From Head to Heart-

Listening to Manitoba healthcare leaders' experiences of structural barriers with meaningful implementation of Canada's Truth and Reconciliation Commission's Calls to Action

by

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Abstract

As a Winnipeg Métis woman and practicing registered nurse, health leader, and traditional ceremony person, reconciliation in Canada's healthcare sector is of paramount personal and professional importance. Settler-colonial relations, which permeate every sector in Canada, continue to pose multiple threats to Indigenous sovereignty. One reason for this is that current structures intentionally silence Indigenous ontology.

Purpose & Design: The purpose of this study was to move discussions about Indigenous health away from a health disparities' focus and towards one that centers Indigenous ways of knowing, being and questioning. At its core, this study explored the present-day effects of colonialism influencing healthcare leaders within Manitoba. The research objectives were to gather health leaders located in Manitoba and listen to their stories of promoting reconciliation, decolonization, or Indigenous self-determination within health service delivery and use Medicine Wheel teachings to extend understandings and consider medicines to move forward in balance while working within colonial structures. A qualitative research design was used.

Methods: Utilizing two-eyed seeing and the Medicine Wheel as guiding frameworks, this study employed an Indigenous ontology, which at its core, acknowledges relationality as central to its methodology. This relationality extended to spiritual realms and incorporated Indigenous and Western research methods into ceremonial work. An integrative review of the literature was conducted to construct a backdrop to the study and describe how reconciliation was or was not progressing in the Canadian healthcare system. The research approaches drew on two Indigenous research methods: Kovach's Conversational Method (2010) informed the one-on-one interviews with a phenomenological approach. Then, Sharing Circles as described by Lavallee (2009), informed the gathering of participants or storytellers to share within a circle, corroborate initial findings, and dive deeper into the meaning of their shared experiences. Individual interviews were transcribed verbatim. Data analysis was done by reading transcripts in their entirety to get a sense of the whole. Direct quotes that highlighted shared experiences of the storytellers were then shared with members of the research team. A facilitated group discussion about the spreadsheet and transcripts followed, and a sense related to the shared experiences of our storytellers began to emerge.

Sample and Setting: A purposive sampling strategy was used to recruit policy makers and administrators working as leaders in healthcare at a community, regional, provincial, or federal level in the province of Manitoba. In total, eight participants or storytellers volunteered to share their perceptions and experiences of promoting meaningful reconciliatory practices, either through policy or activities in the workplace. Seven participants or storytellers identified as having Indigenous ancestry and one participant identified as a non-Indigenous healthcare leader.

Results: The key findings indicated that *voice; claiming; dismantling systemic oppression;* and *roles and life calling* intersected at the center of the Medicine Wheel to support balanced and meaningful engagement with the Truth and Reconciliation Commission's (2015) *Calls to Action.* This Medicine Wheel shows that it is essential for health leaders to walk in-balance to support reconciliatory efforts and provides some insights into the right actions which will support them to do so. These right actions effectively connect the head to the heart to shift ways in which we engage in reconciliatory efforts.

Significance: Ultimately, the participants or storytellers shared that reconciliation must begin by Canadians acknowledging the right of Indigenous Persons and their ancestral rights to self-determinations, while simultaneously understanding that the current relationship between existing colonial structures and Indigenous people requires major restructuring to effectively address the health needs of all Canadians. By privileging relationality and other Indigenous epistemologies, this study facilitated an experiential understanding, reflexivity, and insights on how to move forward with reconciliatory practices from the perspectives of healthcare leaders.

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I would like to thank the storytellers for their candidness, vulnerability and time offered to this project. I hope the findings prove helpful as you move forward in the important and work that is so crucial for Indigenous (Status and non-Status First Nations, Inuit and Metis) people and their communities.

Thank you finally to ceremony for connecting me to hope and purpose. May everyone find their way here.

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Prologue: The Meaning in the Methods- Centering the Self in the Research

From an Indigenous paradigm, all learning is experiential (Doucette, Bernard, Simon & Knockwood, 2004; Wilson, 2001). Over the course of this study, it is this paradigm which moved me beyond a two-eyed seeing approach and towards two-eyed doing (Dr. Elder Albert Marshall, as cited by Martin, 2012), which are more fully discussed and defined in the following chapter. By incorporating the Medicine Wheel framework through each phase of this thesis, I was able to foster a common understanding of what it means to walk-in balance in colonial structures while engaging with the Truth and Reconciliation Commission's Calls *to Action* (2015). Guided by Elder Mary Wilson, we invited spiritual realms into our discussions, by walking together in ceremony[1]. In this way, Elder Mary Wilson and I included a First Nations' perspective as part of the discourse (Saskamoose et al., 2017; Wilson, 2008). By combining those realms with Indigenous methods of data collection (Lavallee, 2009; Kovach, 2010), supported by empirical phenomenological analyses (Giorgi, 1985), my thesis committee and I created a methodology that was based on an Indigenous epistemology with Indigenous research approaches and a Western method. Elder David Blacksmith captured both the methods and the spiritual aspect of the project through art. The painting entitled *Medicine* (shown above) is designed to support the reader to make spiritual connection to the work found herein. It is based on the Medicine Wheel framework, however was designed specifically with the audience of this project in mind. As the painting is reflective of finding for this study, it is discussed further in Chapter 5 where study finds are addressed.

[1] Throughout the document, there is reference to *ceremony*. For the intents and purposes of this manuscript, the term *ceremony* describes sacred cultural practices that are tied to land and culture and work explicitly with spirit. Ceremony is inherent to traditional Indigenous culture.

At the centre of the framework, and thus the study's findings, we find our researcher (me). As a ceremony person, a researcher, and an Indigenous health leader, ethical considerations for this project included obligations beyond Chapter 9 of the Tri-Council Policy Statement 2. Obligations as an Indigenous researcher- as outlined by Lavallee (2009), involve answering the following questions, "Does this method allow me to fulfill my obligations in my role as a researcher? Does this method help to build a relationship between myself as researcher and my research topic? Does it build respectful relations with participants?" (p.178). By working with spiritual realms and inviting not only the study's participants, but also, the reader into ceremony, I created a living document, designed to support an experiential understanding of an Indigenous worldview and one too, of the Medicine Wheel. In that way, I have fulfilled my obligations as a researcher and sought to create meaningful relationships between myself, the participants or storytellers[2], and the research topic. Wilson (2008) stated that we needed to move beyond Indigenous perspectives in research and towards research from an Indigenous paradigm (p.175). This study drew heavily on teachings from Indigenous researchers, namely, Margaret Kovach, Lynn Lavallee, Linda Tuhiwai-Smith, and Shawn Wilson. These Indigenous methodologists were instrumental in advancing what could be possible for Indigenous health research. It is my hope that the guiding frameworks and methods employed in this study continue to advance an Indigenous health research paradigm from within the University of Manitoba's College of Nursing and beyond.

A Note about Language

The use of language is often inconsistent throughout this text. Cree, Ojibwe, Maori and English are all used interchangeably. As a Métis writer from Treaty One Territory, who gained

[2] Here, *Storytellers* are synonomous with *Study Participant*

experience through time in New Zealand, the use of language in this way is intentional and reflects my colloquial way of speaking. Although English may be my first language, using Indigenous language is a means of decolonization. It has been done so here, both purposefully and organically. I was guided by Elder Mary Wilson in many aspects of this thesis. Because you are reading this thesis and I interpret that as you and I co-creating our understandings of this work, I may use different pronouns such as I, me, we, our and us when I am talking about the research.

Chapter 1- Introduction

> **Sperm Whale** (Physeter macrocephalus):* Grows to up to 60 feet long, weighs up to 63 tons; * Follows its food supply through the world's oceans – is generally found in colder seas in summer and in temperate and tropical waters in winter; * Feeds on small fish, squid, giant squid: * Dives to depths of at least 3,300 feet — deeper than any other marine mammal; * Holds its breath while submerged for up to 90 minutes; * Displays enormous teeth on its lower jaw; * Was the principal prey of the nineteenth-century American whale-fishery; * Haunted Captain Ahab in the classic American novel, Moby-Dick. (New Bedford Whaling Museum, n.d.).

The sperm whale exhibits a complex social organization that is not well understood (Encyclopedia.com, 2018). One of the largest cetaceans, it was hunted near-extinction, primarily for spermaceti oil taken from an organ in the nose. In addition to oil, the mammal was valued as the source of ambergris, a waxy secretion used in the fabrication of perfumes. The sperm whale has been commercially hunted for centuries, reaching its peak in 1820-1860 and again in 1960-1962 when new technologies assisted in taking 67,000 individuals in only two years (Encyclopedia.com, 2018).

One of the most devastating effects of European colonization across the globe is the dispossession of land from its Indigenous stewards (Andrews, 2015; Little Bear, 2000; McAdam, 2015). Practiced over millennia, these multidimensional relationships that Indigenous people have to their lands and territories are described as ontological and intrinsic to what it means to be Indigenous. Relationship to land is reflected in Indigenous law and is the basis for Indigenous rights as well as responsibility (Chiefs of Ontario, n.d.; Webber, 1999). Indigenous understandings of their relationships to land are also directly tied to conceptualizations of

Indigenous sovereignty. "[W]e possess inherent rights to self-determination. These inherent rights were not endowed by any other state or Nation, but are passed on through birthright, are collective, and flow from the connection to the Creator and our lands." (Chiefs of Ontario, n.d.). As evidenced by the devastation inflicted on the Sperm Whale, Western Ideology has repeatedly demonstrated that the ontology that drives Western practices is that *any* action, including the taking of lives, is justified if there is an opportunity for profit or for "progress". In this case, the justification of the slaughter of the Kings of our planet can largely be attributed to settler-colonial appetites for perfume. The gestation period for a sperm whale is said to be anywhere from 480-590 days. (Encylopedia.com, 2018). The gestation period for this thesis was much longer.

