Iskwĕwak Mīwayawak

Women Feeling Healthy

Multiple Exposures:

An Environmental Scan of
Miwayawin Health Services
regarding healthy body weight and body image

EXECUTIVE SUMMARY

25 January 2008

University of Saskatchewan

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EXECUTIVE SUMMARY

Background and Purpose
This environmental scan is part of the larger project "The Cultural and Visual Context of Healthy Body Weight and Body Image among Aboriginal Women in the Battlefords Tribal Council Region" that is funded by the Canadian Institute for Health Research (CIHR). Obesity and its associated health risks have been identified as areas of concern for First Nations women. Little is known about the visual, gendered, historical and cultural meanings or experiences of healthy body weight and healthy body image for Aboriginal women. The goal of this research is to identify, analyze and disseminate local knowledge about the cultural and visual contexts of healthy body weight and healthy body image from the perspective of First Nations women in the region.

Environmental Scan:
Currently, research team members from both University of Saskatchewan and Miwayawin Health Services are conducting an environmental scan relating to the issue of healthy bodies and healthy body image of women within the Battlefords Tribal Councils region. This scan began in August, 2007. The purpose of the environmental scan is to identify practices, programs and policies to understand: What has already been done; where are we now; and where do we want to go?

The environmental scan and this executive summary report consist of the following components:

- **A.** Findings: Consultations with Community Stakeholders from the Battleford Tribal Councils Communities, Field Notes and Available Materials from Miwayawin Health Services:
    1. An inventory of concerns/ideas related to healthy bodies and body image;
    2. An inventory of concerns/ideas related to social determinants of health, cultural and historical contexts of health;
    3. An inventory of information and resources about practices, programs and policies about healthy body weight and image in the BTC region;
    4. Battleford Tribal Councils and Miwayawin stakeholders hopes for the study;
- **B.** Key observations and responses to the project
- **C.** Conclusions

A. FINDINGS: CONSULTATIONS WITH COMMUNITY STAKEHOLDERS:

In the consultation interviews with the community stakeholders, four main areas were addressed: 1) health issues; 2) psycho-social and social determinants of health; 3) programs and services offered by Miwayawin Health Services; and 4) stakeholders hopes for the study.

1. HEALTH ISSUES AND DEFINITIONS OF HEALTHY BODIES:

Themes related to definitions of healthy bodies and image and health issues that were raised by the stakeholders included; 1) obesity (in adults and children) and overeating; 2) body image and eating disorders; 3) illnesses such as diabetes, heart disease and kidney failure; 4) quality of life concerns; 5) healthy body size versus media body size; and 6) 'health' as more than healthy bodies and body images. We address three here.

1.1. Obesity and over-eating:

Stakeholders in all of the community consultations identified being overweight and over-eating as a key concern in the communities—yet, one which is identified by some as becoming more socially acceptable.

> …being overweight is becoming more accepted. There are so many overweight people in our communities. Even the young people. When I was growing up on the reserve there were very few overweight people … both youth and adults.

1.2. Diabetes, Heart Disease, Kidney Damage and Related Illnesses:

The concern regarding stigmatization for weight seemed to be around health and quality of life, rather than appearance. This is reflected in concerns about diabetes, heart disease, kidney damage and quality of life concerns (including behavioral concerns for youth).

1.3. Healthy Body Size versus Media Body Size:

Although stakeholders discussed health problems related to obesity, they were very careful not to link their definition of what a healthy body looks like to the slim body.

> We don't want to look at people who are thin and say that they are healthy because they are not. They might be smokers or they may be taking drugs and things like that. And there is a reason sometimes that people with these addictions are very thin. And so, it is not to confuse thin with health.

2. SOCIAL DETERMINANTS OF HEALTH:

Many social determinants of health were identified, which were seen to influence and/or be related to the health bodies and body image. Six key themes identified were: 1) economics, poverty and employment; 2) physical environments/geographic barriers; 3) history, culture and exercise norms; 4) history, culture and nutrition; 5) family and work-life responsibilities; 6) community crisis, strength and resilience.

2.1. Economic Factors/Employment and Healthy Bodies:

All of the stakeholders discussed unemployment, low income, poverty and meeting needs as a barrier to nutrition and health.

2.2. Physical Environments and Geographic Barriers:

Another barrier to healthy bodies is geographic and a lack of available facilities for physical activity. This included problems with transportation into the cities as well as problems with walking in the communities because of unpredictable dogs and unkempt roads, with youth sometimes driving recklessly.

> I'm a strong believer that we don't need a lot of resources you know… but even walking they have issues of poor roads and safety and unpaved roads and dogs that roam quite openly

2.3. History, Culture and Exercising:
Interestingly, exercise in the communities is seen as an anomaly, not normalized. These exercise norms have seemingly changed over time. There is less activity and more sedentary activities such as watching satellite television or playing poker.

> I think in the communities if you are doing it people are stopping to ask you if you want a ride. They don't get the fact that you are walking for the benefit of walking. It hasn't quite caught on.

2.4. History, Culture and Nutrition:
The history of healthy bodies in the communities helps link the problem of obesity to cultural, social and environmental issues. For example, gardening and hunting have become increasingly less common, yet both contributed to exercise and healthful eating in the past. There are also more stores in communities in the present day, with less affordable healthy choices—and more vehicles to get from place to place.

> As far as eating patterns…you ate because you were hungry …a survival thing.. and now food tends to be part of the culture… too much food and without physical activity… plays a big role.

2.5. Family and Work-Life Responsibilities:
Work-life responsibilities and family violence were linked by stakeholders to healthy bodies and lifestyle opportunities.

> …a lot of us women are basically raising our own children and raising our own grandchildren. …Because if they get really sick, who is going to look after the kids right? They do the cooking, cleaning, grocery shopping and could be working full time on the side.

2.6. Community Crisis, Strength and Resilience:
Community members deal with an inordinate amount of family crisis, including death and suicides.

> … I have clients, who given different circumstances, would be very ready to change, but they have had death after death after death after death. I can't imagine how they even keep going. It is like crisis after crisis after crisis after crisis. I might deal with a crisis every one or two years, but because of the community nature, it is

> not your personal crisis it affects your whole community. If it is your neighbor or another person in the community and it just …affects everything.

2.7. Education and Information
All of the stakeholders agreed that a lack of knowledge and skills (and time to develop these) contributes to problems with healthy bodies.

> If you don't know how to cook it is easier just to go out for meals, or to buy frozen, prepared food, that usually aren't …the easier things are usually not as healthy…higher fat, higher salt content and things like that.

3. PRACTICES, PROGRAMS AND SERVICES OF MIWAYAWIN HEALTH SERVICES:
Miwayawin Health Client Services Community Health Program, Home and Community Care and Department of Health Promotion promote holistic health, citing spiritual, social, physical and mental health as themes and program goals. (Annual Report, 2006-2007) Objectives related to healthy bodies and body image reflect this overarching theme towards holistic health, and are addressed through a number of programs run by the Miwayawin staff.

As noted in the Annual Report for Miwayawin Health Services (2006-2007) and through interviews with staff involved, programs reflect; 1) nutritional needs; 2) exercise and physical activity 3) school programs; 4) social, environmental and political needs. There is also a work philosophy that reflects culturally appropriate and non-judgmental principles. This section summarizes (briefly) some of the Miwayawin Health services and work principles.

3.1. Nutritional Needs:
Programs that address nutritional needs are done by: ensuring fresh food is available through fresh food boxes and providing food vouchers; offering nutritional assessments, counseling, education; home support by community nutritionists, chronic disease management and prevention (and more). Stakeholders spoke of many of these programs with enthusiasm.

3.2. Exercise programs and initiatives:
Miwayawin health service also supports exercise programs and healthy lifestyles. There are: exercise leaders; initiatives to train community exercise leaders; walking groups; Sadie's walk; initiatives in schools; and more.

3.4. Social/environmental and political:
There is a strong community development approach into program planning. This is evident in programs, for example, through: Cooks training; MOAUIPP and DREAM.

3.5. Work Philosophies (Culturally acceptable/non-judgmental):
Stakeholders discussed the importance of culturally acceptable ways of working with people in the communities—linking many of the barriers noted above, with program

goals. This involved meeting people where they are at, rather than inflicting their own personal work goals.

> It is trying to meet people where they're at and give them bits and pieces that they can fit into their life. And the struggle that I have is that sometimes we get so formal in what we do, that we forget that these people's lives are…many of their lives are affected by huge amounts of stress and strains. And we just think that they don't want to listen to us today. But I think geez…if I had all that going on in my life I wouldn't want to listen to you either.

3.7. Healthy Work Environment:
This positive and people focused work philosophy seems to make its way into the work environment. The stakeholders agreed that a very positive work environment is created at Miwayawin and that staff are committed to staying.

> …very strength based and that's what I love about here.

4. STAKEHOLDER HOPES FOR THE STUDY

Stakeholders felt the present study was needed/important: 1) as a community up approach to program effectiveness; 2) as a means to increase self-perception; 3) to enhance community sharing and mental health; and 4) towards making healthier and informed choices. We summarize two here:

4.1. Community-up Approach to Program Effectiveness:
Stakeholders were hopeful that this community based study may offer community input into what Miwayawin is doing, and help to assess programming effectiveness. They were very interested in learning what how women would define their own health and body image needs.

> …I would like to learn what people are thinking and how we can best support people in either maintaining their health or increasing their levels of health—both physically and in any other way.

4.2. Enhancing Community Sharing and Mental Health:
There were some hopes that a project like this may create an ongoing talking circle, where women can come and feel safe and talk about issues. This may also lead to increased self-awareness, esteem and maybe increased physical activity and healthy choices.

> I have always envisioned a gathering of women where they can come to a place where they feel safe to talk about their issues…and even just to have fun or even just to have even an hour of talking and ..to start some support –hopefully would work even in getting more physical activity.

B: INITIAL RESPONSES TO THE PROJECT:

This project has been enthusiastically received at a MHS staff day (June 7th, 2007) and at a Stakeholders meeting (September 24th, 2007, between Band Chiefs, collaborators from MHS, Health Portfolio Councilors and the U of S research team). There was a very positive, uplifting atmosphere at both meetings, full of laughter and personal stories. At the stakeholders meeting, the positive atmosphere resonated into ideas for changing the title of the study to reflect: 'feeling good all of the time', rather than 'feeling bad, sick and getting better'. Many people suggested that the project was not only worthwhile but may be "fun" and an opportunity for women in the communities to unite towards enhancing programming, communication and healthy living. There were insights shared about: the influence of the media on body image; historical changes from eating healthy wild meats and garden vegetables towards the present day increase in junk foods from stores, chemicals in products and the soil; increasing sedentary lifestyles; difficulties of breaking habits such as overeating; and community perceptions about weight and health. The conversations seemed quite lively.

