

# Decolonizing Health in Canada: A Manitoba First Nation Perspective

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## Research Article

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# Abstract

## Background

This paper focuses on a longitudinal research program in Manitoba, Canada, by the Innovation Supporting Transformation in Community-Based Research Project (iPHIT) to learn from First Nations across the province that have developed effective community-based primary healthcare models. The research is relevant and timely as First Nations across the country, and Indigenous populations globally, work towards improvements in population health and health equity via critical analysis and restructuring of health services. The purpose of the paper is to deepen an understanding of decolonization as it is defined within the communities, as a central aspect of health restructuring.

## Methods

The study is a qualitative, grounded theory analysis, which is a constructivist approach to social research that allows for generation of theory in praxis, through interactions and conversations between researchers and research participants. Findings are based on 183 in-depth interviews and eight focus group discussions with participants from 8 Manitoba First Nation communities. The study was designed to understand strengths, limitations and priorities of primary healthcare strategies and frameworks of the communities. The iPHIT team was an active collaborative partnership between the First Nation communities, First Nation Health and Social Secretariat of Manitoba, and the University of Manitoba. The First Nation partners led in all aspects of the research, from development to implementation, data collection, analyses, and dissemination. Respected Elders from the communities also guided in appropriate research and engagement protocols.

## Results

Data was coded and then grouped into 4 interconnecting themes. These are: (1) First Nation control of healthcare, (2) traditional medicine and healing activities, (3) full community participation, and (4) moving out of colonization involves cleaning up and moving beyond the mess that colonization has inflicted.

## Conclusion

Decolonizing health involves a taking back of Indigenous wisdom and traditional activities; connections to the land, resources; intra- and inter-community relationships. Participants emphasized the value of full community engagement with respect to inclusion of different interpretations of and experiences in the world, highlighting creation of a shared vision. The study focused on First Nation community experiences

and interests in Manitoba specifically, though the data may be applicable to national and global decolonization efforts.

## Introduction

Primary healthcare for First Nation peoples in Manitoba has been described as a system that is “loosely” interwoven, resulting in gaps and ambiguities in its delivery of health services (Lavoie, 2013: 1). It is a complex system, fraught with jurisdictional issues, often failing to adequately meet the needs of First Nation populations (Lavoie, 2015; 2013). Changes to the programmatic structure of First Nation health services over the past 30 plus years have not de-fragmented the system and serious gaps endure in the health of First Nations compared to the rest of Manitobans (Katz et al., 2019). Notwithstanding attention to inequities and to the rights and liberties of Indigenous peoples (e.g., Royal Commission on Aboriginal Peoples in 1996 and United Nations Declaration on the Rights of Indigenous Peoples in 2007), substantial problems persist. Inequities are evident in hospitalizations, substandard care resulting in increased morbidities and premature mortality rates, and an uneven geographical distribution of health outcomes among Manitoba First Nations (Katz et al., 2019; Lavoie et al., 2020). Colonization may sound like a word borrowed from antiquity, having little to do with modern delivery of healthcare services, however, as an historical and contemporary process, colonization rests at the root of health and other inequities experienced by First Nation peoples (Mundel and Chapman, 2010).

Over the past decade, First Nation Inuit Health Branch of Canada (FNIHB), the branch of Indigenous Services Canada responsible for funding, and to a lesser extent, delivery of services on reserve, has made changes to programming, accountability structures and engagement protocols with First Nations across the province (Office of Audit & Evaluation Health Canada and the Public Health Agency of Canada, 2016). However, in light of the enduring problems and at an historical time when Indigenous peoples worldwide are casting a light on the underlying causes of ill health, it seems vital that we turn our attention to matters pertaining to governance, First Nation autonomy, traditional medicines and philosophies, and then too, to the interconnections between biomedicine, traditional medicines, and health promotion, including the determinants of health.

Decolonization seems to address the multiple facets of disconnect between healthcare and First Nation health outcomes, and the root of perpetual inequity itself. Decolonization is a process of reclamation of political, cultural, economic and social self-determination, including the redevelopment of positive individual, familial, community and nation level identities. Decolonization draws on colonial legacies, drawing on the knowledges and practices of pre-colonial, “traditional” times (Lang, 2001; Mundel and Chapman, 2010). Decolonization efforts require active involvement of Indigenous as well as non-Indigenous peoples (Mundel and Chapman, 2010). It has a revolutionary potential that requires the dismantling of colonialism as the dominant model upon which Canadian society (Wilson and Yellow Bird, 2005), and healthcare provision, more specifically, operate.