If I had to choose the moment that the seed for this thesis was planted, it would have been when I was sitting on the banks of the Assiniboine River in late fall 2017, near the beginning of my graduate studies. I did not know at the outset, that graduate school was to be the thread that I would follow that would lead me back to my grandmother, and so too, back to myself. A raven spoke to me and told me the path I needed to follow based on where I had arrived then. This process of discovery has required blind faith. It has been weaving a tapestry without a pattern. Each experience a thread. The threads soon organized themselves, weaving together and began telling me their story. A story which is my own. A story that I am here to share with you now.

As a Winnipeg Métis woman, traditional ceremony person, and health leader, the concept of Indigenous sovereignty over health services administration has broad implications and possibilities on how Indigenous ways of knowing can shape future health systems in Canada. As a practicing registered nurse since 2003, I have held various nursing roles, and in the past eight years, have moved into health leadership. I have had the opportunity to serve in a number of

roles as a nurse working in healthcare administration, beginning in patient advocacy- as a Patient Relations Officer at an acute care facility in Winnipeg; moving towards program development- as Director of Programs and Engagement for the Manitoba HIV Program; in program implementation as Health Educator for a Tribal Council in Manitoba; and most recently, as the incumbent for the Director of Indigenous Health- Patient Services for the Winnipeg Regional Health Authority. Due to locality, as well as being an Indigenous woman in health leadership, Indigenous health has been at the forefront of many considerations unique to each of the roles described above.

Manitoba has the largest Indigenous population in Canada, making up approximately 18% of the total population (Statistics Canada, 2017), with Winnipeg having the largest urban Indigenous population in Canada (Statistics Canada, 2017). In 2012, I had the opportunity to work internationally supporting emergency relief efforts with *Doctors without Borders.* Upon my return to Manitoba in 2016, given the proximity of that time to the publication of the Truth and Reconciliation Commission (TRC) of Canada's report (2015), there was a lot of excitement and discussion around the implications that *Calls to Action* (TRC, 2015) could have on healthcare delivery, health access, and health outcomes for Indigenous persons in Canada. I had the opportunity to speak with other provincial health leaders who had desire to support the implementation of the *Calls to Action* (TRC, 2015), but who also openly expressed a poor understanding of what reconciliation in relation to Canadian healthcare delivery really meant. There seemed to be little consensus on the term *reconciliation* itself and Indigenous sovereignty over health service administration was only given consideration if Indigenous led organizations could reconcile themselves to providing care through a Western biomedical model. This model, which focuses almost exclusively on health outcomes, perpetuates rather than disrupts colonial

thought, and therefore perpetuates colonial values. Given that the impact of colonialization and government assimilation on Indigenous people has led to health inequities (McDonald & Steenbeek, 2015), conversations at these planning tables, inevitably seemed to focus on health deficits and disparity. Without an Indigenous lens or perspective privileged centrally to the discussion (although there were Indigenous people at the table), reconciliation seemed to be yet another government platitude, which sought to manage the *way* in which Indigenous sovereignty over health services was going to be carried out in the present-day, Canadian colonial context.

Research Aims and Objectives

The report released by the TRC (2015) was written to describe the truth of what happened during the era of Canada's residential school system. The report refers to historical events and context to examine the agonizing truth found in the stories which share the experiences of Indian Residential School (IRS) survivors. But the TRUTH is not historical. As evidenced by the latest National Inquiry for Missing and Murdered Indigenous Women and Girls (MMIWG, 2019), the legacy and impacts of colonialism including the IRS system is still impacting Indigenous lives in Canada today (McGibbon, 2019; McNally & Martin, 2017). Racism and settler-colonialism, land dispossession are ongoing (Andrews, 2015; Little Bear, 2000; McAdam, 2015). It is not too late to change course, but this will require commitment from every Canadian, especially Canada's health leaders. It is this precise commitment from which the study's purpose was derived.

Reconciliation within healthcare services has been proposed to be a foundational step towards addressing current day colonial relations (Jackson & Ward, 1999) and would disrupt the ongoing legacy of colonialism and systemic racism underlying persistent health disparities among Indigenous populations. Despite governing bodies' reconciliatory efforts, current policies,

procedures, and overall function of these health systems are ineffective and at odds to disrupt colonialism (McNally & Martin, 2017; Richmond & Cook, 2016). One could propose that a reason for this is that health leaders, including Indigenous health leaders, function within these colonial systems, and within their job positions, they are most likely required to perpetuate colonial relations. Current evidence indicates that conceptual models guiding reconciliation are rooted in Western science, thereby they may serve to compound the effects of colonial practices rather than disrupt them. *As a result, this study aimed to explore the present-day effects of colonialism influencing healthcare leaders within Manitoba. There were two research objectives:*

i. *To gather Manitoba health leaders and listen to their stories of promoting reconciliation, decolonization, or Indigenous self-determination within health service delivery.*
ii. *To use medicine wheel teachings to extend our understanding of these stories and consider medicines to move forward in balance while working within colonial structures.*

Reconciliation in the Modern Canadian Health Context

To clarify the study's key concept, it is important is to understand the shared lived experiences, and thus shared epistemologies amongst many of the storytellers involved in this study. The reason for this is that the storytellers, who contributed to this body of research, are also the principle knowledge users of the study's findings. The practical application of the relationships drawn from my analysis and the collective analysis supports working in reciprocity with the participants of the study, which is foundational to Indigenous research methodology (Kovach, 2010; Tuhiwai-Smith, 2012; Wilson, 2008). This understanding aided not only with knowledge translation, but with adapting the theoretical framework to the context of this study. Many of the storytellers' narratives focused on health inequities for Indigenous peoples. Public

health and health promotion activities are grounded in the understanding that addressing primary causes of health outcomes is key to addressing health inequity (Flood et al., 2015). Indigenous people in Canada experience far greater health disparity than other ethnic groups (Health Canada, 2018). It is well established that these health disparities are associated with a variety of determinants of health that increase vulnerability to illness (Adelson, 2005; Benbow et al., 2016; Thurman & Pfitzinger-Lippe, 2017). In the broader context, vulnerability to illnesses among First Nations and other Indigenous Persons is rooted in the social determinants that are linked to the unjust circumstances resulting from European colonization (Larkin et al., 2007; TRC, 2015). It was, therefore, ***the study's intended purpose*** *to move the discussion beyond the examination of the roots of health inequity, and towards a common understanding of next steps towards a more balanced and equitable future.* In this way, the study's findings may be meaningful to the storytellers and their colleagues and will provide concrete steps to continue this work.

What do We Mean by Reconciliation?

Before addressing the broader theoretical underpinnings of the study, we begin by cultivating a shared understanding of *reconciliation* as a concept. There remains much ambiguity surrounding the definition and concept of reconciliation in the literature. "Paradoxically, while the confusion remains largely unresolved, the term gains steadily in usage and importance" (Bloomfield, 2006, p.5). Much of the ambiguity is derived from the interchangeable usage of reconciliation as both an outcome and a process (Bloomfield, 2006; Hamber & Kelly, 2004). Much of the literature has concluded that to conceptualize reconciliation, it is impossible to separate the two, "those who separate the former from the latter should, but often do not, tell us what to call the process if reconciliation is the outcome, or alternatively, what the outcome is if reconciliation is the process" (Bar-Tal & Bennink, 2004, p. 46). As reconciliation resides within

the context of cultural genocide and trauma, that are legacies to Canada's IRS, many non-Indigenous Canadians, including health leaders, often experience a sense of blame and shame, followed by defensiveness, when broaching the topic. Such emotional responses contribute to an ambiguity of what 'reconciliation' suggests, that is, what is required from both Indigenous and non-Indigenous people. Subsequently, both the emotional response and lack of clarity contribute to non-action or misguided actions, and failure to redress the impact of historical and ongoing colonialism.

Although reconciliation has been defended as an umbrella term (Bloomfield, 2006) and current context obfuscates our understanding, key defining attributes are presented, regardless of sector or context. These defining attributes are: i) two or more elements (information, ideas, objects, people, groups) must exist in a disharmonious state; ii) followed by a process or action aimed at creating a new dynamic between said elements. If one accepts these to be appropriate, then it is reasonable to state that the quality of both the outcome and the process of reconciliatory efforts supersede the existence of reconciliation itself. Thus, it is not enough to claim one is engaging in reconciliatory actions, but one must consider *how those actions meaningfully engage with Indigenous perspectives and priorities* – and what will be the resulting new relational dynamic.

Adopting a Two-Eyed Seeing Approach

To inform health leaders who wish to advance reconciliatory efforts in the modern Canadian context, we must adopt a two-eyed seeing approach, as envisioned by Elder Dr. Albert Marshall (Martin, 2012). By demonstrating that both Western and Indigenous ontologies can co-exist in often complimentary ways, Western academics and other dominant system thinkers will potentially more easily and readily grasp Indigenous ways of seeing and doing. There is a large

body of evidence that supports the marriage of traditional Indigenous ways of knowing and approaches to health practices within the current Canadian healthcare system as a necessary means to help reduce health inequity (Adelson, 2000; Adelson, 2005; Beiser & Stewart, 2005; Bourque Bearskin, 2016; Martin, 2004; Mohatt et al., 2014), however almost without exception, frameworks used to guide the implementation of said frameworks remain grounded in Western ways of knowing. Therefore, efforts that support an Indigenous perspective for health are evaluated for their usefulness based on a subscribed set of Western values, which remove an Indigenous Paradigm almost entirely from the discourse. "From a First Nations Perspective, everything relates to the spiritual realm" (Sasakamoose, et al., 2017, p.2). Indigenous healing, and thus, addressing the root-cause of the health inequities experienced by Indigenous peoples, recognizes more paths to healing than those typically understood by modern healthcare leaders who may wish to promote health and healing, but whose program activities are only measured in their capacity to treat disease (Hunter, Logan, Goulet & Barton, 2006). Predictably, reconciliatory efforts have therefore, had little impact on population-level health outcomes for Indigenous People (Richmond & Cook, 2016) and health leaders remain perplexed on how to begin to address the issue outside of the current paradigms employed by a biomedically-based health system (McNally & Martin, 2017).