Very helpful and practical ideas were presented about recruitment of participants—which have been incorporated into the project. These ideas included; the importance of childcare during meetings and the taking of the photographs; finding ways to reach all women who might be interested; and finding ways to involve all ages in the project.

C: CONCLUSION AND FUTURE DIRECTIONS:

The stakeholders identified the interdependence of social determinants of health as key factors in determining healthy body and healthy body image outcomes, focusing on root causes. The interviews, field observations and stakeholder meetings raised health concerns (related to healthy bodies) such as obesity and diabetes and showed their interrelationship to inequalities, poverty, economics, employment, mental health issues and infrastructural deficits. This research points to the importance of capacity building and community development.

In summary, this report identifies the importance of and goals related to: 1) infrastructural concerns; 2) recreational opportunities; 3) benefits of information and education; 4) importance of social supports—families, communities, (and problems with isolation, work-life balance, self esteem, suicide, addictions, crisis and death); 5) culturally relevant philosophies; and 6) social justice and health inequalities. Importantly, discussions on social justice and health inequalities are reflected in larger Saskatchewan and Canadian statistics as well.

1. Infrastructural deficits:
Discussions on infrastructural deficits revealed needs to improve road conditions, safe walking spaces and transportation. Issues of safety on the roads are critical. Respondents identified safety concerns related to dog packs and problems with youth driving.

2. Recreational opportunities:

The need to continue to support recreational programs and opportunities, including regular and increased support people/staff to encourage participation was also recommended.

3. Information/education:
The discussions about the importance of information and education, social support and access to healthy food also point to the successes of Miwayawin programs and the need for continued community development (and capacity building). Interviews revealed the need for continued health education related to; exercise, healthy eating/cooking and parenting/care-giving. Support for school programs related to health was also critical, as well as increased access to health care services.

4. Social Supports:
Issues related to mental health including; isolation within communities, problems related to work-life balance, self-esteem, suicide, addictions, stress and violence were also mentioned in relation to maintaining healthy bodies and healthy body images. Mental health seems to be both a healthy body outcome as well as a healthy-body determinant.

Although there is a high staff-client ratio when compared to off-reserve populations, there was still discussion on the need to hire more mental health nurses, diabetes educators and dietitians—to keep up with the communities need.

5. Culturally relevant philosophies:
The importance of culturally relevant protocols, non-judgmental approaches to care (practiced at Miwayawin Health Services) and increased social support programs are impressive and cited by stakeholders as critical to understanding their approach to services.

6. Social justice and health inequalities
Interviews and the larger statistics seem to point to the need for governmental policies to reflect residents concerns related to inequalities, health inequalities and on-reserve communities needs—at all levels of government; municipal, provincial and federal levels. Social justice issues related to inequalities, health inequalities and food security were also viewed as having a critical relationship to healthy bodies.

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ENVIRONMENTAL SCAN REPORT

Team Structure

Mīwayawin Health Services : Patricia Whitecalf, Marcella Bird, Susan Hartman, Sandra Favel-Rewarts, Janice Kennedy, Jessilee Kohut, Laurie Ironstand, Erin Stacey, Jacqui Hoppie, Joan Wentworth. Missing: Louis Churchman, Suzette Starr

U of Saskatchewan: Carolyn Brooks, Janice Kennedy, Jan Baxter-Jones, Roanne Thomas-MacLean, Laurie Schimpf, Sylvia Abonyi, Jennifer Poudrier, Jenn Shea Missing: Karen Chad

Acknowledgments:

This report acknowledges Miwayawin stakeholders, Battleford Tribal Councils Chiefs and Band Councillors for their support and their willingness to share their insights on individual, social, cultural and historical factors which may affect healthy bodies and their advice towards achieving successful Community Based Research. The expertise of Miwayawin Health Services and community stakeholders within the Battleford Tribal Councils communities, and their willingness to collaborate in this research has made this report possible.

REPORT

This environmental scan is part of the larger project "The Cultural and Visual Context of Healthy Body Weight and Body Image among Aboriginal Women in the Battlefords Tribal Council Region" that is funded by the Canadian Institute for Health Research (CIHR). Obesity and its associated health risks have been identified as areas of concern for First Nations women. Little is known about the visual, gendered, historical and cultural meanings or experiences of healthy body weight and healthy body image for Aboriginal women. The goal of this research is to identify, analyze and disseminate local knowledge about the cultural and visual contexts of healthy body weight and healthy body image from the perspective of First Nations women in the region.

Environmental scanning allows researchers to acquire and analyze information, events, emerging trends and developments in a given community (Choo, 1998). The purpose of this environmental scan is to identify practices, programs and policies to understand: what has already been done; where are we now; and where do we want to go? In this report, we summarize our methodology, stakeholder interviews, field observations and community research meetings.

The environmental scan and this report consist of the following components:

- **A.** An introduction to the study and an overview of the methodology;
- **B.** Findings: Consultations with Community Stakeholders from the Battleford Tribal Councils Communities, Field Notes and Available Materials from Miwayawin Health Services:
    1. An inventory of concerns/ideas related to healthy bodies and body image;
    2. An inventory of concerns/ideas related to social determinants of health, cultural and historical contexts of health;
    3. An inventory of information and resources about practices, programs and policies about healthy body weight and image in the BTC region;
    4. Battleford Tribal Councils and Miwayawin stakeholders hopes for the study;
- **C.** Findings: Observations from the field;
- **D.** Key observations and responses to the project: emerging from a stakeholders meeting, held on September 24th, 2007 in North Battleford between Band Chiefs, collaborators from Miwayawin Health Services, Health Portfolio Councilors and the research team from the University of Saskatchewan.

A. DATA COLLECTION AND METHODS

1. Data Collection: An Overview:

Data collection for this study involves three phases: *Phase one* is this environmental scan, which involved compiling an inventory of information and resources currently available—generated into this report. Currently, research team members from both University of Saskatchewan and Miwayawin Health Services are continuing to conduct this environmental scan, relating to the issue of healthy bodies and healthy body image of women within the Battlefords Tribal Councils region. This scan began in August, 2007. In *phase two*, Aboriginal women participants are empowered to document their own meaning of healthy body weight and image, sharing pictures, stories and lives. The components of this phase will: A) document the meaning of healthy body weight and healthy body image for Aboriginal women of different age groups; B) develop a better understanding of the role of visuality in the 'healthy body'; C) identify the local barriers and enablers to maintaining healthy body weight and healthy body image; D) provide a creative and empowering opportunity to contribute to the assessment and transformation of existing practices, programs and policies; and E) evaluate the project. *Phase three* provides the analysis and interpretation of the data and the establish priorities for improving and transforming programs where necessary; an important goal of this project.

2. Data Collection: The Environmental Scan:

Our approach to data collection for this environmental scan included informal interviews of key stakeholders as well as field observation, systematic field notes and meetings with the Battleford Tribal Councils communities. Between August, 2007 and October, 2007, the research team visited the community 4 times, 8 people in the Battlefords Tribal Councils region were contacted and completed a recorded qualitative interview. We detail the specific interview process here.

There were two separate components of the interviews. First, specific programming information was gathered. Second, stakeholders were asked to answer semi-structured interview questions, and were encouraged to speak openly about their own perceptions of healthy bodies, their history and involvement within the communities, their perceptions (professional and personal) of healthy bodies and body image. They were also asked to address their ideas about the cultural and historical contexts of health and body image, including barriers and enablers of the healthy body in the Battleford Tribal Councils communities.

To help the interviews stay focused, the interview guide contained six core questions meant to uncover the participants' knowledge, ideas and experience about and with the Battleford Tribal Councils communities. Under each core question are several prompting questions that were used only when necessary and appropriate. The expected duration of the interviews was one hour. However, four of the interviews lasted two hours.

The community stakeholder interviews were chosen in consultation with a team of community stakeholders, employees of Miwayawin Health Services, invited by Janice Kennedy, the Executive Director of Miwayawin and co-investigator or this research project. The choices of interviewees were made to cover all of the 8 communities and a range of programming related to healthy bodies and body image. Stakeholder interviews were done with the Executive Director, and women from four different departments/areas at Miwayawin Health Services—community research, health promotion and planning, home and community care and child day care. Six of the eight interviews were done with women who worked in all 8 of the communities. The remaining two interviews were done with women who worked solely in the communities of Moosmin and Saulteaux.

B. FINDINGS: CONSULTATIONS WITH COMMUNITY STAKEHOLDERS:

In the consultation interviews with the community stakeholders, four main areas were addressed: 1) health issues, 2) social determinants of health; 3) programs and services offered by Miwayawin Health Services and 4) hopes for the study.

1. HEALTH ISSUES AND DEFINITIONS OF HEALTHY BODIES:

Themes related to definitions of healthy bodies and image and health issues that were raised by the stakeholders included; 1) obesity (in adults and children) and overeating; 2) body image and eating disorders; 3) illnesses such as diabetes, heart disease and kidney failure; 4) quality of life concerns; 5) healthy body size versus media body size; and 6) 'health' as more than healthy bodies and body images.

1.1. Obesity and over-eating:

Stakeholders in all of the community consultations identified being overweight and over-eating as a key concern in the communities—yet, one which is identified by some as becoming more socially acceptable.

> …being overweight is becoming more accepted. There are so many overweight people in our communities. Even the young people. When I was growing up on the reserve there were very few overweight people … both youth and adults.

> I was thinking there is more over eating …and that is the one thing too that I have noticed [that has changed]. When I first started working in the schools … you had very few overweight children. … This would have been 1977, so 30 years [ago]. I think [then] in some of the communities more of the norm was malnourish[ment]. Not everybody generally, but there were definitely some. You wondered if they were getting the nutrition they should and stuff but now, it [obesity] is really high.

Childhood obesity in rural communities, as opposed to urban, was also discussed with deep concern:

> We have a lot of obese children in the communities. To go to our schools…it doesn't … seem to phase people…as much as it would in town if we saw the [same] number of kids.

Another stakeholder discussed the important difference between a problem with being over-weight and a problem with obesity. She clarified that First Nations women have problems with weight, but obesity is less common on reserves.

> Really when I look around, for the First Nations women, I haven't really seen an obese woman, if anything it is like a fat stomach. I think that is where a lot of us have problems is right around our stomachs. I think that is where the problem is. To really see an obese woman on a reserve is very unlikely.

