me an example?

Can you tell me more about this?

- How does that interaction impact you now?

How did this make you feel?

- Is there anything else you would like to add?

How did you feel when this happened?

Is there another positive/ negative (same as above) experience you would like to share with me?

Why do you think this happened?

- Same follow up questions as above.

To make sure that the participant can add anything they feel they need to.

Is there anything else you would like to add to the stories you shared with me?

“Now I am going to ask you about your dreams for the future of health care access for Anishinaabe kweok”.

Looking towards the future.

What are your dreams for the future of access to health care for Anishinaabe kweok (Indigenous women)?

Can you give me an example?

Can you clarify this?

- What does this look like?
- Who does this help?
- What has to happen for this change to happen?
- How do you think this will improve health for Anishinaabe kweok?

Why do you think this?

How else do you think access to health care for Anishinabek can be improved?

Closing question

Is there anything you would like to add or elaborate on?

Do you have any feedback about the storytelling visit?

Appendix G
Debriefing Script

The Experiences of Anishinaabe Kweok (Indigenous Women) Accessing Health Care in Northern Ontario and Dreams for the Future: A Phenomenological Study

Ophelia O'Donnell

bodonnell1@laurentian.ca

Miigwetch for your participation in this study. If you have any additional questions or would like to follow up, you can email me at bodonnell1@laurentian.ca. The purpose of this study is to understand Anishinaabe kweok conceptions of health, their experiences accessing health care and dreams for the future of health care access for Anishinaabe kweok.

Though deception was not involved in this study, it is possible to feel some discomfort about answering questions related to the Anishinaabe life experience. If you would like to contact a counselor you can contact counseling services at indigenoushealth@hsnsudbury.ca or Nogdawindamin at 1 (800)-465-0999.

The consent form that you signed at the beginning of the study stated that the storytelling visit was recorded and will be stored without identifying information. If you have become uncomfortable with that, please let me know, you can still withdraw from the study and the recording will be deleted using a digital shredder.

The next step is to look at all of the stories and make sure the listener understands what was told to them. Then you will be contacted to reflect on the results and the listener will make changes so that the results truly represent the storytellers. After, a summary will be written.

Do you have any follow up questions or comments at this time?