Guiding Principles

It is integral to this study that this Thesis serves to support decolonization within the academy. Decolonization speaks to a restoration of an Indigenous Worldview, restores culture and traditional ways. Decolonization once viewed as the formal process of handing over the instruments of government, is now recognized as a long-term process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power. (Tuhiwai Smith, 2012). To

truly apply a decolonizing lens to research practices, Kovach (2010) states that research should be: a) linked to tribal epistemology and situated within an Indigenous Paradigm- where at its core there is a relational understanding and accountability to the work; b) relational; c) purposeful d) adopting a particular protocol; e) informed and flexible; f) collaborative and dialogic; g) reflective. Theses core principles guided the research.

Theoretical and Conceptual Frameworks

In the context of health leadership, Indigenous epistemologies (ways of thinking), research frameworks (ways of questioning) and methods (ways of doing) need to be respected so that they are represented in parallel with the biomedical-based healthcare system. Indigenous methodologies stem from an Indigenous belief system that has at its core an epistemology rooted in relational understandings (Kovach, 2010; Lavallee, 2009; Wilson, 2001; Wilson, 2008.) As this study was designed to be grounded in Indigenous knowledges and epistemologies, it embraced the understanding that all things are related not only to each other here on the physical plane, but to spiritual realms (Saskamoose et al., 2017; Simonds & Christopher, 2013; Wilson, 2008). To disrupt discussions centered on health outcomes as privileged by Western epistemologies, Elder Mary Wilson and I have centered connection to spirit within the study's overall design and methodology.

Ceremony has been used at every stage of the research process to both acknowledge and respect the impact that spiritual realms have on our collective journey of meeting the research objectives. Therefore, as it pertains to this study, research *is* ceremony. This is not meant to be taken as a metaphor. Ceremony has informed every aspect of the research study beginning with the framework, the M'pisun or Medicine Wheel, which is described in detail in the following paragraph. The ceremonial protocols, and thus the research, has been guided by Medicine

Woman, Wolf Clan Mother, and Elder- Mary Wilson, known also as *Leader of those that walk the Four Paths (Directions)* and *Walks with Wolves*, with ancestry rooted in Maskwacis Nation, Bear Hills AB; but born and raised in Winnipeg, and therefore, has informed protocols central to this territory to ensure the study was conducted in a good way.

M'pisun

The M'pisun, more commonly known as the Medicine Wheel, is a way of organizing thoughts to convey knowledge gained through experience (Doucette, Bernard, Simon & Knockwood, 2004) and served as a guiding framework for this study. The M'pisun is a sacred symbol to many tribes including the Innu, Anishinaabe, Arapaho, Cheyenne, Crow, Lakota, Dakota, Shoshone, Kootenai and Blackfeet to name only a few (Whallen, n.d). It has many different representations and can be applied as a healing tool, a teaching tool, or in this case, a framework. As part of this research, we (the reader and I) will be journeying together around the Medicine Wheel. Comprised of four doorways, we will walk through each four times, respectively, completing four turns of the Medicine Wheel together. As the M'pisun is an experiential teaching and learning tool, for this project, we co-created its final representation which will serve the findings for the project. The turns we make around the M'pisun will take us through stories representative of the threads of experience that have woven together the final tapestry of the project.

In Indigenous culture, traditionally, it is the Shaman that takes the journey into other worlds for those who are seeking answers. In this case, it was my role as researcher to walk through several key experiences- physically, mentally, emotionally, and spiritually. By sharing them with you, I invite you to travel with me on my journey, and together, we will co-create

meaning from these experiences. These meanings, will then, help us collectively walk in balance while working within colonial structures.

As stated, this study was comprised of four journeys around, or turns, of the M'pisun. The first turn of the M'pisun took me to Aotearoa (more commonly known as New Zealand), which led to a workshop presentation at *Ongomiizwin Health Services Indigenous Health Research Symposium* (2020), where the foundational knowledge for this framework was shared and gained. The second turn of the wheel was represented by an integrative literature review, which was guided explicitly by the ancestors through which ceremony was incorporated by physically planting a Medicine Wheel garden. This literal planting served as the seed to support an Indigenous conceptualization of not only the current peer-reviewed literature, which describes reconciliatory efforts in Canada's current healthcare context, but the entire study. The third journey around the M'pisun was undertaken through the analysis of the stories as shared by the participating health leaders or storytellers who contributed to this project. To corroborate and deepen our understanding of the research findings, a sharing circle was held, where the third turn served as the basis for the discussion. The fourth and last turn will lead us through the discussion and allow us to conceptualize an understanding of the research findings, which are intended to support us to walk in balance, while continuing to advance Indigenous sovereignty from the confines of our current context.

Methodology

Qualitative research aims to answer questions about experience, meaning, and individual perspectives (Hammarberg, Kirkman, & de Lacey, 2016) and is therefore the most appropriate research method to meet this study's research objectives. This study was rooted in Indigenous ontology, which acknowledges the relationality found in each phenomenon, with an emphasis on

non-human relationality, including the relationship to spiritual realms (Kovach, 2010; Wilson 2008). The study design draws on two Indigenous research methods: Kovach's Conversational Method (2010) informed the design of one-on-one interviews. Then Sharing Circles as described by Lavallee (2009), informed the gathering of storytellers to share within a circle, corroborate initial findings, and dive deeper into the meaning of their shared experiences.

Because I adopted a two-eyed seeing approach, I also used a methodology that was relevant to the dominant system of Western science. In this case, an *empirical phenomenological* approach (Giorgi, 1985) was most suited to support meeting the objectives of the research. This approach, "involves a return to experience in order to obtain comprehensive descriptions that provide the basis for a reflective structural analysis that portrays the essences of the experience" (Moustakas, 1994, p. 10-11).

Supporting Methodologies

Tuhwai-Smith (2012) described a variety of methodologies that intersect to establish a programme of Indigenous research. Several of them apply directly to this thesis and have been employed alongside the qualitative, phenomenological research approach. I will highlight a few that have either implicitly or explicitly contributed to the methodology employed throughout the lifespan of this project.

Claiming. The impacts of colonialism have led to Indigenous people being required to make claims and assertions about our rights and dues. The premise of this research project was largely based on claims of the rights of self-determination over health service delivery. By examining historical and contemporary documents and legislation, evidence of need for this project was then supported. Without the implications as set-forth in the TRC (2015) and *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) (UN General Assembly,

2007), claiming rights to self-determination over health services would not have been possible. Claiming has helped to scope literature that was included during the integrative literature review and helped frame the semi-structured research guide.

Storytelling. "Each individual story is powerful. But the point about the stories is not that they simply tell a story or tell a story simply. These new stories contribute to a collective story in which every Indigenous person has a place" (Tuhiwai-Smith, 2012, p.145). By identifying study participants as storytellers, we were not only able to harness this power, but we also recognized the importance of their experiences to frame how to move forward with reconciliation in health service delivery and administration in Canada. Other health leaders may see themselves reflected in these stories and then too, benefit from the teachings of how to move forward in better balance with the work. Stories as described by Jo-Ann Archibald, are, "work that educate the heart, the mind, the body, and the spirit" (as cited by Tuhawi-Smith, 2012, p. 146). In this way, storytelling fits perfectly with not only the objectives of our research, but also the guiding framework, the M'pisun that we are co-creating throughout this thesis.

Indigenizing and Indigenists processes. By emphasizing an Indigenous paradigm in which all things are related to spiritual realms, we have invited spirit explicitly into our research project. As a traditional ceremony person, guided by Elder Wilson, the importance of protocols which support meaningful inclusion of the impacts of unseen realms have been felt throughout this project. Elder, Healer and visual artist, David Blacksmith was purposefully chosen to capture learnings from this project as shared by research participants and the thesis committee. As described by Elder Blacksmith (personal communications, February 2021), his paintings are aimed at capturing the spiritual aspects of phenomena and are not based in realism. It is this precise spiritual representation of the research that will be shared to convey the spiritual

implications not only of the study, but of its findings. It allows the audience to be moved beyond words, to form a different connection to the work being presented here.

There is a Need for a New Way Forward

I strongly feel that reconnecting to the land, our ancestors, and each other is essential. Indigenous people understand that health is spiritual. As the Medicine Wheel teaches us, the spirit is inseparable from the physical. The profession of nursing has long understood this and has advocated for spiritual care to be an essential part of caring for patients (Chiang et al., 2016). It is for this reason that I believe nurses to be well-positioned at interpersonal, intergroup and policy levels to contribute not only the TRC *Calls to Action* (2015) related to healthcare, but also directly or indirectly to the social determinants of health and their impact on health outcomes. As I begin now, to walk you through this project, it is my hope that this research will support practices that strengthen the mind to heart connection. I believe that it is this path, the one that travels from the head to the heart, which will lead us back to spirit, to each other, and to ourselves.

Chapter 2- The Guiding Framework: The M'pisun

To find our way forward together, we must foster a shared way of seeing, knowing and being. For this journey, we require a map. In the case of this thesis, our map is the study's framework: The Medicine Wheel, or M'pisun, which guides our path and ensures we stay the course. In this chapter, we plant the seeds of how we will walk together. This first step explores our framework and describes how the framework helps us meet the objectives of our research and the intentions of our ceremony. By establishing this foundational knowledge, a shared way of seeing, knowing and being is established to explore the present-day effects of colonialism influencing healthcare leaders within Manitoba in a good way.

Western Science is grounded in linear thought (Wilson, 2008). A common method used to communicate theoretical frameworks by Western academia is to adopt *Theory Description* as a methodology. A *Theory Description* is a process of inquiry into the concepts of a theory, followed by a structured approach to applying one's own interpretation of the inter-relational and inferential meanings of said concepts (Chinn & Kramer, 2015, p. 188). The process consists of asking a series of structured questions designed to understand the functions and limitations of a theory, framework, or model thoroughly and adequately as it applies to study in question (Chinn & Kramer, 2015, p. 187). Chinn and Kramer (2015) propose that by systematically examining a theory or a framework's concepts and definitions, structure, and assumptions, it can be more effective in its practical application and utilization. The difficulty here is that the emphasis is placed on the concepts and ignores the relationality found within the context of their application. This relationality, therefore, become secondary to the theoretical structure.