1.2. Body Image and Eating Disorders; Anorexia and Bulimia:
The perception of one stakeholder was that incidents of eating disorders such as anorexia and bulimia were lower than problems with over-eating and being overweight. Where it does exist, however, it is taken very seriously.

> I don't really think there is much awareness in the community of some of the eating disorders—those two eating disorders anyway [bulimia and anorexia]. When I was working hands on in the school…sometimes you would wonder about some youth, but over all the years I worked there it would be a really low number.

Another stakeholder describes her concerns with her daughter, linking this to magazines and mainstream images.

> My 21 year old was... I found out later was basically starving herself…like...just drinking water and having salads all the time. She lived on those magazines where it showed all of these women being models…being super skinny and that was her role models. But she got out of that too because… I got her some help with some counseling. She was a vegetarian…and there is nothing wrong with being a vegetarian as long as you ate, you know, good…but with her it was more like salads and water, salads and water, salads and water. And then when she became pregnant she decided I think I will start eating meat because I need that for nourishment and the baby.
>
> So personally, my two daughters have gone through something like that between 16 years and 20. So I have often wondered: how many anorexic First Nations girls are there? My daughters went through that experience.

1.3. Diabetes, Heart Disease, Kidney Damage and Related Illnesses:
The concern regarding stigmatization for weight seemed to be around health and quality of life, rather than appearance. This is reflected in concerns about diabetes, heart disease, kidney damage and quality of life concerns (including behaviourally for youth).

I think it is more switched to health now, like, if you are really watching yourself and you are healthier…so I think if you are over weight… you might be targeted as someone who is not healthy.

Everybody is worried about their health …The number of people that have diabetes now is increasing.

The other thing, we have a lot of people that are showing the early signs of kidney disease—and that is something that we have worked very hard to give people the information over the years so they can be aware of where they are at and talk about their kidneys calling out for help. I am frank. We don't know if pounding that much protein into your bodies is going to damage your kidneys. My professional guess is that it is going to. I am very careful to lay it out and let them know, that I am just not confident that you are not going to damage your kidneys if you go this route.

1.4. Healthy Bodies and Quality of Life Concerns:

With regards to quality of life concerns, healthy bodies were not defined by measuring weight, rather about being able to live life fully, enjoying time with family and community. Being able to do the things that you enjoy was linked to healthy bodies. Weight was seen as a barrier to quality of life.

…if it [your weight] stops you from having a certain quality of life… to do the things you want to do … [then it is a concern]

For myself … my perspective of a healthy body is that we are maintaining a life and you are able to do the things that can perhaps prevent chronic disease in the future.

I think because most of my health work has worked in areas where chronic disease is the big health issue … looking at [being able to] maintain a healthy active life would be my perception of what a healthy body is.

Being over-weight, food choices and even eating breakfast in the morning is also linked to other problems for children such as concentration in school, delinquency and work abilities.

An example, when I was in one of the schools...they started a breakfast program. One of the teachers was telling me they had discipline problems in her classroom and that this decreased so much because the children were having breakfast in the morning. It was amazing the ability of some of the ones that were causing a little more trouble in the classroom, that increased their concentration and ability to do their work. So food does make a big difference. That was an amazing revelation. You realize that, but you don't realize the broader impact, it is not just the physical health it is impacting their ability to learn and their behavior. One little guys quit stealing others lunches. I mean if other people have lunches and you are hungry… So, just to work with more of the communities to see if we can build more partnerships with the schools and programs.

1.5. Healthy Body Size versus Media Body Size:
Although stakeholders discussed health problems related to obesity, they were very careful not to link their definition of what a healthy body looks like to the slim body.

> When we are talking about weight…it is so individualized. Like my weight might not be good for your weight. You know, so it is very individual and that's what people don't [often] get.

> We don't want to look at people who are thin and say that they are healthy because they are not. They might be smokers or they may be taking drugs and things like that. And there is a reason sometimes that people with these addictions are very thin. And so, it is not to confuse thin with health.

> I have a friend that is overweight and she will admit it any day. And she is more fit than the average thin person… We call that the thin syndrome … because, anyone who is thin thinks they are in shape or better shape than your average overweight person … [which is not the case].

> ….you know, a lot of sedentary thin people, people who don't do any activity at all just kind of have a high metabolism, they are at more risk for heart disease and all of these other diseases…like diabetes and whatever…than the person who may be overweight, who's BMI may be too high, and their cardiovascular system is in shape. There was a 300 pound man in the U.S. doing a marathon and he did it. So …that perception that thin people are in shape is not the case.

1.6. 'Health' is more than Healthy Bodies and Healthy Body Images:
Stakeholders' perceptions of healthy bodies extended definitions from calculations of "weight" to harmony with body, mind emotion and spirits.

> A healthy body … to me… when you link healthy body it always links to image, unfortunately. It should be about your spiritual background, what your mindset is, your attitude, your…

> There is …a study done in Saskatchewan, from The Commission on Aboriginal Peoples and they stated [something like] "Aboriginal cultures link their body and emotions" … good health is like a state of balance and harmony involving body, mind, emotion and spirit. So body, yes, but they linked a whole bunch of other things together too…Nowhere in that quote did it say image…or whatever…that you must look like a rail!

2. SOCIAL DETERMINANTS OF HEALTH:

Many social determinants of health were identified, which were seen to influence and/or be related to the health bodies and body image. Six key themes identified were: 1) economics, poverty and employment; 2) physical environments/geographic barriers; 3)

history, culture and exercise norms; 4) history, culture and nutrition; 5) family and work-life responsibilities; 6) community crisis, strength and resilience.

2.1. Economic Factors/Employment and Healthy Bodies:
All of the stakeholders discussed unemployment, low income, poverty and meeting needs as a barrier to nutrition and health.

> [There are] a lot of low income families that I see. It really does come down to money and what they can afford at that time.

> And I think financially ...you know most people that are unemployed… the money comes once a month and they have to cover a great majority of needs and it has to last for the whole time. I think that would be challenging you know they may get that stuff but it doesn't actually stay in the home for the whole month. Keeping it there consistently would be a challenge with financial restraints.

Not being able to afford certain foods as well as inaccessibility to healthy and affordable foods in their communities was a concern. This same theme was reflected in the field notes and the interviews.

> I think I forgot to buy some bannock one time and I stopped at the local grocery at the town there…and I noticed pop was 2 dollars but milk was 6 or 7 dollars a ridiculous amount. So that is another food insecurity right there. The economy has to charge high prices because of the shipping.

The ease and lower costs of unhealthy foods is linked to unhealthy choices:

> I think it is the availability of junk food in the communities. I think that is a big one. You know if it is a little bit more money or making those choices with the small amount of money that people have. So rather than choosing healthy food, those people are preferring to buy the junk foods for their kids.

The types of foods people regularly buy were discussed as economic practicalities, such as ensuring that people are filled up (often meaning more carbohydrates and fewer vegetables).

> Many people in the community make meals that fill a lot of people up. I know that there is a high carb intake because it is easier to feed a lot of people and for the food to go further when you are cooking for eight people. So, I would think that you know economically that would be the biggest challenge. When they shop you still see people buying large cases of the noodles—things that are very high fat and high salt, but it is stretching your dollar. Those are challenges that we face. When we do the dietary and nutrition thing…taking what their saying--that these are ways that you can make it better. We never say don't eat noodles, you shouldn't eat noodles but this is a way to improve the nutrition.

Stakeholders quite powerfully talked about large families in the communities, tight budgets, lack of resources within communities and being in a vicious cycle. Stretching dollars is seen as a major challenge towards health. Economics is also linked to whether people can engage in activities and exercise.

> And the people in the communities have four or five kids and farther to go...and the money is tight.

One stakeholder provides an example of challenges a single mother faces in the communities:

> I think the bottom line is money. People think that you know…there can be a single mom with a baby...so she lives on that child tax which is three hundred and then her two hundred …well that mom is living on five hundred dollars a month. When you look at pampers and clothes and kids jackets now a days cost 100.00 and you know like how they have to stretch that dollar…

2.2. Physical Environments and Geographic Barriers:

Another barrier to healthy bodies is geographic and a lack of available facilities for physical activity. This included problems with transportation into the cities as well as problems with walking in the communities because of unpredictable dogs and unkempt roads, with youth sometimes driving recklessly.

Geographically the communities don't accommodate physical activity and there are transportation barriers:

> To get their kids anywhere you have to travel. To get to the school you have to travel. It is not something ... most people can walk to because of geographically how the reserves are set out. So, I think that, you know, geographically things aren't set up to accommodate physical activity in the communities.

> Oh yeah, for sure, economic barriers would be the big thing for people to travel. Even to get to their home to the clinics…we have to provide transportation. And for them to come and see the doctor people have to provide transportation. There are lots of people with vehicles but not everybody has access to them.

> And I think of the large size families, I know lots of families that have 5, 6 kids and how would you even fit people into a vehicle to travel. You know the families are much larger and the access to transportation is one of the barriers that people would definitely face. And your time would be spent around accommodating that.

> You know like I mean everything you did would be based on: how do I get there and who do I travel with, and so it would be much more difficult to do something than if I decided to do something. You know, like, I could either walk, I could drive, I don't have to wait to find transportation. But that is an issue in the community for sure.

> So, we have a lot of facilities in our cities, but there is a barrier with transportation… I wouldn't want to drive 40 minutes just to go to a swimming pool. I mean some people do…but for them, why would they want to do that. I mean walking trails…for some of them it might be too dangerous…it is unfortunate. A lot of them are interested though. They are interested in getting active and things like that.

Walking becomes more of an issue because of safety concerns with dogs and unpaved roads:

> We don't have a lot of resources other than walking. And I'm a strong believer that we don't need a lot of resources you know… but even walking they have issues of poor roads and safety and unpaved roads and dogs that roam quite openly and um …. I think those are issues that people have to deal with.

> If it is walking you have the whole world to walk around…but another thing is that there are mean dogs out there so walking might not be available for them.

There are communities which are trying to increase involvement by opening up the schools and community centers for physical activities, but generally a lack of facilities, problems of people abusing facilities in the past and disinterest by community members has stakeholders assuming that not a lot is going on successfully.

> And there aren't a lot of facilities in the communities. Some of the communities have tracks and school yards where people can walk. But as far as walking trails, people have said, well, we don't want to walk because there is an issue of dogs in the communities. And there are school gyms but maybe if they have been abused by one group, the school board has decided no extra curricular activities. Some of the schools have opened it up to the communities. A couple of activities per week and there is staff that are at school to be there for those evenings and things like that. So there are some communities where they are trying to increase community involvement, but generally I think there isn't a lot of facilities.