A focus of our research on decolonization stemmed from community discussions on the underlying issues of healthcare provision and the transformation efforts in on-reserve communities with effectively developed community-based primary healthcare models. First Nation active involvement and leadership in the research program brought us to see more directly into elements of healthcare provision that constitute First Nation governance. Within effectively developed, community-based healthcare models there was ample consideration to community-informed direction and interests, social determinants of health, holistic programming, traditional medicine, and jurisdictional bridging. By their very participation, not only in the research program but also in the communities' developments of the primary healthcare models, solutions to complex and persistent issues seemed straightforwardly solvable. Could it be that the problems of modernity, non-dismantled colonialism and the isms it nurtures, can be (are being) effectively resolved within communities with straight-to-the-point discussions based in First Nation ways of knowing, dealing with, and being in the world?

This paper focuses on research by the Innovation Supporting Transformation in Community-Based Research Project (iPHIT) to learn from First Nations that have developed effective community-based primary healthcare models. It emphasizes data collected from the interviews and focus groups pertaining to decolonization as fundamental to transformation, and ultimately to effective healthcare provision. Within decolonization, community representatives spoke on issues of self-governance, traditional medicine, holistic human and ecological wellbeing, full community participation and inter-governmental, inter-population collaboration. The beauty and richness of the research emanates from its methodology – from its reconsideration of expertise regarding the requirements of primary healthcare that is away from providers and institutions towards those requiring and receiving care.

## **Background**

# **International Human and Indigenous Rights as the Backbone for Decolonization of Healthcare**

Canada has a complex history of recognition, denial and acceptance of its colonial relationship with Indigenous peoples. Although, by now, sufficiently recognized within official government discourses, i.e., National Inquiry into Missing Indigenous Women and Girls (2019), Truth and Reconciliation Report (2015), and the Royal Commission on Aboriginal Peoples Report, 1996, Canadian institutions have not made any significant headway in implementing any of their recommendations or progress towards decolonization. Notwithstanding global motions towards restoring emancipation and equality of nations, and nations within nations, we have witnessed Canada's trepidation in its commitment to move forward, despite Indigenous rights being endorsed in international human rights declarations, i.e., UN Declaration on the Rights of Indigenous Peoples (UNDRIP, United Nations, 2007). Even Canada's initial resistance to endorse UNDRIP was met with criticism, for example, Richmond and Cook described the act as Canada's "universal failure to acknowledge both the human... and inherent rights of its Indigenous peoples" (2016:10).

These global reports highlight the need for cohesive public policy that recognizes and supports Indigenous rights to health equity. UNDRIP established what its commissioners regard as a “minimum standard” for endorsement of human rights (United Nations, 2008). UNDRIP is, to date, the most comprehensive international human rights instrument, explicitly addressing Indigenous rights (Coalition for the Human Rights of Indigenous Peoples, 2018). The Declaration is collective in nature, affirming to political, social, cultural, spiritual and environmental rights. It is grounded fundamentally in principles of non-discrimination, self-determination, and cultural integrity (IBID, 2018).

The declaration emphasizes self-governance, control over lands, resources, and recognition and respect for surrounding traditional practices as foundational to health. Non-indigenous accountabilities are affirmed in their contribution to (the space for) diversity and richness of civilizations and cultures, constituting a commonality within the heritage of humanity. It does away with thoughts of a necessary universality, admonishing that for adherence to Indigenous philosophies, education, and aspirations, to be reflected in education and public information (IBID, 2018).

## **Canadian Healthcare Services to First Nations**

Canada operates a publicly funded healthcare program known as Medicare, providing reasonable access to medically necessary hospital and physician services without leaving individual users of healthcare having to pay out of pocket. Health coverage is through provincial and territorial tax-funded public insurance plans. The model’s development was influenced by such policy movements as the WHO Declaration of Alma-Ata. As such, since the Constitution Act of 1867, responsibilities of the federal and provincial/territorial governments were delineated and have evolved in reforms made over the past 4 decades, including in the 1984 Canada Health Act, 1995 Canada Health and Social Transfer, 2003 Accord on Healthcare Renewal, and Canada Health Transfer, 2006-07 and 2013-14. Over time, a greater responsibility for delivery of services has fallen to the provinces and territories, though the basic policy has remained unchanged, i.e., utilizing language and an ideal that universal coverage for medically necessary healthcare services is to be provided to citizens on the basis of need, rather than on their ability to pay (Government of Canada, 2011).