As a result, the Western process does not support an Indigenous worldview, and as such, likely would continue to silence Indigenous knowledge. The key to working with an Indigenous

ontology is to understand the relationships between the theory, the research, and its context. From an Indigenous perspective, you cannot separate theory from context, there is no true objectivity without the subjectivity of one's environment included in the discussion. To paraphrase Wilson (2008), the relationships between the theory, the analysis of data amassed, and the subsequent findings are circular, they are relational, they are interrelated, and each blend into the next in a cyclical fashion. A change in one indicates a change in the other. The findings are not grounded in theory, nor is the theory derived from the findings, all parts are equal, and no part can exist without the rest of the circle (p. 70). In this way, each chapter will need to support the development of our framework. The analysis of the applicable literature as well as the analysis of the participant interviews, will all serve to develop the framework that we introduce in this chapter. It is difficult to begin at the end of a process. Our framework, that of the Medicine Wheel, cannot stand alone without the rest of the thesis which supported its creation. A way of explaining this, would be to say that the term 'framework' becomes circular and thus, synonymous with the term 'findings', they are inseparable, each lending a part to the other.

An Introduction to the M'pisun

As discussed, we have chosen the M'pisun, more commonly known as the Medicine Wheel as the theoretical foundation of this study. The M'pisun is a way of organizing thoughts to convey knowledge gained through experience (Doucette, Bernard, Simon & Knockwood, 2004). There are many different medicine wheels. All have a circular pattern and show the relationship between the doorways. Divided by cardinal direction, Medicine Wheels show the balance of body, mind, sprit, and emotion, as well as representing each season, and growth-stage (Wilson, 2001; Doucette et al., 2004; Wenger-Nabigon, 2010). It recognizes the interrelatedness of all things-- that our values influence our decisions; our decisions lead to actions; our actions

influence our emotions; and our emotions influence our values (Skewerers, n.d). The circle serves as a canvas, the colours- the medicines placed within those doorways- those are unique and are bound to the relationships that have created them—"and then we are shaped by the experience of living in that framework" (Wilson, 2008, p.92).

The M'pisun has supported our desire to ensure that all aspects of health leaders' experiences with reconciliatory efforts are considered on equal footing with one another and remain relational to each other. In this sense, we are co-creating our framework as we move through the thesis chapters together. We will be revisiting and adding to our Medicine Wheel as we deepen our understanding of our Medicine Wheel, based on what we are learning at each stage for the research process. Therefore, only a foundational teaching of the M'pisun will be presented here. It is my hope that by combining a traditional outline of a masters' thesis, but changing the linear application of theoretical frameworks to a circular one, we are moving beyond two-eyed seeing and towards two-eyed doing. This approach will help us better understand what medicines will help our participants, and thus the reader, to walk in balance while addressing both the process and outcomes of reconciliation as it relates to the health system in Manitoba.

Foundational Knowledge for Understanding the M'pisun.

The following paragraphs highlight teachings received about the Medicine Wheel from Elder Mary Wilson, also known by the names of *Runs with Wolves* and *Grandmother* (leader*) of the Four Paths* (directions) between the early winter of 2019 and the late fall of 2020. This teaching began on a trip away from Turtle Island in early December of 2019 while attending the Health Services Research Association of Australia and New Zealand (HSRAANZ) conference in Aotearoa (New Zealand). Drs. Annette Schultz and Moneca Sinclaire, Elder Mary Wilson,

Mary's Granddaughter Teah Wilson, and I had a wonderful opportunity to spend some time with Maori and Aborigine health researchers, while exploring the beautiful nation of Aotearoa. We cooked together, laughed a lot, took care of their little people, and made a pilgrimage to honour the ancestors at *Te Rerenga Wairua,* also known as Cape Reigna.

On a clear day at Te Rerenga Wairua, you can catch a glimpse of Manawatāwhi, or the Three Kings. The Three Kings are islands off the mainland marking the official Northern most part of New Zealand. They are said to be the location where spirits heading out to sea would turn to get one last look at Aotearoa before leaving for the afterlife. There are many plaques that dot the path of this sacred site. One plaque pointed out the Pōhutukawa tree positioned at the very edge of a landmass over the water and pointing east toward Kapowairua, known in English as Spirit's Bay. This is the tree where the spirits make their departure from this world to the next. Another Maori legend at the same location tells us of the Tasman Sea to the West and Pacific Ocean to the East that come together here like male and female in the creation of life. The circular nature of life and existence is palpable here. This seemed to be the perfect place for me to step boldly into my quest for deepening my understanding of the M'pisun. At the time, I felt completely inept to set out to do the work of creating one with you here, now. It required time and patience and many teachers as well as lessons along the way.

During our time together, Elder Wilson and Dr. Sinclaire were generous with their teaching that supported the basic understanding and inner knowing required to do this work. In the evenings, we would go and sit and discuss the Medicine Wheel and its applicability to this project. This discussion led to a collaboration a few weeks later, in late January of 2020, where members of this thesis committee- Drs. Annette Schultz, Donna Martin, Moneca Sinclaire, and Ms. Monica Cyr, led by myself and Elder Mary Wilson- facilitated a living Medicine Wheel at

the *2020 Ongomiizwin Health Services* (OHS)- *Indigenous Health Research Symposium.* A living Medicine Wheel is where participants self-select their doorway based on where they have chosen to sit in the room. It is thought that each participant has chosen the appropriate doorway based on where they may find themselves during their current growth phase. As facilitators, we asked one question to the group, *"Based on the Medicine Wheel teachings related to your doorway and thinking about your work as it relates to engaging with the TRC calls to action, what are ways that you can walk in balance while doing this work?"* As this is a form of ceremony, we were not able to capture narratives of individual participants, and therefore, consent was not requested. I have however, asked that each group's facilitator share some key take-aways or teachings with me, and hence, they too have become my teachers and an integral part of this thesis. Their teachings will form the basis of our framework, which will extend to its practical application during our analysis of the literature and the interviews related to this project. The findings, from our research study will lead to the final conceptualization of this framework as it relates back to our original research questions.

The following teaching is from Elder Mary Wilson, spring of 2020.

> In Western culture, medicine is often associated with prescription medications and other recommendations that the doctor gives us. To Indigenous people, medicine is described as healing. The emphasis is put on wellness and a balance, rather than sickness. Work that heals the spirit, positive and right action, and living in harmony with the land are all ways of knowing medicine. One of our ways of knowing is the teachings of the Medicine Wheel (which has over 360 teachings). There are Archeologists who have found Medicine Wheels as far back as 4000 years B.C.- Bighorn, Alberta in Canada has one of the oldest Medicine Wheels (Figure 1).

Figure 1. Medicine Wheel in Bighorn, Alberta, Canada (n.d.)

> One of the teachings of the Medicine Wheel is that it is a chart of the stars and a connection to the celestial skies. The sacred circle that represents the teachings to all humans alike. A common way to discuss the Medicine Wheel is to discuss the wheel as being comprised of the four directions. You will hear talk of the doorways and what directions they hold or lead to. All directions- East, South, West, and North hold their own teachings. They all meet in the middle at a center point. In this way, one can travel between doorways in a non-linear fashion, moving from East to West and North to South, but also from South to East (Elder Mary Wilson, 2019).

Adopting the Medicine Wheel as a framework allowed us to conceptualize Canada's and Indigenous Peoples' pathway towards reconciliation as a holistic journey and not just a mental exercise. Often, reconciliation is seen as something that exists as a mere concept housed in the mental realms, but the Medicine Wheel shows us that it is represented in the emotional, physical, and spiritual realms as well. We can use the framework to extend our understanding of the interplay that each doorway has with the other, and therefore, as a result, have a greater understanding of the whole process of reconciliation, which is found not just within the four

doorways as stand-alone entities, but in the relationships and the spaces in between each of the doorways, and their meeting point at the centre of the wheel.

Understanding Each Doorway

A basic understanding of each doorway is, of course, a necessary step in applying our framework to our context. With each turn of the wheel, we will move now from East to North-clockwise around the Medicine Wheel, to explain the doorways as we have come to understand them through this work. As discussed, Living Medicine Wheel teachings as captured by each thesis committee member, has helped define each doorway in this chapter. During the Living Medicine Wheel, at *OHS's Indigenous Health Research Symposium*, each member sat in a designated doorway and captured their learnings. After a brief description of each doorway was provided, session attendees were asked to think about what helped them to walk in balance. Each thesis committee member, who served as a facilitator for the various doorways, shared their takeaways with me. Those learnings will serve as teachings for us now.

The Eastern Doorway. The Eastern Doorway represents our childhood. It is where we first connect to self, to spirit and sets the stage for a common vision. It holds the first teaching of Universal Love and it is here that the Eagle sits to help guide us. Our decisions and our actions must all come from this place. Teachings received in the Eastern Doorway that support walking in balance while engaging with the TRC (2015) *Calls to Action*, were rooted strongly in family. This doorway was seen to bring honesty and a child-like sense of wonder. In this doorway, there is still hope for change and hope for the future, as children are our future. This doorway is thought to represent innocence and taking everything in with new eyes. It asks us to leave our anger and our assumptions before entering. Just as children are, it is in this doorway that you find yourself closer to spirit, to your true self. Most of all, this doorway asks for compassion of

self and of others. To understand that everyone has a beginning place, and it is up to us to meet them there. Special thanks to Dr. Moneca Sinclaire for capturing the youthful essence of this doorway. During our time together travelling abroad, you were always enthusiastic and approached each day with the same joy and innocence that this doorway holds.