2.3. History, Culture and Exercising:

Interestingly, exercise in the communities is seen as an anomaly, not normalized. These exercise norms have seemingly changed over time. There is less activity and more sedentary activities such as watching satellite television or playing poker.

> …I don't know why you don't see people walking in the communities. I have never lived there though. I have only lived in town where it is quite normal and we have walking paths and people don't question if you walk, because there are so many people doing it. But I think in the communities if you are doing it people are stopping to ask you if you want a ride. They don't get the fact that you are walking for the benefit of walking. It hasn't quite caught on. I think, um, the whole

environment hasn't caught on to being more physical in the communities. So I think when it does happen it is not really normal.

I would think that, you know, lifestyles changed in the communities and there isn't a lot of things to replace it. In the communities there is not a lot to do. You can't come to town everyday. A lot of people have satellite TV now and that seems to be the big thing… if there is not much to do you stay at home and watch TV all the time. It is getting control of um…most of the communities there aren't the community events that there used to be. I remember that there used to be people out playing ball. After supper people would go to the ball diamond in the communities and everybody played ball. You don't see that anymore. We have soccer in some of the communities and soccer practices. But it doesn't take out as many people as the ball used to. Everybody could play slow pitch…you didn't have to be at a certain level to play.

And I think that just how people entertain themselves has changed. They play poker now… that's the big thing. You know, they go around in houses and play poker… so they stop doing things that used to be, um, physical and they started entertaining themselves…and I think that goes for the general population. The way we entertain ourselves and our leisure time has changed completely to being very sedentary compared to what it used to be.

2.4 History, Culture and Nutrition:

The history of healthy bodies in the communities helps link the problem of obesity to cultural, social and environmental issues. Stakeholders spoke of historical changes to bodies and different lifestyles. For example, gardening and hunting have become increasingly less common, yet both contributed to exercise and healthful eating in the past. There are also more stores in communities in the present day, with less affordable healthy choices—and more vehicles to get from place to place.

Stakeholders addressed the history of hunting, eating berries and gardening:

I think basically our people were big meat eaters, you know, because that is what was available. I don't 'think there was … traditionally a lot of other choices. I think traditionally, Plains Cree were more nomadic…they went where the meat was…the wild meat. And probably berry picking and things like that. They weren't farmers or gardeners. In the days when you know they had reserves, I think you know there were Indian agents that were promoting, you know, gardens and things like that.

As far as eating patterns…you ate because you were hungry …a survival thing.. and now food tends to be part of the culture… you know…too much food and without physical activity of course… plays a big role.

Stakeholders described always being outside, having healthier choices, not worrying about body images and yet enjoying good food (and sometimes lots of it).

> …There are a lot of us that grew up with our grandmothers. I'm not saying I was raised by my grandmother, but grandmothers' presence was always there as we were growing up. And…as children we were always outside… we made up our own games. We were always busy… at that time we didn't have … you know… the computers and the Nintendo's… so we were always playing outside and doing physical things and out grandmothers would, you know, feed us different foods …
>
> I guess the number one thing was so that we ate. So we were always eating. And then my late mother was a good cook, a great baker. So, every morning when we would get up there would be cinnamon buns or you know, stuff like that. I remember growing up there was always fresh food to eat and then... Our grandmothers were not always there saying watch your body weight... you can't eat that... you can't eat this… it was always like ... make sure you have enough food to eat.

One woman described the difference between her mothers lifestyle in the early 60s to what is going on today.

> …when I look at the pictures that my mom had when she was starting work in the early 60s…when I look at those pictures, there are not that many overweight people. I think… there was more physical labor and the foods were different. A lot of people had gardens and worked in their gardens and that was more for survival and necessity than for choice. But … that was probably the healthier choice than the choices that we have today. We didn't have stores in the communities. People really relied on their own, on what they could provide for their family. There was a lot more hunting and gardening in the summer and people were more self reliant. And I think that made a difference.

Traditional ceremony (historically and in the present day) was viewed by stakeholders as contributing to obesity and to healthy bodies—depending on, for example, whether one was a spectator or dancer:

> I guess when you look at some of it…the dancers—these woman or men have to be in incredible physical condition to dance the way they do…so there is that aspect of it. Though on the other hand, when you go to a powwow…and I haven't gone to many, you know the food booths, they are not selling necessarily the healthiest food. You know, all your junk food, type thing…you know, bars and all that kind of stuff…and fries and that kind of thing... So, yeah, on the one hand, the people who are active, it is good for them, but the people who are there watching and buying food from these facilities, the choices aren't there for them, necessarily.

Common unhealthy fast food choices people may be making are joked about as "traditional foods":

> You know and this is kind of an Indian joke. When you talk about traditional foods, a joke is that KFC is a traditional food. And I'm thinking: why is that? I'm not saying it is a traditional food, [it becomes the] choices that people are making, versus making choices that might be healthier. I was thinking of different gatherings and people would make those jokes that KFC is a traditional food.

The idea that healthy bodies are seen as linked to thin, sexy bodies is also discussed as a more present day phenomena.

> In my opinion women [in the past] were free, and they were physical enough and they probably ate what was there… and it wouldn't have been such a big concern. And it is changing now with all the publicity…and you see so much on TV, in the paper, magazines…people are thin…women strive to be sexy and not a healthy weight.

2.5. Family and Work-Life Responsibilities:
Work-life responsibilities and family violence were linked by stakeholders to healthy bodies and lifestyle opportunities.

Stakeholders discussed the importance of work-life balance as affecting women's healthy bodies and lifestyles.

> …a lot of us women are basically raising our own children and raising our own grandchildren. …Because if they get really sick, who is going to look after the kids right? They do the cooking, cleaning, grocery shopping and could be working full time on the side.

Stakeholders spoke of the burden of responsibilities on women in the communities and how difficult it would be to find time to do anything for themselves.

> You really just need to look at their background. Like maybe this is a single mother with 5 kids or 7 kids or whatever. And, what can they do now. You know, are they even worried about their own health or they just worried about all the kids that they have to look after. Do they have time for them?

Family violence was also seen as a barrier.

> Or maybe they come from an abusive relationship. What can they do for themselves right now…just even talking to someone might be the best thing for them. It might not be me necessarily.

Three stakeholders spoke of community members who put weight back on, because of pressure/control from their spouse.

> But on the other side, I get people who put weight back on because they get pressure from a partner or spouse that is not comfortable with the new body image.

> They feel that there is going to be other people looking at that person. You know, because now they have changed that body shape or that body image or maybe because that body has changed, there is a different persona about that person. Maybe they carry themselves differently—perhaps more outgoing.
>
> One woman shared that she put her weight back on because she was getting negative messages from her spouse.

2.6. Community Crisis, Strength and Resilience:

Community members deal with an inordinate amount of family crisis, including death and suicides. Maintaining or working towards goals of achieving a healthy body was a mute point when dealing with these realities. Even people who expressed an interest in becoming healthier, or changing their lifestyles could not affect change because of frequent crisis.

> One of the things that stand out in my mind… I have clients, who given different circumstances, would be very ready to change, but they have had death after death after death after death. I can't imagine how they even keep going. It is like crisis after crisis after crisis after crisis. I might deal with a crisis every one or two years, but because of the community nature, it is not your personal crisis it affects your whole community. If it is your neighbor or another person in the community and it just …affects everything. Like, the whole community shuts down—by the time the wake, the feast after. It affects your ability to …and struggling like that and the grief process after. It is just huge, just massive. So I find that to be a huge barrier for people to look ahead …crisis after crisis after crisis.
>
> Other crisis as well, but death is the one that … I just cannot believe the numbers of deaths that we have to deal with.
>
> …it can range anything from vehicle accidents, to suicides, to health related, to drowning because of no life jacket on, that type of thing. …some families have multiple family members. They may have lost multiple children, due to a variety of things. How do you keep going?
>
> On the board here there is a debriefing coming up for youth 12 and up for Saulteaux because they have just had a suicide. There were two suicides on one day in two communities. I could never have comprehended that before I moved here. Ever… Quite often it is siblings, mother and they just keep plugging away. It is huge.

One stakeholder explains how these crises affect body image and healthy body, noting an admired resiliency within community members and problems that occur as a result of these crises in mainstream health care systems.

> It is an emotional and mental health issue. It is not just body image. It is all the things that people have to deal with. And quite often…I know I need to exercise

> and eat healthier, but I am trying to cope with all of my family members needs and I don't have time to exercise. So it is not hard to see why people are looking for quick fixes, because they don't have a long time in some cases, before the next thing they are dealing with. It is phenomenal. I don't think I could cope.

One stakeholder describes how mainstream health care systems may not have an understanding of the crisis community members are dealing with, and therefore how these health care systems may become (albeit unintentionally) additional barriers towards maintaining healthy bodies.

> I think the health care systems, outside of tribal councils have no understanding. …If they have a client that doesn't show up for an appointment; number one: can they even call to cancel it? …because they may not have long distance on the phone or they may not have a phone at all. And, you are booked for maybe 2 months, 3 months, so the flexibility to get them back in is impossible. By the time you get them another appointment, they may have another crisis and we don't know anything. None the wiser. We think, oh, they are not interested. It is just huge, huge, huge, huge, huge, huge. That is a big part of it. I couldn't have understood that until I worked here. … So, if we get a referral from a physician it may take me one year or two years for me to actually get to see that person because of everything that has happened.

> I admire the resilience and strength of the community members. It is quite touching to see.

2.7. Education and Information

All of the stakeholders agreed that a lack of knowledge and skills (and time to develop these) contributes to problems with healthy bodies.

> …education plays a role as well… as far as being educated on healthy lifestyle choices, how you were raised plays a role in your decisions on how you are going to live.

> If you don't know how to cook it is easier just to go out for meals, or to buy frozen, prepared food, that usually aren't …the easier things are usually not as healthy…higher fat, higher salt content and things like that.

Other stakeholders discussed the lack of general education in the communities suggesting that this may also contribute to problems with healthy lifestyles.

> I have talked a bit about barriers like their depression and um…not being educated on nutrition or … just basically not having education… I don't know what the percentage is with the level of education women have…but I think it is maybe high school…. I don't think there is a lot of women that go on to post secondary that I am aware of … maybe half. Not even half.

One stakeholder felt that additional problems with mainstream healthcare systems, has also led to the perception that there is not a sincere effort by mainstream helping professions to assist members of the communities.