The federal government prepares and administers national principles for the healthcare system under the Canada Health Act. Principles include financial support to the provinces and territories for implementation of health services and functions, including, funding and delivery of primary and supplementary health to certain specified groups, i.e., First Nations.

The Canada Health Act establishes insurance plan criteria and conditions in order for the provinces and territories to receive full federal cash transfers in support of health. Within the relationship parameters, provinces and territories provide reasonable access to medically necessary physician and hospital services. Cash and tax transfers in support of health are provided through Health Transfers. Equalization payments support the less prosperous provinces and territories (Norris, 2018).

For decades now, the federal government has taken on responsibility to deliver a limited complement of healthcare services directly to First Nations, they claim, on humanitarian grounds (Lavoie, 2018). The First Nations disagree with this stance, proclaiming that health and health services are fundamental to their rights as first peoples. The limited services that do exist include primary healthcare services to remote and isolated reserve communities where no provincial or territorial services are readily available, community-based health programs on-reserves, and a complement of steadily decreasing non-insured health benefits (i.e., services not covered under Medicare) for Indigenous peoples, no matter where in Canada they reside. Generally, these services are provided at nursing stations, health centres, in-patient treatment centres, and through community health promotion programs. The programs and their resources are insufficient to meet the demand and the communities struggle to find accessible opportunities to build capacities of the membership to deliver them. Further, it is with hesitancy that federal and provincial governments (or through Regional Health Authorities, where they exist) and First Nation organizations work collaboratively to integrate service delivery within provincial/territorial systems. Notwithstanding a growing interest and understanding of the benefits of collaboration, and alternately, of the detrimental repercussions of jurisdictional barriers (e.g., the life and death of Jordan River Anderson, culminating in the passing of Jordan's Principle in 2007) jurisdictional confusion and a lack of cohesion persist.

Problems with Canadian healthcare services to First Nations are well documented (Lavoie, 2018; 2013; Lavoie et al, 2010; 2015). In fact, Canada has stated its intention to actively grapple with its colonial history. In the Truth and Reconciliation Commission of Canada Report (2015), seven of 94 calls to action refer directly to steps required to address health inequities in Canada. Crucial themes addressed include valuing traditional healing practices, training Indigenous healthcare providers (i.e., doctors and nurses), and setting measurable goals to close gaps in healthcare service accessibility. Further, the Report addresses critical self-governance issues. The Truth and Reconciliation Commission (TRC) calls to action, should they be addressed, would help in reducing disparities in social determinants of health, leading to improved healthcare outcomes (Martin et al., 2018: 1729).

## **Delivery of Healthcare Services to First Nations on-Reserve**

Indigenous Health, as department of the federal government responsible to fund and provide services on-reserve, is supposed to support the delivery of public health and health promotion services to First Nation communities. The Department is to provide non-insured health benefits, i.e., prescription drugs, transportation services to medical appointments, dental and ancillary health services to First Nations regardless of residence, and primary care services on-reserve in remote and isolated areas, where there are no provincial services (Indigenous Services Canada, 2020). On paper, the process seems straightforward, but on the ground, the situation is quite problematic, with families suffering unmet healthcare needs. Claimants of the non-insured health benefits program are often denied reasonable claims. Up against Indigenous Services Canada with their last word, incorporation of a weak and bureaucratic appeal system, and decisions often made by non-medical personnel, it's difficult, and in some cases impossible, to see the benefits realized.

The Assembly of Manitoba Chiefs and First Nation Health and Social Secretariat of Manitoba document services, particularly within dentistry, that have been discontinued once ceilings of expense coverages are reached. An eye on monetary expense overshadows health need to such a degree that individuals are left to suffer pain, and in some cases, more serious illness sequelae. One case made national headlines when a First Nation family from the province of Alberta took the federal government to court after the First Nation Inuit Health Branch of Health Canada denied a child's claim for braces even though her malfunctioning jaw caused pain, and without orthodontics, she would have required invasive corrective surgery, according to court documents (Galloway, Parliamentary Reporter of the Globe and Mail, January 26, 2017).

On-reserve health services are provided to community members from locally situated health facilities. For individuals living in remote First Nation communities, nursing stations, funded by Indigenous Health, Indigenous Services are typically the first point of contact for accessing clinical and client care services both inside and outside of the communities. Nurses typically provide acute care and health promotion services, including assessment, determination of urgency, identification and implementation of necessary action. According to Health Canada, in Manitoba, there are 22 federally funded nursing stations: 21 operated by ISC nurses and one operated by the First Nation community. Additionally, there are two provincially funded nursing stations (Office of the Auditor General of Canada, 2015).