The Southern Doorway. Moving clockwise we enter the Southern Doorway, the door of emotions and of adolescence. It represents the time in our lives where relationships outside of our families become more pivotal. This doorway is rooted in partnership and relationships. There is more tension found here. This tension stems from a keen awareness of the truth. Teenagers are very aware of the truth, and most adults tend to grow out of this phase due to feeling conflicted with their inner knowing that is contrary to the larger systems' expectations. There is discomfort and confusion of how to speak the truth and bring your true self forward and into the conversation. It is an active phase where there may be engagement in fighting systems and people that exist outside of you. This conflict is what aligns you with the deeper understandings that you carry. The turtle sits in this doorway. The turtle teaches us patience and to move in a slow and thoughtful manner, as she knows both the importance of the journey and the destination, no matter the length of time each may take.

A teaching about the turtle that I received during a sweat lodge ceremony, was that Grandmother Turtle represents the truth, as she was here at the beginning. She represents the place from where the water and the earth both came, and so it makes sense that here, we face our true selves. We face our truth. Thank you to Dr. Annette Schultz who shared her learnings from this doorway with me. Beyond the Living Medicine Wheel Workshop, you supported me throughout this research process, allowing for it to take the time that it needed for things to come

together in this way now. You have been instrumental in me arriving at my truth and finding my voice. You have helped me come out of my shell, so to speak.

The Western Doorway. As we move towards the Western Doorway, we move into adulthood, into responsibility and accountability. It is where we face our wolf teaching- our humility, and our mortality. By leaving our ego at the door, we move closer to wholeness and experience a true body, mind, sprit connection. In this way, it becomes easier to connect the dots and the larger picture can truly come into view. In the West, you move out of boxes and linear thinking, and into a circular way of knowing and understanding. Your thinking shifts here, and you lose your fear of challenging norms. New pathways are forged and connection to a community becomes central in your work life. In the Western Doorway, one's life's work truly happens, as there is openness to learning and an understanding that your truth may not be anothers', but there is still opportunity for collaboration. It is moving away from a desire to dismantle and towards a desire to build. This doorway is centered on listening and it can be said that this is where true *Two-Eyed Seeing* lives and moves into two-eyed doing. Your priorities emerge as your thinking begins to shift away from self and towards the collective. In this way, it was fitting that Monica Cyr was able to share these teachings with me. I have known Monica through several work collaborations and during our time together, Monica has shown an ability to move projects and collaborations with true grace. She has modeled for me how to stay humble and how to work as part of a team, and for that I am truly grateful.

The Northern Doorway. Lastly, we move to the Northern Door, it is the doorway that represents the next world. It moves us beyond the veil and can be described as where true wisdom sits. We are closest to this doorway at the time of our birth and at the time of our death. It is where the white buffalo sits. Here light spans lifetimes, and the doorway is a vessel for

wisdom, kindness, generosity, and ultimately freedom. This generosity stems from open sharing and the knowing that the roles of teacher and student are inter-dependent. It is this doorway where you become a true *Skaabe*, a helper for all beings. In the north, we act from a perspective of that of the *Seven Generation Teachings*. We plant seeds here for Seven generations in the future, recognizing that our ancestors, seven generations in the past have done the same for us. In this doorway, you realize that you are never truly alone. You have the wisdom to understand the importance of rest. As the buffalo does, the Norther Doorway both brings and teaches respect. It is no surprise then, that it was Dr. Martin who captured these teachings. Of all my thesis committee member, I have known Donna the longest. When I was a young nurse, Donna served as a board member for the hospital where I worked. She mentored me with the same respect and openness that this doorway teaches us, and I am forever indebted.

The Story of the Centre. Every M'pisun must have a centre point. It allows us to come back to ourselves. It is here where the wheel is pulled together, where the doorways intersect. From the centre, we can move to any doorway. We can move freely from the East to the West, but move to the West from the North. We move from this place and always return here. It is how the meanings of each doorway tie themselves together to describe the whole. The centre is the great connector and it is integral to our framework. In the case of this Medicine Wheel, it is at the centre where we find our researcher and her reflections of her journey. By doing so, space is also created for the reader to find their centre-point as well.

As stated, for me, this project has been very personal. A reflection of my own cultural reclamation. The centre allows me to centre myself in order to share my journey with you. From here, I can highlight key takeaways and insights that support the study's purpose and helps answer the question of where health leaders can find balance.

In Summary

It is my hope that chapter helped to lay the foundation for the work that lies ahead. If we use these teachings of the M'pisun to describe the stories told by our study participants as well as common themes found in the applicable literature, we can better understand where we are currently walking in balance and where there are still gaps and limitations in our learnings and in our doings. Ultimately, it is these gaps which prevent us from truly reconciling. In this way, we begin to reframe some of the efforts, currently being put towards reconciliation in Canada today through an Indigenous lens. This allows for an understanding of where our efforts are best placed in the future. By moving beyond the more colloquial conceptualization of a Medicine Wheel, the doorways become a means to *experience* walking in balance through reconciliatory efforts. It is my hope that by moving beyond the mere lip service that we pay to balance being representative of the spirit, emotions, body, and mind, we begin to use the Medicine Wheel as intended- to serve as a tool for examining the whole. In other words, we can use this M'pisun as a framework that supports our understanding of what it means to walk the path of reconciliation in a good way when it comes to health administration and health service delivery in Canada today and in the future.

Chapter 3-Integrative Review of Applicable Literature

Despite over half a decade of the use of the term reconciliation in Canada, walking the path towards it remains out of focus. To-date, there is limited understanding of practices that support the implementation of the *TRC Calls to Action* (2015) in Manitoba and beyond. Ultimately, reconciliation in Canada must begin by federal, provincial, and regional governments acknowledging the right of Indigenous persons to self-determination (Gallagher, 2019; Kelm, 2004). Self-determination in Indigenous health practices has been evidenced throughout history (Gallagher, 2019). From a legal perspective, Indigenous rights to self-determination were established in article 3 of the UNDRIP which states, "Indigenous peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development." (UN General Assembly, 2007). Self-determination over health service administration was further articulated for Western governments in article 4 of the UNDRIP, which states, "Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions." (UN General Assembly, 2007). Thus, it is not only natural law, but also International law which supports sovereignty as integral to reconciliation. Without acknowledging this fundamental right of Indigenous peoples, the dynamic between settlers and Indigenous people in Canada will always remain paternalistic in nature.

Many governing bodies have committed to reconciling by stating that there is an openness to supporting these efforts (Bourque Bearskin 2015, Di Lallo, 2017), however without the requisite knowledge of self-determination practices, and successful nation-to-nation partnerships, it is difficult for health leaders to know the best way forward. If we respect the

reciprocal nature of the theoretical model as outlined in the previous chapter- that we are deepening our understanding of the M'pisun through data exploration, while simultaneously extending our understanding of data by applying the lens of the M'pisun as our framework, we can see how a review of current published literature is a useful exercise to support a two-eyed seeing approach to the work in question. Through our Western eye, we will methodically review peer-reviewed and grey literature which describes the processes of moving towards reconciliation in Canada. Through our Indigenous lens, we will use that knowledge to help refine our framework to adapt it to support understanding our current context. In this way, we maintain the experiential imperative of living our truth and walking the truth as the path to our study's findings.

Initially, this process felt as though it was nearly an impossible feat. The thought was to use Arksey and O'Malley's (2005) *scoping review* methodology to explore literature that examined current efforts towards reconciliation in the modern Canadian context, or literature that evidence Indigenous self-determination in the areas of health policy and health programming. The problem with this methodology is it necessitates a Western or linear approach aimed at dissecting and compartmentalizing information and therefore, ignores an Indigenous understanding of the intuitive nature of knowledge acquisition. The spiritual aspect of gathering information acquired alongside, but outside the scope of the methodology is not acknowledged and the relationships that the reader has to the material is often, largely unaccounted for. In the spirit of reconciliation and in the hopes that we are co-creating knowledge, we must return to context. According to Wilson (2008), "[d]oing a literature review can be seen as the culturally relevant way to communicate with dominant system academics" (p. 4). With this in mind, we will attempt to meet the academic requirements of a thorough literature review, but also support

our audience to step into the circle with us, to begin to support the linkages that their own intuition makes while exploring what has been found in the peer reviewed literature.

In the complex area of reconciliation and decolonizing practices, to the authors' knowledge, there has been no prior attempt to establish a baseline of knowledge regarding reconciliation and health policy and health programming in Canada. Therefore, a scoping review methodology is an appropriate approach for knowledge synthesis, which allows for a broad exploration of reconciliation and decolonizing practices in healthcare and to map key concepts, evidence types and gaps (Arksey& O' Malley, 2005). For reasons discussed, this methodology proved inadequate to disrupt Western methods and silencing of Indigenous ways of knowing and being. Two failed scoping review attempts resulted in the following integrative review. We will draw on some scoping review methodology, but then attempt to synthesize the findings and reconceptualise the research. This reconceptualization, drawing on the literature, as well as the experiences and teachings that reviewing the literature provided, will help to enrich our M'pisun as outlined in the previous chapter. We will therefore compliment the structure of a scoping review by employing integrative literature review objectives as outlined by Torraco (2005). In this chapter, results of a literature review that examined current efforts towards reconciliation in the modern Canadian context, or that evidence Indigenous self-determination in the areas of health policy and programming are presented.

Methods

While the scoping review aims to map the literature, seeking to describe the results in a graphic and classificatory way to have a better idea on what is there, integrative review proposes to integrate the literature found on a determined object of investigation (Soares, 2020). "The integrative review method is an approach that allows for the inclusion of diverse methodologies"

(Al-Husseini,2019, no page #). Arguably, it is the marriage of these two methods which is best suited to meet our purpose of reviewing the applicable literature. In this case, a structured review of the literature drawing from Arksey and O'Malley's framework (2005) followed by synthesis of the findings- applying them to the M'pisun, to reconceptualize the literature has been undertaken. The latter method draws on ceremonial elements aimed to integrate spiritual realms into the interpretation of the data. This process supports the intuitive nature of knowledge acquisition that has had a direct impact on the analysis of the literature, as we place our interpretations of the findings within our framework.