> And you get into all of the determinants of health. Unemployment, poor access to health care. And when they get access to health care, a lot of doctors (people are telling us) are writing prescriptions before people tell them anything. I am generalizing a bit, but I don't think the perception is really very good that people are really interested in helping some of our community members. I think it is not consistent enough. So, we try very hard with what we have power over to try to provide the best health care we can to our clients. So, determinants to health is a huge issue.

3. PRACTICES, PROGRAMS AND SERVICES OF MIWAYAWIN HEALTH SERVICES:

The focus here is on the services and programs of Miwayawin Health Services which emphasize healthy bodies and healthy body image—and ways in which some of the issues identified above are being addressed. This section draws on interviews with stakeholders as well as annual reports and field notes.

Miwayawin Health Client Services Community Health Program, Home and Community Care and Department of Health Promotion promote holistic health, citing spiritual, social, physical and mental health as themes and program goals. (Annual Report, 2006-2007) Objectives related to healthy bodies and body image reflect this overarching theme towards holistic health, and are addressed through a number of programs run by the Miwayawin staff.

As noted in the Annual Report for Miwayawin Health Services (2006-2007) and through interviews with staff involved, programs reflect; 1) nutritional needs; 2) exercise and physical activity 3) school programs; 4) social, environmental and political needs. There is also a work philosophy that reflects culturally appropriate and non-judgmental principles. This section summarizes some of the Miwayawin Health services and work principles.

3.1. Nutritional Needs:

Programs that address nutritional needs are done by: ensuring fresh food is available through fresh food boxes and providing food vouchers; offering nutritional assessments, counseling, education; home support by community nutritionists and more. Stakeholders spoke of many of these programs with enthusiasm.

3.1.1 Food Vouchers:

The Health promotion department offers Food vouchers towards healthful choices, working towards improving nutritional intake. These vouchers for milk products (7 dollars) and vegetables (8 dollars) are offered weekly to prenatal women and postnatal breastfeeding women (until the infant is 6 months).

> This is through the CPNP program… there is a voucher system and it is just for prenatals or postnatals or women that are still breast feeding and these vouchers have limitations on them. Basically, they can get certain milk and milk products and vegetables and fruit. These are the two things that we are focusing on –that we realize they don't have enough in their homes.

Stakeholders were pleased that these programs seemed normalized in communities and were not seen as handouts. These are seen as cooperatives, which worked under fair business principles:

> I make sure that the recommendations are followed and that the grocery stores and stores in the communities are part of it. They understand that there are vouchers out there and this is what the clients and families can only have. They understand where it is coming from and it is normal. Everyone is in the know. No one is left in the dark. The whole community knows about it and it is good.

3.1.2. The Fresh Food Box

The fresh food box offers fresh vegetables and fruit to the communities. This program stems from a partnership with the Midwest food resource project. Miwayawin supports the mileage for the volunteer community coordinator positions who bring the fresh food boxes into their communities and are responsible for assisting with packaging, collecting money and delivery. Stakeholders seemed to be very interested in improving existing programming and making things like the fresh food box more readily available to everyone (especially prenatal moms).

> There are two good food box programs that our clients have access to. One is run out of North Battleford and …it is a pooling of resources. So they pay up front and it is usually around 15.00 per box. They have a fruit and vegetable box and a fruit box. Not every community has a community contact. We would like community contacts in each one. They are part of the planning meeting for that box. They come in, I believe, and they are responsible for picking up the boxes for their community and bringing it back to their community. And they are covered for the cost of bringing it in and taking the boxes back out.

> We have the fresh food box. It used to be called the good food box. But we call it fresh food because it has the connotation that it is only for people who have low incomes need good food. Not true, anyone can get fresh food box.

> That is another way that I focus on food security. And this is not just about having food in the house it is about having nutritious food in the house. So that is what we focus on too.

> It is a really good project … you know in order to get fresh affordable produce into the communities.

> Saulteaux runs their own. They pack right on their community and it is a very popular box. It is driven by the community.

3.1.3. Nutritional Education, Counseling and Support:
Although food vouchers and fresh food boxes are practical, stakeholders felt that these do not work towards long term family budgeting or towards being able to feed the whole family. Miwayawin also offers nutritional assessments, counseling and support by the community nutritionists. The food experience program, grocery store tours and information around budgeting, nutrition and food preparation (even food recognition) were seen to make a more long term difference.

There is also a program called: Home and Community Care Food Experience, which is run once a year, and offers practical information on nutrition, cooking and preparing foods.

> This past week we have run a program called: Home and Community Care Food Experience, which we run once a year and it is only one session per community. You can take a maximum of 15. You are not touching a lot of people. But everyone there goes home and they have family members and grandchildren, their own children, kokum, and all of those things. With those programs, we weave healthy nutrition into; how do you prepare the foods. I have found generally that people, if they know they can get something at least no more expensive, or maybe less expensive than what they are already buying and they know how to cook it and they know it is good for them they will cook more.

> One of the programs that we run is our food experience program which is just a four basic sessions on basic nutrition and cooking skills for our prenatals and moms. A lot of them don't cook in their own home…they live with their parents...the mom cooks for the children living at home, who have their children living there too and the grandchildren…So we're finding a lot of people don't know how to read a recipe and they just don't cook. Or they are living with their in-laws and they don't have that opportunity to cook. So that is one thing

One of the operational objectives for the Health Promotion Department is to improve the health of babies born in the communities by working on improving women's health when they are in the prenatal period. The food experience program provides education and practical support towards learning about healthy foods, nutrition and helps develop practical shopping and cooking skills (helping to also ensure foods from the fresh food box are used).

> I have to say it is a short term solution [fresh food box]…because [the amount they get] it doesn't feed the entire family. And another part of my job is that there has to be education to it as well….

> I do grocery store tours that I do take families on…I try to get families unit costing… Let's weight our vegetables and see what we are paying for and…

> budget. Not a lot of people know how to budget or think about it. They just grab it. So it really comes down to those … basic steps which will make a long term difference in the end.

A large part of what the nutritionist does is a practical application of recommended healthy foods.

> If we want people to use more sweet potatoes, then they have to have an opportunity to work with those sweet potatoes and taste those sweet potatoes and see how good they taste. If we want them to use more whole wheat flour, we have to incorporate that into the bannock that we are working with in the communities.
>
> When we run programs, we use at least ½ whole wheat flour in our bannock, if not 100 percent. So any opportunity for people to try those things. So, a big part of what I do, is a practical application of the foods that I want to see people using more, that is recommended.
>
> …and we do nutritional classes and healthy eating and people learn simple ways that are budget acceptable about how to prepare …healthier.

Portioning, budgeting, reducing fat, increasing fiber and much more, are all part of nutritional education.

> Other things that we offer, you know…reducing your fat, increasing your fiber. There are no programs that we don't offer.
>
> One of the interesting things that people look at is portions. They are still blown away by what an acceptable portion is compared to the portions that people consume. We look at portions of bannock –portions would be one inch by two inches but people eat much larger pieces of bannock so their intake of carbs is very high. So, I mean that those are things that people are shocked by.
>
> And I think that the education is getting out there and it is improving. Many people were using hard lard for bannock making…and most people now use a vegetable oil rather than using a hard fat. I think the education is available, but when it all boils down to it is…you know…it is stretching that dollar … and making the groceries last for a month that is the hard part.

Consistent messaging is seen as key towards nutritional information. For example, one nutritionist talks about reasonable portions and how consistent messaging about portioning has resulted in community awareness.

> When people are ready, we do consistent messaging… we work [a nutritional message, such as portioning] into everything that we do…[and then] everyone knows it.

> For example, not as a diet, but [we give] people an idea of what are reasonable portions. So, for example, we use something called plate method (hand size method of portioning) and messaging. They are methods that are used by the Canadian diabetes association. So, we work that into every program that we do. I have been doing that for literally years. Now, when I say, does anybody know how can we use our hands to measure portions, everyone knows it. It is not a diet.

3.1.4. Chronic disease Management—Health Care, Prevention and Nutrition:
The home and community care program and home support services does chronic disease management but is also involved in primary and secondary prevention—looking at programming for people at risk of diabetes and/or heart disease. Their focus is also to make sure that people have the information (and in a culturally appropriate way), to be able to make informed decisions.

> …right now we look at people who are at risk for developing diabetes and all the complications that are associated with diabetes or heart disease. So my role is…to make sure that people are informed so they can make informed decision and so that they have the right information. And that we offer it in a way that is culturally acceptable. And that people can deal with it. We don't need to tell everyone they need to join weight watchers and lose 50 pounds. Lets make small changes so that people can accept it.

There is a full time registered dietitian who works with people who are at risk or have diabetes. The dietitian goes into homes, providing nutritional education including healthy choices, healthy portion information, and a wide range of other services.

> We have a full time registered dietitian and she works with all of our diabetics and we are targeting people at risk for diabetes. …we get lots of referrals medially and actually the dietitian is very good and she will go right into a home so people have an opportunity to show her what they use and she can make suggestions about how to make it a little more nutritionally better. Not to tell people that that's no good, because that's not realistic.

Every one of the communities has a full time home care nurse and full time dietitian so ratio of staff to client is seen as being high. There is also a full time diabetes educator and a full time psychiatric nurse.

> I think that if we based home care service availability …against what is available outside the reserves…I think our clients have access to… probably a higher number of services.

> We have a full time dietitian that works in our 7 communities…her population base would be far less than what the out patient dietitian would have to provide service to. So, as far as accessing service, we have…a high staff—the ratio of staff to client levels is quite high. We have a full time diabetes educator…we have a full time psychiatric nurse. You know, so, I think our ratio [of] staff is quite high.

3.2. Exercise programs and initiatives:
Miwayawin health services also support exercise programs and healthy lifestyles. This is seen by having exercise leaders, initiatives to train community exercise leaders, walking groups, Sadie's walk and more.

> Once a year in there is a Sadie's walk—named after a little girl who was diabetic. She is involved with school and they do a walk. This past year what we did was a community cleanup and walking.

> We have little workshops…and then we've been running exercise programs at the gymnasium…for the summer …we had to quit for the summer…the ladies are eager again to start.

One stakeholder described the attempt to have community leaders trained and certified to run exercise programs in the communities. The intention was good, but the plan was not as successful as they had hoped.