First Nation communities without nursing stations have locally situated health centres, health stations or health offices operated by First Nations through federal funding streams. Services vary between the communities, depending upon the size of the population, availability of medical and medical support staff, and geographical characteristics. Typically, however, they include a combination of primary care, cultural programming, alcohol and drug prevention and health promotion, community development initiatives, social support services, and referrals to health specialists. Where available, First Nations may host traditional medicine, thus ISC may include some funding support for herbal prescriptions, land-based activities or ceremonies, e.g., sweats, fasts, or sun dances, and some travel within provincial boundaries to visit traditional healers.

Local health services may employ a local health director, diabetes prevention, maternal-child health worker and/or mental health worker or counsellor and/or community health representative (the latter's responsibility is to support the healthcare providers and provide information and support to community members, based on holistic and health promotion approaches to health and healthcare). Each community healthcare team also includes one or more alcohol and drug prevention and treatment workers through the National Native Alcohol and Drug Abuse Program (NNADAP).

Beyond this mostly community-based workforce, medically trained staff, i.e., doctors, nurses, and/or social workers, may be available to travel to the communities according to set schedules, as required, or for urgent or special cases. This situation is less than ideal. Funding is not the only obstacle to having permanent or, at the very least, available medical presence in the communities. Often it is difficult to attract medical practitioners to come out to live and work in the remote locations (Communication with

Indigenous Health Regional Director, January 16, 2020). In the meantime, First Nations are working in collaboration with the College of Medicine, University of Manitoba and with provincial and federal governments to expand and improve upon accessibility of medical education and training for Indigenous peoples.

## **Methodology**

### **Analytic Strategy**

We followed the general theoretical assumptions of grounded theory (GT) as described by Charmaz and others in her footsteps (Charmaz, 2003; 2006). GT is a constructivist approach to social research that allows for generation of theory in praxis, through interactions and conversations between researchers and research participants (Srivastava & Hopwood, 2009). The theoretical approach advocates use of sensitizing concepts, which Charmaz defines as background notions that inform the research problem and provide the lenses through which we see, organize and understand experience. Sensitizing concepts become rooted within our conceptualizations of what is and how things ought to be in the world through ideological constructions and relative interpretations of reality. Though they may deepen perceptions, “they provide starting points for building analysis, not ending points for evading it.” In doing the work of GT, we use sensitizing concepts only as points for departure from which to study the data (2003: 259). The principles of GT provide a conceptual grounding while, at the same time, remain open to emergent themes (Sacks, 2018).

Findings are based on 183 in-depth interviews and eight focus group discussions with participants from eight Manitoba First Nation communities. The Innovation Supporting Transformation in Community-Based Primary Healthcare Research Project (iPHIT) was designed to better understand the strengths, limitations and priorities of primary healthcare strategies and frameworks of the communities. The iPHIT team was an active collaborative partnership between the First Nation communities, First Nation Health and Social Secretariat of Manitoba (FNHSSM), and the University of Manitoba.

Participants were chosen who have a substantial interest in First Nation health and healthcare services and who may also have had significant experience working in health services. Elders who had an understanding and/or expertise in traditional healing and medicines were integral to the study.

### **Focus Group Recruitment and Sample**

FNHSSM, First Nation community leaders (Chiefs and their Councillors), and health directors developed the purpose of the research program, collaboratively working through and evolving the overall design and details of the studies. Discussions including researchers and members of the community allowed for critical discussion of relevant issues, education on cultures, values, priorities, commonalities and uniqueness among and between the communities. Relationship building allowed for a better understanding of the kind and degree of work and transformation that was possible through meaningfully developed partnership. A word spoken in one of Manitoba’s original languages offered a

deeper understanding of being – of what it means to be human, First Nations, healthy, and, as the case may be, a health provider, researcher, or political advocate to the peoples.

## **Interview Recruitment and Sample**

Community leaders and health directors suggested community members they felt would be interested in participating in the research program; who would benefit from and be valuable to the studies. Recruitment also occurred through a sort of snowball sampling method, where one invited participant would recruit another. Of the 63 Manitoba First Nation communities, 8 were included, representing language, culture, type of local health service (health centre or nursing station), and geographic location (Phillips-Beck, et al., 2019). Though it appeared, on paper, that there were some communities with nursing stations and others with health centers, in reality, the communities with nursing stations had also developed community-driven health centres or services. This fact is an indication of community striving towards increased community control over and active involvement in community health, with more substantial efforts being placed in prevention and health promotion programming.