Indigenous Methods

To support clarity surrounding the literature review, and with the aim of creating a Medicine Wheel from the findings, a literal medicine wheel was created and planted in my front yard in the summer of 2020 (Pictured below- Images 1, 2 and 3). This process was guided by Elder Mary Wilson. As discussed, the overall structure of the M'pisun has a centre-point surrounded by a circle, separated into four doorways, or quadrants. This was a small medicine wheel, compared to larger ones, as found in Bighorn, Alberta. It consists of 7 stones in the centre, 28 stones around, and 7 stones to delineate each doorway. The stones were collected from different places based on my own personal history. Prayer flags were prayed over and created with tobacco and placed in the medicine wheel according to their appropriate colour and directions. Yellow for the Eastern doorway, Red for the South, Black for the West and White for the North. A compass was used to ensure accurate placement. The flags were then covered with dirt. The stones were placed, and carefully curated plants were planted.

Image 1- Breaking Ground for the M'pisun

Image 2- After the Stones were Laid

Image 3- Planted M'pisun

Stones for the centre-point were gathered from the creek bed of where I walk my dog daily. During these walks, I have an opportunity to tune in to the shifts that happen gradually each day, supporting the changing of seasons. I notice the buds on the trees starting to form in late spring, blossoming at their peak in the summer, then their natural dying off towards the fall. I see the beaver working here. Deer. I see the creek freeze over and then harden during the winter months, only to melt and begin again. I am centered by this process, and so too, is our wheel.

The stones for Eastern Doorway were collected with my youngest sister, Alexis near the neighborhood where we grew up. We grew up on the Eastern end of Winnipeg in the suburbs. It was typical 1990s suburbia and despite having a relatively wonderful childhood, complete with all its privilege, it is here where I developed a distaste for the whole of what those suburbs represent. It is also Alexis, who, although being the youngest sister, forged the way for our immediate family to begin our journey to culturally reclaim our Indigeneity. That road has served to help us heal the trauma carried through our blood from our ancestors. This thesis too, has supported that process, but that story is for another time. The plants chosen for this doorway were those of my early childhood. Hens and chicks that I remember pricking my finger on when my Dad told me what they were. I could see the babies and their mommas. I loved them. Daisies, Tiger Lilies as an homage to Peter Pan. I tried my best to capture my innocence here.

The stones that formed the Southern Doorway are from the shores of Lake Winnipeg. It was warm enough to swim on the day that they were collected. During my adolescence, on the Western side of the lake, my best friend Kristy and I would drive an hour out of town to visit with her boyfriend Mike. While they would sneak away, I would hang around with a boy who would eventually become my first boyfriend. His name is Rick. He would go on to partner and

have children with my middle sister Gillian's best friend Hillary. All of us are still connected, but never in the same way that we were those summers on the lake. But that story too, is for another time. The plants in this doorway were red and fiery. A rosebush was planted to symbolize the passion of those summers. The plants here are lush, fragrant. An homage to the height of summer and the height of youth.

The stones of the Western doorway were found in my own backyard. In the fall of 2019, I purchased my first home. It is here where I currently write from. It is here where I have begun to face my Wolf Teaching- that of humility. The process of writing this thesis, has also supported that. As guessed, that story is for another time- however, all the stories, have of course influenced me as a researcher and glimpses of them can be caught throughout this thesis. I chose to plant medicines here. It was too late in the season to begin sweetgrass and sage from seed. A quick trip to the greenhouse allowed for the planting of chamomile and motherwort, lavender. Next year, the traditional medicines will join them here.

The stones for the Northern Doorway do not need to be gathered. It is made from the East and the Western stones- compromising the stages of all the other doorways, from childhood to adulthood. A moon garden was planted here, consisting of mostly white flowers whose blossoms open in the moonlight and close for the sun. This is nod to the representation that this doorway has of the nether world. The life beyond the veil from which we have come and to which we shall return. It is my favourite doorway that I planted.

Western Methods

Scoping review study design drew on Arksey and O'Malley's framework (2005), along with more recent methodological advancements put forth by Levac, Colquhoun H and O'Brien (2010). In keeping with Arksey and O 'Malley's framework (2005), the following iterative

stages or processes guided our study: (a) identifying the objective of the review; (b) identifying relevant studies; (c) study section; (d) charting and extracting the data. We will then move onto our results section, where we will collate and summarize the articles reviewed- which will be placed within our *M'pisun*. This aims to ensure that an Indigenous paradigm is co-guiding our analysis and synthesis of extracted data. Each stage is outlined below.

Stage I: Identifying the Review's Objectives*.* Our aim was to review the literature to gain an understanding of current efforts being put towards reconciliation in health policy and programs in Canada today. By identifying past and current initiatives, this review allows to move beyond actions and examine the drive which is influencing how we are moving towards reconciliation. By searching for explicitly stated rationale or inferring our own interpretation of the reasons behind the action, we are better able to meet the aim, three research questions guided the integrative review:

i. What policies and programs exist and can be found by searching academic databases that support reconciliatory practices in health settings in Canada today?
ii. By what means do these programs and policies support reconciliatory efforts?
iii. How have Indigenous knowledges and ways of being informed the healthcare policy or program?

Stage II: Identifying Relevant Studies. A search strategy utilized a key-word search of subject headings, titles and abstracts as shown in *Tables 1* and *2*. To capture a comprehensive sample of healthcare literature related to Indigenous reconciliatory or self-determination policies and practices, a comprehensive search of *Scopus; Ebscohost* (for *CINAHL* only); *ProQuest* and *Google Scholar* was conducted. The medical librarian (Janice Linton), who comes with decades of experience within the field of Indigenous Health, suggested to exclude *Pub-Med* because any

results from that database will be captured by *Scopus*, and Scopus is a richer database source for this topic area. Although initially it was thought to include a search of *Google,* a decision was taken to limit our scope to the academic databases. The reason for this was arguably that it was these databases which health leaders would turn to while attempting to implement programs that honour the TRC (2015) *Calls to Action*. This decision was of course taken with the understanding that much of the work being led by Indigenous organizations, people and perspectives, will not be represented here. Therefore, the focus becomes placed on that of the dominant system and attempts to show the ways in which said system is currently engaging with the reconciliation process. After removing duplications, the citations and abstracts were placed into a spreadsheet for use in the eligibility screening and charting processes.

Parameters placed on database searches included English-language studies, and all types of published articles: commentary articles, case studies and empirical studies employing all types of methodologies (i.e., qualitative, quantitative, and mixed methods) and study designs. Because of the historical significance of the Royal Commission on Aboriginal Peoples (RCAP, 1996) and its influence on the TRC's Calls to Action (2015.), the search included 1996 – April of 2019. It was determined that search terms utilized during the first attempt of the scoping review were too limiting to have a fulsome understanding of the applicable literature. This was because an initial decision had been taken to utilize the term "Truth and Reconciliation" as opposed to reconciliation alone. The rationale at the time was that there were over 50,000 results and therefore, the review itself became unmanageable. To find balance, a subsequent search was undertaken in August of 2020. This was limited to the *Scopus* database, with an additional quick search of *Cumulated Index to Nursing and Allied Health Literature database (CINAHL)* to ensure that most of the applicable literature was captured. This kept the review manageable for

the purpose of this study- please refer to *Tables 1* and *2* in *Appendix A* for an outline of all search terms used during this phase of the review. Finally, to have a firm grasp on the quantity and focus of literature surrounding reconciliation and health policy and programming in Canada, the search remained within the confines of the modern Canadian health context.

Stage III: Study Selection. A screening process included a title and abstract scan, followed by a full-text review, which was carried-out by two reviewers (Stephanie Van Haute and Dr. Annette Schultz). A *Prisma Diagram* that summarizes this process can be found in *Figure 1 of Appendix A.* This process determined eligibility to be included in the analysis that would lead to our findings from searching the databases. Once duplicates were removed, titles were screened for potential inclusion (SVH). This included the 653 titles already selected for inclusion in April 2019 (out of a possible 958) and an additional 1220 selected in August of 2020, for a total of 1923 titles to review. After contrasting the two data sets, an additional 665 duplicates were removed. In some cases, articles not meeting inclusion criteria were easily identified based on the title alone. However, if there was any uncertainty based on title the reference was retained. An additional 1258 articles were excluded during the title review, for a total of 1835 exclusions during the title review. Reasons for exclusion of titles from further review can be found in *Figure 1 – Appendix A.*

After reviewing titles, the next step in the study selection process is to review abstract that seem promising to meet inclusion criteria. A total of 88 articles were retained for abstract review. Two-reviewers (SVH &AS) independently read the abstracts and recorded reasons for inclusion or exclusion, which began with previously outlined criteria and discuss additional criteria that arose. Abstracts excluded and their reasons for exclusion can be found in *Table 4* below. Of note, there were many articles that described efforts towards reconciliation which

focused solely on programs or interventions aimed at pre-licensure education for healthcare providers. Due to the shear volume of literature, and given that the aim of this project sought to explore systems level changes as they relate to health service administration, a decision was made that healthcare provider education would remain outside the scope of this review. Similarly, many organizations have published point-of-view articles and position statements on how reconciliatory practices should be implemented within the Canadian context, as these articles did not describe a program, policy, or intervention, they too were excluded from the review.

The full-text review followed the same process with two reviewers (SVH & AS) independently reading each article. To be considered for inclusion in the final analysis, the text focused on reconciliatory practices in relation to healthcare policies and practices in Canada. During the full-text review, the reviewers' assessment was guided by the following questions:

i. Does the text describe a policy, program or intervention focused on Indigenous self-determination or reconciliation?
ii. Does the text describe an intervention, program, or policy in the field of healthcare, in Canada?