> We had …partnered with home care with the diabetes prevention … training community fitness instructors in the communities. …we contracted the Y [WCA] out of Saskatoon who helped us with this. And we did have between staff and community members I think we had about 17 people that did complete the training and our idea was to give people enough skills…not necessarily certification, unless they wanted to go that route. But to run walking groups or to have some basic information about exercise and increase in physical activity in the communities. The interest in most communities was actually pretty good. I was surprised in some communities there was no interest. But we had a couple that worked in the school, which was really good and some that worked in the community center and just general public that wanted more information on things…so we did get people trained. And most people chose to write the exam. That was an optional thing. If they wanted to go ahead with certification. And very few people passed the exam. I think there were 3 or 4. And that was very disheartening and I think it just took the wind out people's sails… We have done all this, we worked hard, we gained all this knowledge and it was…and…I think the instructors did try to prepare us, but it was way more difficult than even I anticipated. And especially you know if there were some literacy issues.

> Yes, it was very disheartening for people. We had wanted to keep pulling them together and keep supporting people, but eventually everybody just kind of disappeared. So I guess we can say there are people out there with personal information and things like that, but as far as what we had wanted to get out of the program, it wasn't as successful as we would have liked.

Five of the interviews pointed to the presumed availability of existing resources in the communities, including facilities which could be used for recreational purpose and exercise. Although some facilities are being used sporadically, programs seem to fizzle

out quite quickly and the communities are not making use of them. The availability of resources within these communities are seen as an opportunity to expand exercise, activity and social support. Stakeholders expressed hopes for the communities and the importance of recognizing that not a lot of resources are required.

> I think people need to get the perception that just walking from here to your nearest neighbors is physical activity. The day to day stuff in your life becomes part of that. People don't need to have the gym or the halls for walking. There are small things that we can do in our homes that would benefit people and sometimes people in the communities you know they think they need to have financial resources to do things but they don't necessarily need to have them because they can walk certain places.

> …it would be nice to see if people identify a walking path in the communities. It wouldn't take a lot. I think if they did that and they put some financial resources into it…that it would then create a social place too. If people were to do that. And continue to give the messages that …a little is good to start off with and kind of keep going like that.

3.3. School programs and initiatives:
School programs include food policy, educational opportunities, nutritionists, and counseling. School children are offered knowledge related to healthy lifestyle choices through school programs. Community Health Nurses provide health education when this is requested. They are also a resource for school health programs. School education sessions are also developed by health care teams (sexual health nurses, nutritionists, women's counselors) to provide healthy lifestyle education. There is also counseling services offered to youth regarding suicide and addictions prevention—and providing knowledge and skills for a foundation to "succeed and choose life".

The food policy within the schools is supported by Miwayawin and part of education, which stakeholders feel may have positive outcomes.

> We have a food policy now; most of our schools don't have pop machines or junk food. That was an education or a process that is taking time but it is definitely having I think positive outcomes. These things seem to move slowly but the changes are coming but they are coming slowly.

This policy work includes making changes in the schools and the types of foods they offer, even eliminating pop and junk food machines.

> We have a food policy now; most of our schools don't have pop machines or junk food. That was an education or a process that is taking time but it is definitely having I think positive outcomes. These things seem to move slowly but the changes are coming but they are coming slowly.

There is also a focus on trying to increase physical activity in the schools.

> Like I said to work with the schools, in order…what we do affect the children's ability to learn. I think the one area too, is physical activity. How can we increase their physical activity in schools? One thing we were talking about was trying or attempting to have a 15 minute walk, a mandatory 15 minute walk in schools for students and see if schools who are interested in doing that. There are some principals who are more open to trying some of these kinds of things.

Other programs also deal with self-esteem issues, which are seen by many stakeholders as linked to body image.

> Myself, and the community family counselor are running a girls program for girls in grade 6, 7, 8, and 9. Our goal is to, of course, delay sexual activity in girls but as well, hopefully, giving them some confidence and increasing self esteem—which would influence healthy body image and healthy relationships…so that is one project that we are doing on Saulteaux with the school.

Involvement with the schools could not be understated. This was seen to influence not only physical health issues, but concentration in school, delinquency and trouble and work abilities.

> An example, when I was in one of the schools...they started a breakfast program. One of the teachers was telling me they had discipline problems in her classroom and that this decreased so much because the children were having breakfast in the morning. It was amazing the ability of some of the ones that were causing a little more trouble in the classroom, that increased their concentration and ability to do their work. So food does make a big difference. That was an amazing revelation.

> You realize that, but you don't realize the broader impact, it is not just the physical health it is impacting their ability to learn and their behaviour. One little guys quit stealing others lunches. I mean if other people have lunches and you are hungry… So, just to work with more of the communities to see if we can build more partnerships with the schools and programs.

Yet, there is resistance to interference with youth by some parents within communities that stakeholders are sensitive to as well.

> In one school [in the communities] …they had decided that they were going to have a food policy for lunches and they weren't going to allow pop and chips and things like that to come in the lunches and they would be confiscated and sent home. Well there was a real uproar in that community. From some of the parents to say: What right do you have to say what I can put in my child's lunch? And I think the school did end up backing down.

3.4. Social/environmental and political:

There is a strong community development approach into program planning. This is evident in programs, for example, through: Cooks training; MOAUIPP and DREAM.

3.4.1. Cooks Training:

The cooks training program is part of building capacity and means that the schools may become more involved in their own decision making and planning towards healthy foods and living, and less dependent on outside support (from the nutritionist). There were some problems noted, however that when cooks were trained, they often then moved into better positions, leaving a new person to train again.

> It used to be when our dietitians would first come to the schools they would want them to make the menus. And then we thought, well, that's not good, because these people in order for them to be self reliant should be able to do this themselves. So, we provide the training so that these people can then make the choices themselves as to what menus to provide in the schools and in the daycares. So, we have moved along way too…. because she did provide that menu and that was time consuming. So, now we have taught people to do that for themselves. So it is changing how we provide service, too. The demand is changing …[and this] has changed how we provide service.

> We started running, a number of years ago--in 1999 I think was their first program—we invited all of the cooks for daycares and schools to come in to a cooks training program. Total of 5 days in length but spread out. And, every year it seems like we get them barely trained and they are off to bigger and better things. It is wonderful to see, but it causes us to keep training people. They get training under their belt and they move on to another job that meets their needs better.

Stakeholders talk about the cooks training program and staff education as building capacity in communities:

> A lot of what we try to do, with things like the cooks training program is to build capacity. So, we've had people ask us to review the menu, but we prefer to have them come for training so they know how to develop. And who wants to be told that something is not working so this way they can figure that out for themselves. A lot of people have come for this capacity building program. So we're quite proud of that. We try very much wherever we can to build capacity and that is a fundamental thing in our communities. People feel empowered.

3.4.2. Staff Training:

Extra training for staff (home care nurses) and teachers is done, so they can partner with dietitians and diabetes educators towards long term consistent changes.

> Staff education is a big part too. … a big part of our job is to train staff. So, the staff can do a lot of that basic nutrition information and they help to keep that message consistent.

> And all of our home care nurses are considered diabetes educators because they are provided with extra training so that they can work as a partner with a diabetes educator and the dietitian. So they can provide survival information until a dietitian can be seen.
>
> We work in teams so that everybody can share the same education and support each other. The home care nurse then can support the client in between the dietitian visits or in between the diabetes nurse educator visits. So that is kind of how we set up our services.

Training teachers to work with their students and in daycares with healthy menus, exercise and nutritional information is also viewed as an important long term goal.

> The workshops/training sessions in the communities are also passed along to teachers so they can do more work with their students, daycares and help with healthy menu planning.
>
> We have workshops quite often, we have wellness clinics once per month and generally a topic will be discussed. Or our exercise therapist will do community sessions or be in the schools.
>
> We do, … information sessions to teachers so they can pass it on to their students, we provide training to the daycares, the school, our dietitian does all the food experience so they are all taught how to provide healthy meals, and make healthy choices and help with menus.

Partnership amongst programs, people and with other community partners seems key to Miwayawin successes.

> If I didn't have the home care nursing supervisor saying it is important that we wouldn't have the nurses and home health aide saying it is important. So it rolls back. And then having people to refer clients to for counseling. And the exercise therapist, diabetes educator and then the training program we work with, community health and health promotion. I couldn't do anything that I do without them.
>
> And then we have partners, we do some high-risk pregnancy, gestational diabetes and we partner with the diabetes team at the hospital and we have rounds every Tuesday morning from 8:30 to 9:00am. And we have been doing that for years. Where the clients can share their information and allow them to move between systems with no barriers to care. So they don't have to start over with their story when they go to the hospital. We have partners with outside and of course supports –I partner with the dietitians that work with First Nations communities throughout. And we have communities supports –a number of tube fed children and we work closely here with Saskatoon.

> We partner wherever we can to make sure the community members are getting the best care possible. And then with DREAM project we partner with doctors in Toronto, Edmonton and Saskatoon and with your project and Jennifer. So, I could not do my program without the support of many many people.

3.4.3: Food Security and MOAUIPP:
Stakeholders also discussed the importance of the fresh food box and the Métis Off Reserve Aboriginal and Urban Inuit Prevention and Promotion program (MOAUIPP)—in relation to food security and sustainable agriculture.

> Another program …is the Métis Off Reserve Aboriginal and Urban Inuit Prevention and Promotion. It is another government program and it is about food security. So … another part of my job is to focus on food security. Food security is to have enough food on a daily basis. It does focus on hunger issues but it also focuses on the bigger perspective which is economy. Can we grow our own food, our own local food? Are we supporting our local farmers?
>
> It also focuses on environment. What kind of herbicides and pesticides are the farmers using. What about if a drought comes along how does that affect our grocery stores. Yeah, it affects our families so that ..if we only get one meal today, how does that bring families together. It focuses on the individual, which is hunger issues. Learning –can kids learn in school if they are hungry on a daily basis?
>
> It is like a cooperative in a way. It is not meant as a handout. The principles behind it are wonderful. One of the things is sustainable agriculture. Not having your fruit have to be trucked thousands and thousands of kilometers. In the boxes, it runs the way the principles are laid out. They actually get their potatoes local. Their carrots local. I don't know how much of that is happening. But I do know, they get grains, like lentils and things are actually from Radisson. They need some of that community support. So, to try to encourage sustainable agriculture within your communities.

Stakeholders are quick to point out, however, that these programs will likely not eliminate food insecurity or health inequalities.

> I mean it is not going to wipe out food insecurity…not at all…I wish…but it is not going to be for a long time. Like we are still going to have the food bank which is a short term solution…and so …short term is a band-aid solution. So, unfortunately we are not going to see that leave any time soon,

3.5. Work Philosophies (Culturally acceptable/non-judgmental):
Stakeholders discussed the importance of culturally acceptable ways of working with people in the communities—tying together many of the barriers they noted above, with program goals. This involved meeting people where they are at, rather than inflicting their own personal work goals.