## **In-depth Discussions**

Interviews were conducted from 2013-14 in the selected First Nation communities. Discussions were held in participants' homes or at central locations, like health centres or band offices. Interviews generally lasted 90–120 minutes in length.

A semi-structured interview guide included questions with probes organized into several categories regarding health needs, interests, service availability, accessibility, as well as the more fundamental aspects of health and delivery of healthcare programming for First Nations, i.e., philosophy, the history of colonization and self-government. Questions were included about personal and familial experiences in the different levels of healthcare, from community to tertiary or emergency care. Questions focused on biomedical as well as traditional knowledge and resources. Interconnections between jurisdictions, ecologies and areas of expertise were also brought into the discussions. Participants were seen as experts of their health experiences and were invited to share their wisdom in order to add substance to a transformative agenda, which it was hoped, would encourage vast improvements in self-governance, healthcare, and ultimately in the health of First Nations.

## **Analysis**

All of the discussions were audio-recorded and transcribed verbatim. Analyses were informed by GT methodology and techniques for categorization and coding of qualitative data. Transcriptions were imported into Nvivo software, which assisted in the management and organization of the large datasets. Excel was also used to organize observations from the data and to record the emergent themes. Transcripts were checked for accuracy against the audio-recordings.

A second phase analysis included line-by-line coding and constant comparative method by which newly collected data is compared to former existing data in order to derive new codes, themes, and conceptual focal points. Codes were grouped into the following 4 themes: (1) First Nation control of healthcare; (2)

traditional medicine and healing activities; (3) full community participation; and (4) moving out of colonization involves cleaning up and moving beyond the mess that colonization has inflicted.

## **Ethical Overview**

Ethics approvals were sought and obtained from the University of Manitoba Research Ethics Board and from the Health Information Research Governance Committee (HIRGC), which is supported by the FNHSSM and is responsible for ethics reviews of all research proposals involving First Nations. Consent to participate was communicated through Band Council Resolutions made by each participating community, after meeting by project team members. The research adhered to the First Nation principles of ownership, control, access and possession of data (OCAP), which gave the communities decision-making authority regarding the details of information collection, utilization, and management (First Nation Information Governance Centre, 2020).

## **Findings**

Joint analyses and interpretation of the findings revealed substantial evidence that the communities were looking more profoundly into the problems of poorly delivered healthcare services and health inequities. Issues brought to the fore were consistent with those highlighted by national and international commissions regarding reconciliation, health and wellbeing, Indigenous rights and liberties. What the community members generated through the interviews could be described aptly as substance to conceptual images conceived in central discursive circles. Essentially, we were all on the same page regarding it being high time colonialism was brought to the head, however, the work that the communities were doing was providing an actual ground upon which to build a decolonizing, and therefore, transformative agenda. A culmination of work that can be described as decolonizing was broken down into pieces of not only coming out of a colonized mindset but re-entering into and revival a traditional mindset, that included values, aspirations, and a way of doing health work that was outside of what has for over a century been shaped via colonial and, inside of that, biomedical power and control.

## **First Nation Control of Healthcare**

The first theme involves a realization that someone must be controlling what gets done in healthcare, including what gets prioritized, attended to, and ignored. Community members believed it was necessary to inquire about one's roles and responsibilities in order to create change. If one is not actively involved in decision-making about health matters that involve self and family, it is important to ask how this has come to be so or, perhaps, where that authority has gone lost. Interviewees across the communities agreed that control over such matters was taken from them by the Canadian governments. Consequently, they agreed in the necessity of resuming that control.

First Nation control and ownership would provide better access and would have the biggest effect on community health (A027).

Government has just conditioned us too much as Aboriginal people... They want to control us, and they want to stop where we are (wanting to move forward). Now we need to start empowering our people with knowledge and power and give back to take ownership of their communities, their health (GFG004-4).

What we need is less interference from government. Like right now, we are simply agents of the federal government. We administer their programs. We need access to resources which we can control and be accountable for, but control as we see fit (C008).

We need to have more awareness and more participation from individuals themselves, patients themselves. I believe they need to be more accountable for their own health (C016).

Self-governance begins with the family. The healthy part is to have vision by the community. We want the community to be healthy and it has to start from the self and then family and then community – just having the opportunity to make decisions and for communities to create their own guides for wellness (D005).