Once texts were reviewed using these questions and after some discussion where there were questions regarding inclusion criteria, we reached consensus on including a final 15 articles eligible for analysis and inclusion in this review. Access for one article was requested from the University of Manitoba Library, however, was never received, and therefore, not reviewed. A *Prisma Flow Diagram* summarizing this process and outlining exclusion criteria are also found in *Figure 1, Appendix A.*

Stage IV: Charting the Data. Data were extracted from each eligible article using a standardized charting form, which included categories for the following: characteristics of the study authors; characteristics of the publication; and characteristics of the policy, intervention, or program- which asks by what means were used to support reconciliation and whether Indigenous epistemologies were considered, and if so- how. Results of the review for each category are shown in *Appendix A- Table 3- Integrative Review Findings- Summary of Interventions.*

Stage IV- Collating, Summarizing, and Reporting the Results. Data extracted from the 15 eligible articles were summarized to produce descriptive details of the collection, which was followed by a thematic analysis, co-guided by the *Medicine Wheel*. The combination of these two processes results in an overview of the type of reconciliatory efforts being carried out, by whom and for whom. Then, the major themes that emerged provide the stories of reconciliatory actions along with contextual details surrounding efforts being made to implement the TRC (2015) *Calls to Action*. These stories were then placed within our Medicine Wheel framework to support our understanding not only the breadth of actions taken, but to make visible the spectrum on which reconciliatory practices lie.

Results

Authors' Identities

The materials focused on Canadian healthcare contexts, and the authors came from diverse disciplines. As we reviewed the authors, we noted the absences of acknowledgement of author's positionality, background, and ethnicity. This is of note, as from Indigenous perspective, all things are relational, and positionality is integral to understanding the research findings.

Characteristics of the Publications

Of the 15 articles selected for inclusion in the final analysis, 13 were from peer reviewed journals, one other was a thesis from the University of Manitoba, the other a University Newsletter article from the University of Saskatchewan. When looking at articles by health discipline, most interventions and programs described could be classified under the umbrella of *Health Administration.* This could refer to anything from large-scale initiatives, such as the devolution of health services which led to the development of the British Columbia First Nations' Health Authority (BCFNHA) (Gallagher, 2019; O'Neil et al., 2016) to provincial collaborations taken by Alberta Health Services (AHS) (Drost, 2019; Williams et al., 2019;), as well as local community initiatives, such as the *Sturgeon Lake First Nation Community Health Center* (de Leeuw, 2017).

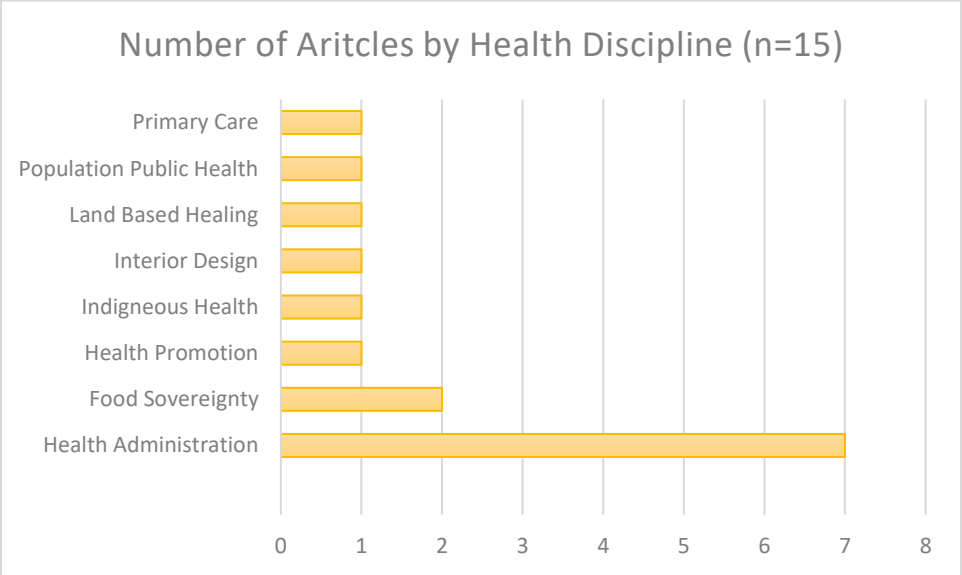


Figure 2. Number of Articles by Health Discipline

Despite the historical significance of the RCAP, the oldest article included in this review was from 2004, with the majority being published after the TRC was released in 2015. The graph found in *Figure 3* clearly shows the upward trend in the number of articles addressing

reconciliatory practices. One of the sources found in the grey literature did not include a date and were therefore excluded from this analysis.

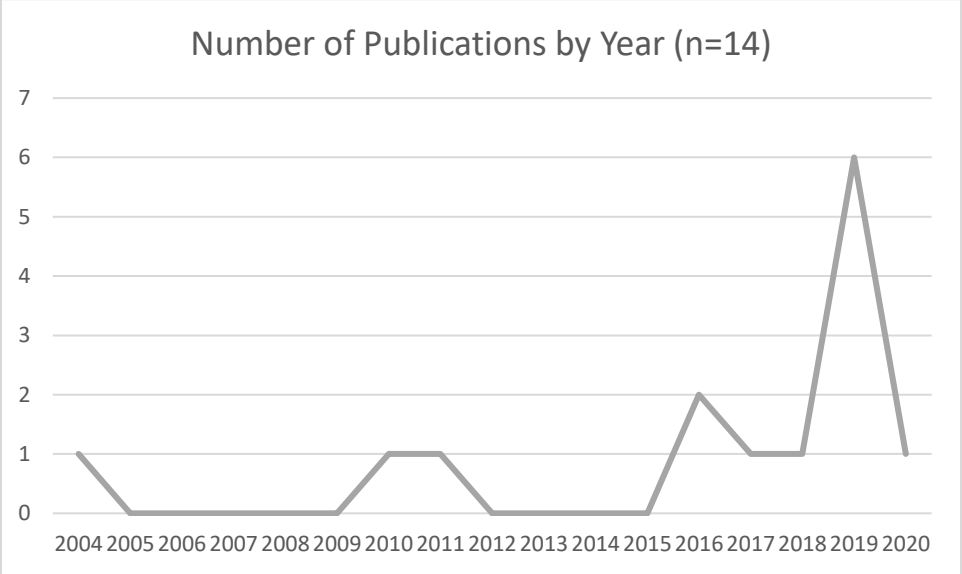


Figure 3. Number of publications by year

Characteristics of the Programs and Interventions

To examine the characteristics of the programs in interventions undertaken, it is helpful to centre ourselves by acknowledging Indigenous self-determination over administration of health services as integral to reconciliatory efforts in Canada today. Once we do so, we are able to see that the programs and interventions in these articles fall on a spectrum that ranges from consultation of Indigenous persons and groups (Mundel & Chapman, 2010), through to the complete devolution of current health service delivery to an Indigenous led model (Gallagher, 2019; O'Neil et al., 2016). At minimum, all the included interventions in some way, relied on Indigenous ways of knowing and doing to shape their programs and interventions. A deeper exploration of Indigenous epistemologies considered, will help support the final step of placing the interventions into our Medicine Wheel. This will be based on the framework as introduced

in the previous chapter, which we will expand upon as we locate the intervention found in the literature into the doorways of our framework.

Indigenous Epistemologies Considered

As discussed, in every article selected, Indigenous epistemologies, at minimum were considered in each of the included articles. Be it that Indigenous ways of knowing supported the intervention itself, or the analysis, or the evaluation- each author highlighted the importance of including divergent worldviews alongside interventions aimed at reconciliation in the modern Canadian health context. Authors often acknowledged Elders' teachings (Drost, 2019; Hadjipavlou et al., 2018), such as the one put forth by Elder Emil Durocher who emphasized that to advance cultural competency and safety among Alberta Health Services (AHS) leaders and employees, training should be experiential rather than formalized: ''The best thing a person can do is try to learn these traditions and the protocols because I can't write them, and I can't share them.'' (Drost, 2019, p. S73). In many ways, this teaching highlights the starting place for many of us. Reconciliation is a path that we much each walk to understand its process. Many academics may struggle with the concept that traditional teachings are given through experience, and cannot be taught through texts, nor through lecture- the path to understanding the teachings must be walked. It is for this reason that we are walking together through this thesis and co-creating our M'pisun as we move from chapter to chapter.

The process of co-creation, another Indigenous concept, was also highlighted by O'Neil et al. (2016), when discussing the relationships that were integral to the creation of the British Columbia First Nation Health Authority (BCFNHA). It is here where relationships and partnerships become integral to the reconciliation process. In addition, many of the articles focused on the Indigenous worldview of holism as foundational to health (Bagelman et al., 2016;

Long et al., 2019; Mundel & Chapman, 2010). Image 4 (below) illustrates the importance of holism as a key concept in relation to health and wellness. It was this holism that allowed authors to acknowledge the importance of spirt and ceremonial work as central to an Indigenous approach to health and healing. This relationship extends beyond provider and patient to nation-to-nation ways of engaging, such as those undertaken during the co-creation of the BCFNHA, where it was acknowledged that "leading with ceremony is foundational to the success of the work" (Gallagher, 2019). It is through ceremony where we are tied back to the land, to each other and to our experiences, leading us back to where our discussion surrounding Indigenous ways of being began:

> "The timing of the ceremonies is dictated by the natural world: when the first strawberries ripen, when green corn grows, when the maple sap runs, thereby ensuring that our human activities are synchronized and inextricably connected to the natural world. Practicing ceremonies implies carrying on the responsibilities of being grateful and attentive custodians of the life-sustaining gifts, bestowed upon humans, in the natural world" (Delormier & Marquis, 2019, p. 27).