> …the more experience that I have the more I see bad situations in the homes and I think…ok this is probably not the time for me to talk about healthy eating and stuff when they have other issues like alcoholism and other things going on in their families.
>
> In the assessments… they will talk about alcohol and you look at the things…that you can manage. I think that's just it…setting priorities. Right now we have …chronic paraplegics with chronic wounds whose nutrition status is poor…mainly to addictions… whose wounds are never going to heal at the rate that we are going now, because the nutritional status is mostly related to addictions. So you have to work with what you can work with. We do the dressing changes.
>
> We do everything in our power …you are not going to change their lifestyle… you can offer guidance, and counseling and service, but until that individual person makes the choice to change their lifestyle, we can only work with what's there.
>
> That's it…we take people where they are at. And offer them what we can offer them and offer them what they will accept. Making it still their responsibility to make those changes. But we really take people where they are at and try to offer them…you know...some options…but it is up to them ultimately… and alcohol does play a major factor.
>
> ….it is very small change…taking where people are at…what they can afford. Because you can't expect changes with someone who is struggling, you know, with just keeping food on the table… keeping enough food in the house.

Stakeholders talked about offering small bits and pieces to fit into their life, following from where community members are at. You deal with whatever is presented on a particular day. They talk about working gradually with people and their willingness to accept that changes may take a long time.

> It is trying to meet people where they're at and give them bits and pieces that they can fit into their life. You are an educator but you really need to know where that person is at…and what is best and going to work with them. And the struggle that I have is that sometimes we get so formal in what we do, that we forget that these people's lives are…many of their lives are affected by huge amounts of stress and strains. And we just think that they don't want to listen to us today. But I think geez…if I had all that going on in my life I wouldn't want to listen to you either. So you know….to make people feel respected by acknowledging that you know… know this is tough…and so, you know you need to do what you can do to deal with that but… here is a little something that may help you in this area.
>
> We can't have a meeting set up with a diabetic …to say that we are going to go there to do diabetic education…that client may be way somewhere else. You may not even get there that day. But that's ok.

Much of their work is based in relationship building:

> Much of it is relationship building and knowing that people have good days and bad days and …yes there house [may be] a wreck… and you walk in and think…the house is a wreck and we wonder what we can do about that. We accept these people for where they are at right now, lets move small and …yes, their house is a big mess and yes they need to have things going on in their life….but we are not going to go to the band and say that these people need to have their house cleaned up and someone needs to help them. They will eventually get there if we keep working with them but you need to look at the issues that have gotten them to where they are at right now.

> We can't base our programming on our standards. It has to be on what is acceptable to the people we provide services to. People are at so many different levels out there and… we can't just provide a blanket type service because it doesn't fit, and it will never will fit. And I think that is why our services are so different than what is provided in the cities…you know…I mean I have done wellness clinics where you want to talk about this…but someone has sexual abuse thing go on in their life…or something. So you deal with whatever that person presents that day and just gradually get to where you want to go… It takes a long time.

The focus is on the root of problems as well as dealing with immediate health difficulties.

> It's like people who suffer from addictions…you know you never look at them the same. You know, this is an alcoholic. What are the things in their life that brought them here? And I think for staff…I think everybody is only one step away from that. So you need to remember that…what are the things that brought them there. Things can change very fast in a person's life. Don't just judge what you see. It is probably a symptom of something that you will probably never understand, you know…so…I think that is what we struggle with the most, is keeping people um…open minded so that they see people for where they are at and just start at that point.

> You can't just like…heh, we are going to talk about healthy eating…and this is not a good situation here but you know…we are still going to talk about it. Well, they are not going to change anyway…they are not going to learn anything from what I will say because they have other things going on in their minds. It is tough sometimes I would say…

A very strong work philosophy emphasizing no judgment is heartening and humbling. This is also linked to what it means to be culturally acceptable within work in the communities. One staff member summarizes the complexity of what culturally acceptable work means, including the necessity of not personalizing anger and real challenges faced by people in the communities. To some, culturally acceptable means

open-mindedness, especially because there is not a homogenous understanding or following of culture:

> …you have to not personalize the anger…because you do get anger. This person is angry and you just happen to be the person was there…you know…The paraplegics can be very challenging…you know…they are struggling with where they are at. For disabled people in the communities the barriers are 10 fold. There is no medical transportation…there are just so many more issues for them.
>
> These are things I think when we hire people, we look for people who are able to be open minded and really just see people… not that you don't' get frustrated, with the work at some point, but you need to always be able to say, well…this is where they are at and this is what I can do about it…or, you know…what I can offer… I think if you keep that attitude you are far more successful in helping people to move. To me, that is what culturally acceptable means. It is not that we need to know a great deal about culture. You do, at some point…but you cannot just blanket these people and say that they are traditional people… some people don't follow any followings at all and some are very traditional people. I think to be open minded is the biggest characteristic that staff have to have to be successful, I'm sure.
>
> And I think that people who just start to work with us struggle with the time it takes. But we are in their home…we are visitors in their communities…visitors in their homes…And that is the whole thing about culturally acceptable…it is meeting people where they are at and not judging them.

3.7. Healthy Work Environment:

This positive and people focused work philosophy seems to make its way into the work environment. The stakeholders agreed that a very positive work environment is created at Miwayawin, where staff is committed to staying.

> I think they try to create a work environment where they [staff] want to stay. It is not promoted in the way I discuss, but it is trying to meet the needs of staff. But, I personally find that a very satisfying part—to see those light bulbs go off and say: "Oh!, I didn't know that".
>
> It is not just our community members that are focused on…but the agency feels that that is important to give that to staff as well. I think that says something as well, for an agency that is concerned about their staff.
>
> So very strength based and that's what I love about here. To see someone come in here and talk about a lot of negative things is kind of unheard of, sort of.…A lot of people are pretty satisfied here and pretty happy to work here. And that's good. Laughs…

One stakeholder adds that this long term commitment to her job, benefits the outcome of her services provided within the communities.

> Every job I have been with has been for a long time. The people I worked with in the hospital are those in the community. Part of what I professionally get from my job is seeing the outcome long term and so I am there for the long haul. I see long term changes that you need and I am there to try to support that.

4. STAKEHOLDER HOPES FOR THE STUDY

Stakeholders felt the present study was needed/important: 1) as a community up approach to program effectiveness; 2) as a means to increase self-perception; 3) to enhance community sharing and mental health; and 4) towards making healthier and informed choices.

4.1. Community-up Approach to Program Effectiveness:

Stakeholders were hopeful that this community based study may offer community input into what Miwayawin is doing, and help to assess programming effectiveness. They were very interested in learning what how women would define their own health and body image needs.

> I think [what I hope to see from the study] maybe more of a realistic or a maybe more direction or community input into what we do…I would like to learn what people are thinking and how we can best support people in either maintaining their health or increasing their levels of health—both physically and in any other way.

> I will be very interested to see what comes out of this project. I really do hope it helps the health services to plan programming towards helping women.

> I think it will be interesting. It will be interesting to hear others perspectives. We are all caught in our own perspectives of body weight and image and it's an eye opener to hear what everybody goes through.

> I think this research project will be really good for our whole community and I am interested in hearing what others say.

Stakeholders discussed quite honestly that it is often difficult to erase our own personal perspectives regarding healthy bodies and how important the study may be to break down this personal bias.

> So I think that's what I'm looking forward to…because I think we are all kind of helpless in our own shells as to our own personal perspectives of our health or our weight or our families situation or what is going on in our lives on that day…so I think from this, that you know, we will here, I think, a lot more from people.

They are also interested in hearing some of the traditional and old stories about weight.

> …I have not heard what the old stories were traditionally about women's weight and stuff and I am thinking that probably some of that will come out.
>
> So I am interested to see if people are able to share some of the older lessons that were passed down and that we don't hear anymore. I'm actually quite anxious to here the outcome of this.

The desire to help women achieve better health and to learn more about how women really feel about themselves generated this project. Concern about women's health is also a concern for the entire community's health. Women are over-extended as caregivers and employees with little time to care for themselves or their own health needs.

> So I thought why not look at a project where it will meet the needs of the Indian women working in the North Battleford area. I thought lets study the weight issue of women. How do women really feel about themselves and how can we help them be healthier. So that is how I started generating ideas and thought we should generate a project based on that.
>
> We are all at the age where we are getting older and also health wise you know we could afford to be more healthy. So I thought why don't we look at how women's health can impact them as a care-giver because a lot of us women are basically raising our own children and raising our own grandchildren. I thought lets look at something where we can help women deal with their health. Because if they get really sick who is going to look after the kids right. They do the cooking, cleaning, grocery shopping and could be working full time on the side.

4.2. Self Perception and the Beauty of Difference:

Stakeholders hoped that the study would be empowering for women and felt that it may help to increase self-perceptions.

> [I hope that] the women that are participating in it… I hope they can get something out of it for themselves. I think a lot of it is thinking you can be healthy and it is a lot in your mind…how you feel about yourself--being comfortable in your body and your skin and I think if you can achieve that, you can also work towards a thinner body if that's what want.
>
> I can ask them what don't you like about themselves… and they can probably list easily…if I build up enough rapport they can build a whole list. And if you focus on the positive...then they would probably have the shortest list ever. And that is another thing; some of the qualitative studies are focusing on the negative outcomes, not focusing on the positive, which is kind of unfortunate.
>
> I hope they have a better perception of themselves and secondly others

A few stakeholders discussed the importance of not seeing body shape as important, and hoping that this study may assist in the recognizing the beauty of difference.

> I wish we could all just close our eyes and just not look at each other…I mean that's what we do…that is the first image we see is that person…their body shape what they look like and then when they start talking and stuff like that hopefully some of that perception goes…the way they look goes.

> …but for some people that's how they see people…the way they look…that's what they concentrate on…how they look… [I wish we could] just close our eyes and just talk, you know.

> I hope they have a better perception of themselves and secondly others. Learning how to …learning that difference is beautiful…I wouldn't want to walk around in a world full of thin people. We would have more body issues then…

4.3. Enhancing Community Sharing and Mental Health:

There were some hopes that a project like this may create an ongoing talking circle, where women can come and feel safe and talk about issues. This may also lead to increased self-awareness, esteem and maybe increased physical activity/healthy choices.

> I have always envisioned a gathering of women where they can come to a place where they feel safe to talk about their issues…and even just to have fun or even just to have even an hour of talking and ..to start some support –hopefully would work even in getting more physical activity.