We need to get over what was imposed on us, those laws. One way... is creating our own constitution, creating our own laws. The Province of Manitoba and the government of Canada have to ensure, the economic capabilities of First Nations are supported, we need room to grow. The best way of doing that is by giving First Nation people opportunity to govern (D014).

First Nation models of health and wellbeing were holistic, including multiple domains of human development – physical, emotional, mental/cognitive and spiritual, as opposed to biomedicine's focus on the anatomical/physiological body. Further, healthcare included attention to how individuals live within their multiple ecologies, including what they eat, how they hunt, gather, and prepare their foods. Paying attention to prevention and health promotion strategies would go a further way than medical surgeries in resolving chronic disease epidemics.

Prevention! We are so focused on intervention right now, it's tough to turn to prevention, but we're taking steps in the right direction and if we can just front load our prevention models, the better it will be because that means we're doing everything we can to provide tools and skills to emerge to address those health issues before they become life threatening (D014).

Decolonizing the mind and the way the mind is interpreted, to participant interviewees, meant having thoughts and behaviours understood and respected from within a perspective that acknowledges the values and meaningful existence, what it means to be a First Nation person.

We need more psychiatry, but psychiatry based in our society. They come in and they don't understand our society, the way the society is (A007).

To decolonize requires an emphasis by communities to develop local expertise, working within communities, and according to traditional methods of health provision and understandings about the human condition.

We would have our own band members as physicians, which we might be close to having in the next couple of years. A lot of people in the health centre are our own band members, which is fantastic. A lot of First Nations communities don't have that yet (D014).

Quality healthcare is to have a good nursing station with all of the programs that are needed, NNADAP, mental health, nurses, medications, having all of those services here, all complete... A lot of lives can be saved just by keeping people here instead of sending them away so much (C011).

To train people better, work together with the community in our way and I think you'd have something substantial. I think now the people lack capacity (C011)

Permanence is essential, permanent... not temporary nurses... (C011).

Decolonizing spaces as well as work patterns were aspects of taking back control of health, as the following comments suggest.

The (community health representatives) need to get out of the offices, go door-to-door and see about the people in their homes, home visits, taking healthcare to the people and embracing health as a community (A007).

We're all scattered. We're not in one building or space as health workers. The nursing station is over there, social services is over here, and the other health workers are in a different area too. Sometimes no one knows what's going on (A005).

## **Traditional Medicine**

Communities saw colonization as a system of beliefs and practices imposed upon them, at the same time devaluing, ridiculing and forbidding traditions. Biomedicine halted development of First Nation medicines and healing philosophies. Now, the participant interviewees said, it was time to bring these knowledges back to the forefront of healthcare.

We would have traditional medicines brought back at the nursing stations for people to use. Our people are losing their limbs from diabetes and this isn't supposed to happen. I have that medicine for that so that won't happen to them. They won't have to lose their limbs (C012).

The main thing, the fear of the traditions has to be erased (A005).

Too many people now don't believe in our culture. They don't even believe in traditional values anymore. There's been a conflict, I guess, between white society and our own culture. There's just a lot of people have been brainwashed into thinking that culture is bad. You don't want to see a medicine man because generally, people think it's bad to go to one. And when somebody does go, they think they're practicing black magic or something like that. So, people tend to stay away from something like that (A007).

We have to re-educate our people on our own traditional medicines. We have a lot of learn and to differentiate, which herbs to use for spirituality and for physical health and so on. Educating to the purpose of the benefits of traditional uses of medicines is important. A lot of these chemically produced medicines have a lot of side effects. We need to get the people that have knowledge of these traditional medicines to explain the benefits of the traditional medicine, the herbs, and so on, bringing down the disillusionment that the community may have of using such traditional medicines (C005).

Revival of First Nation traditional knowledge would involve collaboration between the communities.

We can have a guide, a guide that would be for the community or for all the nations. If we're going to have our own guide, I guess to have some understanding, there's only certain things that are growing or could be grown in this community. In other communities there's only things that can be grown there. So, a guide would be a good thing to begin with. Like, we're got access to this, this is what we can grow and that is how you can use it, stuff like that. Because you have a lot of Manitoban communities, they do come pick sweet grass here, even from Saskatchewan, Alberta, Ontario, and British Columbia (the other provinces). They actually travel all that way to come and pick the medicines (D005).

Elders in each of the communities are thought to hold pertinent knowledge about traditional health.