Some stakeholders discussed the dissatisfaction people have with their bodies and their concern for their mental health and health. They felt this study may help women who are concerned about their weight share these concerns. Miwayawin programming, communities and the women themselves could benefit from learning what women are willing to share.

> The mental health and health implications of that constant stress and that constant dissatisfaction with how they look and how they feel, is really worrisome to me. And I think that one of the reasons I am so excited about this project is learning a bit more about what people feel…

> We have a lot of very dissatisfied people and it seems to manifest itself in people restricting unnecessarily to the point that they get discouraged and then they overeat.

> I'm thinking it has to start small, where you have a small group of women who want to make a change. So start from there and … a talking circle even… you know…we have a lot of good ideas…but if they don't want to work. We kind of

know what people need or should do…but a lot of times people themselves don't know. So its helping them choose …maybe this research project will do that too.

4.4. Making Healthier and Informed Choices:
Importantly, two stakeholders were quite concerned that the emphasis on esteem, mental health and sharing weight concerns did not deflect from physical health concerns. Although they emphasized that thin was not necessarily healthier, they argued that being overweight is not necessarily healthy either, and wanted to ensure that this study did not simply appease the problem of access weight. Their hope was that women may also learn to make healthier choices.

… My perception [is that]…I don't want it to come out that being overweight is necessarily physically healthy for us. But I think it is also to maybe help people look at themselves and maybe some of the choices that they might want to make in the future. Whether it is walking more… a lot has to do with movement and being able to do things to enjoy life.

Like I have a sister who is, you know, very well educated and very overweight and some of her health issues right now…and she has got a lot of issues where her mobility is being impaired and she is not old –she is only 58. But, you know, life is too short to curtail it so early because of bodies physical condition. So, I guess I do want people to be healthier, not the image the media portrays, but healthier.

C: OBSERVATIONS FROM THE FIELD:

Members of the U of S research team (including Brooks, Shea, Schimpf and Poudrier) attended part of a MHS Staff Day on June 7th, 2007. Poudrier was invited to present current information about the newly funded project and to seek feedback from MHS staff. About 61 people were in attendance and the meeting. The research concerning healthy body weight and the use of photography were taken up with some enthusiasm. Poudrier conveyed the importance of the role of a Community Based Research Assistant and several staff offered to assist with filling this role. Several of the team members made contact with especially interested MHS staff. There was a wonderful relaxed yet very productive atmosphere at the meeting. A lot was accomplished and the laughter was contagious. There were also very healthy snacks, which were generously offered.

We were given a guided tour with a Health Portfolio Councilor. We traveled to Moosomin First Nation, Mosquito First Nation, and Red Pheasant First Nation. At each of the First Nations we toured the community sites and the rural areas. At the Moosomin First Nation we toured the arena and health clinic. At the Mosquito First Nation we toured the health clinic and band office and talked with one of the band officials. At Red Pheasant First Nation we toured the health clinic. We were struck by a number of things within the band offices and health clinics. At one health center there was a sign that read "laughter is contagious". This reminded us of the MHS staff meeting, where laughter and humor did seem contagious. The people that we were privileged to meet through the guided tour were also full of humor and kindness—offering information on many of the

programs discussed throughout this report. The atmosphere in each facility was also quite impressive. We saw historical photographs, emphasizing the importance of history. There were also colorful posters and information throughout each facility, which promoted much of the programming discussed throughout this report.

The tour of the communities showed a variety of houses, some in very good condition and others not. There seemed to be a division between conditions of homes, demonstrating a socio-economic division (as exemplified in the interviews, where poverty and socio-economic conditions and problems with housing were viewed as important concerns). There were two quite distinct patterns of settlement. In the first, houses are spread throughout the countryside. This is the majority. The second pattern has a higher density of houses in a smaller area. Our tour guide reiterated some of the other themes within the stakeholder interviews such as: problems with wild dogs, fire and roads. We only saw one dog while we were touring. We felt quite close to nature throughout the tour—a day of sunshine, beautiful prairie countryside and lakes. As we were driving we saw an eagle flying with a live fish in its claws, the fish was still flapping. These examples highlight our feeling of being closer to nature on this trip.

D: INITIAL RESPONSES TO THE PROJECT AND A SNAPSHOT OF THE ENVIRONMENT (STAKEHOLDERS MEETING):

A stakeholders meeting was held on September 24th, 2007 in North Battleford between Band Chiefs, collaborators from MHS, Health Portfolio Councilors, and the research team from the University of Saskatchewan. The purpose of the meeting was to explain the project as a whole and to hear responses from the stakeholders.

Kennedy, Brooks and Poudrier co-presented to the group. Poudrier and Kennedy introduced and discussed the history of the project starting in 2004 and Brooks detailed the method of Photovoice in research. Most importantly, Kennedy described her experience 'piloting' the Photovoice method by sharing the personal pictures that she captured to represent her meaning of the 'healthy body.' The project was enthusiastically received. In particular, it was felt that the method would be a very powerful and creative tool for learning from women – this was made particularly compelling because of Kennedy's willingness to share her personal pictures and describe their meaning. There was a very positive, uplifting atmosphere full of laughter and personal stories. The positive atmosphere resonated into ideas for changing the title of the study to reflect: 'feeling good all of the time', rather than 'feeling bad, sick and getting better'.

Very helpful and practical ideas were presented about recruitment of participants—which have been incorporated into the project. These ideas included; the importance of childcare during meetings and the taking of the photographs; finding ways to reach all the women who might be interested; and finding ways to involve all ages in the project. Everyone at the meeting supported the project moving forward. There was some discussion of hope that males may be included in this type of study in the future.

E: CONCLUSION AND FUTURE DIRECTIONS:

The stakeholders identified the interdependence of social determinants of health as key factors in determining healthy body and healthy body image outcomes, focusing on root causes. The interviews, field observations and stakeholder meetings raised health concerns (related to healthy bodies) such as obesity and diabetes and showed their interrelationship to inequalities, poverty, economics, employment, mental health issues and infrastructural deficits. This research points to the importance of capacity building and community development.

In summary, this report identifies the importance of and goals related to: 1) infrastructural concerns; 2) recreational opportunities; 3) benefits of information and education; 4) importance of social supports—families, communities, (and problems with isolation, work-life balance, self esteem, suicide, addictions, crisis and death); 5) culturally relevant philosophies; and 6) social justice and health inequalities. Importantly, discussions on social justice and health inequalities are reflected in larger Saskatchewan and Canadian statistics as well.

1. Infrastructural deficits:
Discussions on infrastructural deficits revealed needs to improve road conditions, safe walking spaces and transportation. Issues of safety on the roads are critical. Respondents identified safety concerns related to dog packs and problems with youth driving.

2. Recreational opportunities:
The need to continue to support recreational programs and opportunities, including regular and increased support people/staff to encourage participation was also recommended.

3. Information/education:
The discussions about the importance of information and education, social support and access to healthy food also point to the successes of Miwayawin programs and the need for continued community development (and capacity building). Interviews revealed the need for continued health education related to; exercise, healthy eating/cooking and parenting/care-giving. Support for school programs related to health was also critical, as well as increased access to health care services.

4. Social Supports:
Issues related to mental health including; isolation within communities, problems related to work-life balance, self-esteem, suicide, addictions, stress and violence were also mentioned in relation to maintaining healthy bodies and healthy body images. Mental health seems to be both a healthy body outcome as well as a healthy-body determinant.

Although there is a high staff-client ratio when compared to off-reserve populations, there was still discussion on the need to hire more mental health nurses, diabetes educators and dietitians—to keep up with the communities need.

5. Culturally relevant philosophies:
The importance of culturally relevant protocols, non-judgmental approaches to care (practiced at Miwayawin Health Services) and increased social support programs are impressive and cited by stakeholders as critical to understanding their approach to services.

6. Social justice and health inequalities
Interviews and the larger statistics seem to point to the need for governmental policies to reflect residents concerns related to inequalities, health inequalities and on-reserve communities needs—at all levels of government; municipal, provincial and federal levels.

Social justice issues related to inequalities, health inequalities and food security were also viewed as having a critical relationship to healthy bodies. These results also parallel broader Saskatchewan and Canadian findings regarding levels of poverty and unemployment generally for Fist Nations Peoples, especially those living on reserves. According to the Final Report and Recommendations of the Commission on Improving Work Opportunities for Saskatchewan Residents (Pearson, Cuddington, and Thorn, February, 2006), 57 percent of on-reserve Aboriginal peoples in Saskatchewan do not work. We can compare this to the 27.4 percent of Saskatchewan non-Aboriginal people's rate of 'not working' and the off-reserve Aboriginal population, whose rate of not working was 45 percent. The rate of full time work for on-reserve Aboriginal peoples 15 years or older is 14 percent and the part time rate is 29 percent. There is a lack of indicators to recognize low income on Aboriginal reserves. The National Council of Welfare, however, states: "we know…that poverty rates on-reserve, along with urban Aboriginal poverty rates, which we can measure, are very high".

Stakeholders healthy body related concerns of obesity, increasing weight problems for youth and increasing levels of diabetes on reserves are also reflected in national and provincial statistics, showing a need for multiple levels of governmental support. In Saskatchewan, obesity amongst Aboriginal peoples is a growing concern. The House of Commons Standing Committee on Health's report on childhood obesity, "Healthy Weights for Healthy Kids" shows that more than 50 percent of First Nations children are obese or overweight—an alarming trend. Self report diabetes rates in the Canadian population show similar trends. First Nations populations self reported rate is three times higher than for all of Canada (Assembly of First Nations Fact Sheet, 2007; Health Canada, 2005) and this is directly linked to obesity within children and adults. "Diabetes in First Nations communities is now considered to be an epidemic, and rates are higher within the on-reserve populations (Health Canada, 2005) Miwayawin Health Services 2006-2007 Annual Report shows that Diabetes was the top chronic condition. 333 people were seen for diabetes in 2006. This has grown dramatically from 1972 when only 72 people were diagnosed.

Phil Fontaine (Report for the Assembly of First Nations, March, 2007) reflects stakeholders' position that there is a strong link between structural deficits, economic issues, poverty and healthy bodies—including obesity.

Poverty among 1 in 4 First Nations children compared to 1 in 6 Canadian children is the greatest social justice issue facing this country, and it's at the heart of this health crisis.

Childhood obesity among First Nations children is directly linked to overcrowding, poor access to healthy foods and lack of opportunities to be physically active in First Nations Communities.