It's more than the medicine men or medicine people involved in spirituality or have knowledge of such medicines. It's our Elders have a working knowledge of these medicines but they are not being utilized so we need to promote education, give them a place to share, in a working group, groups together that are interested in medicines and further our understanding, utilize what we have and study (C005).

Reconnecting after colonization was seen as pivotal to reclaiming health and healthcare. Traditional medicine and healing activities presupposed human-ecological interconnection. Importantly, what was interrupted with by the colonial regime was still accessible to the people, it may be hidden, in need of rediscovery, but discoverable, ready to be revitalized, nonetheless.

My dad was torn apart from his land and traditions. When I came back here, I was filled by that, all of the traditions and family that I missed out on. I never wanted to leave, the sense of community, the sense of the land and the people. When I do leave, even for a day, I get lonely, I get physically sick. We're safe here and you feel it, you're at home, on the land, something with the land, a bond, something (A007).

Our medicine people are coming back strong. The western doctors, they did so much harm than good (D012).

## **Full Community Participation**

Participant interviewees highlighted the fundamental importance of full participation in community development matters. Everyone had a voice. Personal and unique experiences of each gender and age group were vital to the creation of the type of healthcare services that would attend to the needs of the people. This type of participation is inherent in a First Nation conception of self-determination.

It's an integrated system we need that delivers services based on the health needs of the community (A027).

Most of our problems are about social issues. People are hurting, suicidal, heart-broken parents, these need to be understood and addressed, people need a place to just be heard and to be (A029).

We need to listen to the kids, our youth, because they are the ones that are going to take over this health centre one day. If these kids get healthier and more cultural that will be such a positive thing in the community (B005).

Open dialogue, I'm looking at this question from our oral tradition, which is more or less for me, open dialogue. Get the feedback from the people, the ones that are receiving the healthcare and what they think can be improved (C005).

People get stuck and it's only one person making all the decisions, it's got to be everybody, the whole community to say, "Let's get on board, let's help one another, support one another and make those changes as a community" (F006).

The vision should be created in consultation with community. So many times, the community is left out (F1).

With the older people that are out there now, I would want... the youth to do that... go and visit the Elders... Visit them, learn something from them while they're still here... We need to get their input and learn. We need to get back some of that what the Elders had in how they grew up and how these youth have grown up that which are two different things all together! Learn from each other because some of these older people, even a lot of young people don't know medical things... It is time consuming, but you can learn and teach in discussions (C010).

### *Moving out of Colonizing Involves Cleaning Up and Moving Beyond the Mess that Colonization has Inflicted*

Whether or not participant interviewees focused on a need for more biomedical intervention brought closer to the communities, or even, into communities, or for improved health and wellness via holistic, health promotion and preventative strategies, one thing was agreed upon – colonization has reeked a havoc on individual, family and community life, so much so that all facets of life and living must be attended to in order to revive health. Healthcare in First Nation communities would have to delve into the social determinants of health, issues of self-governance, and human-ecological interactions – across the life span. The multiple perspectives are evident in the following comments.

Our population has grown in the last few years. This place needs a hospital, should have had a hospital years ago (A002).

More resources instead of having to go out of the community for care, such as x-rays (A008).

We have different doctors coming and going but we need to have a permanent doctor stationed here (C003).

By far, not all of the research participants agreed that the antidote to the serious health inequities in Canadian society was more biomedicine. Most focused their discussions on the social determinants of health, preventative measures, and on cultural traditions in order to create healthcare programming in line with First Nation perspectives on health.

There are a lot of ailments in this community, major deficiencies regarding health and there is a disequilibrium of wealth. There is a lot of abject poverty and with poor health conditions. I don't think access to healthcare is equitably distributed. Negative dynamics like drugs, alcohol, solvent abuse and dysfunction in peoples' lives (C016).

When it comes to health, it's not just the physical health of the person, it's a whole lot of things that surrounds that person and preventing them from becoming healthier. We can focus on those things (D014).

We have to go back to the land. Going back to the land means going back to culture. Chopping wood, making a fire... we have to bring that stuff back (A007).

Reconnecting with the land is all a part of health and the governments can support us on that (A0101-2).

## **Results And Discussion**

The participatory research study gathered voices of First Nation community members on the topic of transforming primary healthcare practices, ultimately towards improving the health of First Nations. The stories, comments, and ideas culminated in an action-oriented response to decolonization. Across the communities, people knew what they needed in order to live a healthy life – to participate in the making of that healthy life. Contrasting the knowledge gained through data analysis brought us to wonder – have we complicated health so much so that we have destroyed the simple logic of how to live a healthy life? It seems power and governance issues have had such detrimental impacts on humanity as to cause discernable differences based on race, class – the creation of boundaries between human beings. Participant interviewees shared community struggles in taking back their wisdoms about the land and healing properties of substances that come from it. Colonization shaped people to doubt themselves, to feel shame about the very things meant to keep them well in the world, in their governance, and in their interactions between others and the natural environment.

Wisdom, after colonization, was a privilege only of those who earned degrees from colonial institutions. In this way, Elders stopped sharing what they knew, and medical men and women almost no longer existed. Community members at large were not asked what they thought nor invited to participate in health development activities. Instead, they learned to consult with experts outside of themselves and

their cultures. All of these losses were discussed. All shaped the determinantal social determinants of health, the poverty, the serious addictions to drugs and alcohol that we see today.

In discussions on decolonization, participant interviewees talked of the need to encourage self-determination within the communities. They emphasized the value of full community engagement with respect to inclusion of different interpretations of and experiences in the world. They highlighted the creation of shared vision for health, a notion that is consistent with previously published research (Nussbaum, 2003; Murphy, 2014). Self-determination is a capacity realized in common by members of a distinct political community, working together within shared political institutions to determine laws and policies that will share their individual and collective futures (Murphy, 2014). Engagement, for the participant interviewees, was essential for self-determination. Community empowerment developed out of a shared respect for the engaged work of community members – a kind of vitalizing medicine that develops from within.

The focus on full community participation in planning, knowledge sharing and decision-making is also in keeping with previous published research. For example, Smylie et al. (2016) reported that local investments in all aspects of healthcare including planning, community perceptions of the programs as intrinsic, otherwise stated as having claimed a sense of ownership through high levels of engagement, are linked to positive health results.

Decolonizing health means clearing and taking back in a sensible and instinctual way. It involves a sharing of power – the power to know, based on being in the world and a power to do, according to one's learned and sensual interactions with physical environments. The participant interviewees shared deep thoughts about reviving lost, hidden, and denigrated knowledges. Importance of cultural continuity, revival, and the relationship between preservation, health, and self-determination was studied previously (Kirmayer et al., 2017; Oster et al., 2014).

## **Conclusion**

The paper focused on the work of community members from 8 Manitoba First Nation communities to decolonize health in Manitoba, Canada. Decolonization as a concept is consistent with the work of national and international commissions discussed in the background section of this paper. The participant interviewees, guides to our overall research program, informed on the nuts and bolts of decolonizing – the how to undo colonialism and its detrimental impacts.

According to principles of qualitative research, one important limitation to consider is the generalizability of research findings from some small communities to, in this case, First Nation communities broadly. From a decolonizing lens, this research adds an important dimension to advancing the knowledge-base as it raises the voices and iterates the perspectives and opinions of First Nation people – healthcare workers, directors, community leaders, Elders and members at large – on a grave and timely topic.

Decolonization, as the participants of this research describe it, essentially involves all members of the communities, their wisdoms, and life experiences. Future research will only strengthen our understanding about how to move past colonization to greater inclusion, development of traditional medicines, and of being in and interacting with the natural environment. Ultimately, the data gathered over the course of this research will offer meaningful and transformative strategies for improvement of primary healthcare in First Nation communities, by empowered First Nation communities.

## Declarations

- Participation in the study was voluntary and withdrawal available at anytime. Full consent was given by each participant and by the community leaderships, as per First Nation community protocol and University of Manitoba ethics for scientific study. Ethical approvals were obtained from the University of Manitoba Ethics Board and from the Health Information Research Governance Committee (HIRGC), which is supported by the FNHSSM and is responsible for ethics reviews of all research proposals involving First Nations.
- Consent to participate was communicated through Band Council Resolutions made by each participating community, after meeting by project team members. The research adhered to the First Nation principles of ownership, control, access and possession of data (OCAP), which gave the communities decision-making authority regarding the details of information collection, utilization, and management (First Nation Information Governance Centre, 2020).
- Permissions and consent forms included consent for participation, given by all participants, accepted by the ethical oversight committees. Qualitative data and material is available to the researchers with privacy protocols assured.
- There are no competing interests to declare.
- Canadian Institutes for Health Research (CIHR) provided the funding for the research.
- All of the authors listed contributed to the research and writing of the paper, listed in the correct order above.
- We are thankful to the 8 First Nation communities who participated in the study and the First Nations Health and Social Secretariat for taking leadership and providing oversight throughout the study.

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