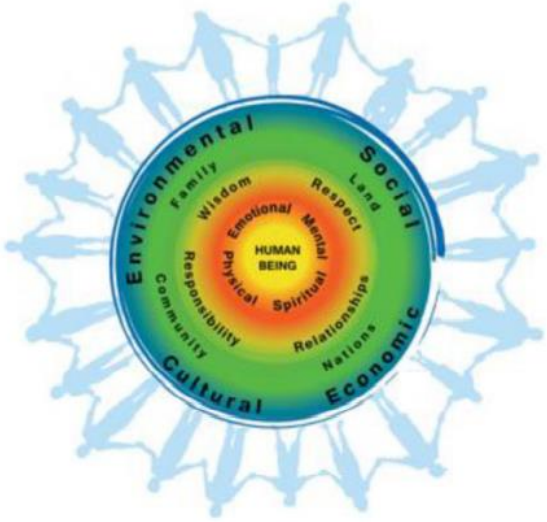


Image 4. First Nations Perspective on Health and Wellness (as cited by Gallagher, 2019).

Locating the Interventions Within the M'pisun

Just as planting the M'pisun at the outset of this process could be said to be a form of ceremony, the process of placing the interventions found in the refereed literature, is a way for us to continue that work of inviting ceremony into our analysis. Many prayers were said while placing this data into our doorways, and thus my ancestors helped to support this process, connections made, and my own interpretation of the data. Sage, sweetgrass, cedar and tobacco were offered to bring each doorway into further clarity. It is also my prayer that my understandings are communicated clearly and with good rationale as we move from East to South, to West, to North during this process. As discussed in the previous chapter, although we will travel clockwise in a linear fashion through the doorways, it is important to remember that the wheel itself is non-linear. The ways in which organizations and individuals move through each doorway is not a hierarchical, nor necessarily an organized process. Each of the doorways has its place and its part to play as we return to centre and are able to view the whole. That being said, we will begin the second turn of the M'pisun now.

Eastern Doorway- Consultation with Indigenous Stakeholders and Embedding Traditional Medicines into Dominant System Approaches. This doorway was seen to be the place of childhood, a place where we learn to walk before we learn to run. This doorway depicts a beginning place, and although consultation with Indigenous stakeholders is a process that has been ongoing for decades, much of the work towards reconciliation in Canada is still being done in the Eastern door. This doorway echoes of colonial relations but it is here, also, where we have an opportunity to not have reconciliatory efforts governed by the dominant system. In this doorway, there remains a lack of understanding which would place Indigenous approaches as whole and on equal footing with the biomedical Western system. However, in this way, the

doorway is also a bridge that births us into a new way of conducting health service planning. As discussed previously, this doorway asks for compassion of self and of others. To understand that everyone has a beginning place, and it is up to us to meet them there. This is the doorway of patience.

The literature highlights how Alberta Health Services (AHS) has formed preliminary partnerships that supported discussions around embedding traditional Indigenous healing modalities within the modern medical system as a starting place (Drost, 2019). Ultimately, the goal of AHS is to move from this starting place towards nation-to-nation partnerships and these preliminary discussions highlighted that consultation with Indigenous stakeholders was underway, however, discussions were aimed at activities yet to take place throughout AHS. The literature stated that only after readiness has been established within the health system could Elders, Knowledge Keepers and Healers be granted the opportunity to "define and assert Indigenous rights to traditional medicines and healing practices within the health system" (Drost, 2019, p. S75). Another means of consulting with Indigenous stakeholders was undertaken by Parkdale Queen West Community Health. Firestone et al. (2019) describe a collaborative project where an Aboriginal Advisory Council, comprised of service providers, community leaders, Elders, and Indigenous services users come together with the aim of enhancing Harm Reduction services for First Nations clients.

Embedding Traditional Medicines, Elders and Healers within the dominant health system is another manner of Indigenous engagement undertaken throughout initiatives found in the literature. Mundel and Chapman (2010) describe their *Urban Aboriginal Community Garden Project*. Guided by the teachings of the Medicine Wheel, the project aimed to provide culturally appropriate health promotion. By drawing on Indigenous approaches to healing, acknowledging

the legacy of colonization and providing a context for cultural celebration, the authors suggest that the project can be seen as an example of what decolonizing health promotion could look like. One inner-city clinic, whose name and location were not disclosed, moved one step further towards reconciliation and self-determination over health administration. This study examined the inclusion of Elders as members of the care team as a strategy to improve care of Indigenous patients in Canadian healthcare systems. This study described the initiative as a Cultural Intervention. Five overarching themes related to client experiences were identified as project outcomes: experiencing healing after prolonged periods of seeking and desperation; strengthening cultural identity and belonging; developing trust and opening up; coping with losses; and engaging in ceremony and spiritual dimensions of care as a resource for hope (Hadjipavlou et al., 2018). One example was the Sturgeon Lake First Nation Health Centre, administered in collaboration with First Nations Inuit Health Branch (FNIHB), recognizes the value of Aboriginal healing practices and uses them in the treatment of Indigenous patients in collaboration with healers and Elders (de Leeuw, 2017).

These approaches felt fitting for the Eastern Doorway as they highlight the possibility of what could be and they engender hope of moving towards true self-determination for Indigenous people. It is here where Western health leaders have begun to open themselves to the idea of the importance of other worldviews being incorporated into allopathic treatment of illness. Power dynamics and consideration on equal footing with Wester approaches, is still lacking in this doorway and we find an immaturity to the approach of the dominant system to truly engage in reconciliatory actions as a result. That being said, it has been a long road to even enter the Medicine Wheel and it is no surprise that many interventions are still found here.

Southern Doorway- Partnerships with Indigenous Leaders and the Dominant Health System. As discussed in the previous chapter, this doorway represents our adolescence. This is the time in our life where we are more open to forming relationships with others who reside outside of our family and community. From a systems' perspective, it is where partnerships between Indigenous and non-Indigenous systems' leaders can come together to begin true collaboration. AHS's Population and Public Health unit has already begun this work, where the Population, Public & Indigenous Health Strategic Clinical Network (PPIH SCN), which launched in 2016, is designed to support AHS' commitment to closing the gap in health outcomes for First Nations, Métis and Inuit in Alberta. One of the missions of the network is to improve the health and wellness of Indigenous peoples by engaging them as equal partners in their own health, wellness, and care (Williams et al., 2019).

Long et al. (2019) continued in the same spirit of collaboration, by building a broad coalition of community, government, First Nations and Métis organizations (tribal councils), and other stakeholders, with the scientific team at the University of Alberta and the University of Saskatchewan acting as brokers for the Two Row Wampum Project. This project aims to center public health surveillance based on movement between First Nations communities, rather than basing it on provincial, colonial jurisdictions.

These collaborations mark the understanding that Indigenous sovereignty must be respected in relation to reconciliatory efforts. Although current efforts may be seen to be privileging a Western approach, it is this coming together, the sharing of experiences which are integral to this doorway. Ultimately, in this doorway, these partnerships begin to acknowledge the truth that we must meet as equal partners while advancing efforts to improve health outcomes for Indigenous persons, and those of all Canadians.

Western Doorway- Transfer of Control for Indigenous Self Determination of Health Service Delivery and Administration. In this doorway, we face our Wolf Teaching- humility. It is here where one begins to move beyond their own ego and allow the work that needs doing to be done in the best possible way, regardless of who is leading. It is where true Indigenous self-determination of health services is found. Kelm (2004) describes one of the first published examples of the devolution of health services with the inception of the *Wilp Wa'umsNisga'a* health center, in British Columbia. This initiative highlights the importance of local administrative control over health services versus the incorporation of Indigenous ideologies, and thus the commodification of Indigenous epistemologies by the dominant health system.

In the reviewed literature, O'Neil et. al. (2016) and Gallagher (2019) describe the devolution of provincial and federal health services to create Canada's first, First Nations' Health Authority which grants First Nations complete administrative control and oversight over health service delivery. Much of this was done through partnership agreements and in alignment with the provincial and federal health leadership. "In the context of First Nations health governance in BC, processes of negotiations and relationship-building over the past decade have led to many examples of co-created solutions at the strategic level between political representatives of federal, provincial, and First Nations governments, and at the operational and service level through shared health and wellness planning" (O'Neil et al., 2016, p. 233). In some community-led initiatives, such as *Feasting for Change* in Salish BC, non-Indigenous stakeholders were invited to partner in delivery of health programming. This project, "determined that a "solidaristic" (i.e., undertaken in unity) project could be possible if all events associated with Feasting for Change took leadership from First Nations. In particular, it was determined that

Elders would play a leadership role, identifying proper protocol for all activities" (Bagelman et al., 2016, p. 8).

These examples of true Indigenous sovereignty show a maturity and the first realization of true reconciliation found within the Canadian health system. Here, administrators and government officials in the dominant health system had the humility to step aside to allow for transfer and control of health services to an Indigenous led entity. Now being used as an exemplar of how other provinces can advance reconciliatory efforts, and ultimately improve Indigenous health outcomes, this initiative serves to role model future efforts for the rest of Canada.

Northern Doorway- Decolonizing Spaces, Both Inner and Outer. This doorway represents the generosity is represented by the open sharing of knowledge. In this case, I have chosen to look at this as the open sharing of Indigenous knowledges with the Western health and academic systems. In some of the articles, space, whether it be physical space, or connection to the land, were central to the interventions. Connor (2011) speaks to the importance of decolonizing space, by using interior design methods based in cultural and spiritual traditions, practices, stories, and meanings. These methods were used to support the design of a centre for Indigenous youth suffering from acute suicidal ideation. The reconceptualization of a Western institution through reclamation of traditional knowledges centers us in the Northern doorway. Another article that described the decolonization of colonial spaces was the *Nanatawihowikamik Healing Lodge and Wellness Clinic* at the University of Saskatchewan. "The Lodge was designed as a radical departure and disruption of current academic strictures in order to facilitate culturally responsive training and emerging forms of research, particularly those guided by

decolonizing methodologies. The process required essential shifts in the university culture" (Saskamoose & Snowshoe, n.d., p. 8).

Space can also be decolonized by returning to healing on the land itself. Danto and Somerfield (2020) described a land-based initiative in a Mushkeowgowuk community with details abouts how youth can be engaged directly to support their own healing and wellness by working with Elders who bring them out on the land to heal. Another intervention where land was integral, and which also tied everything back to spirit, to the ancestors was *Leiénthos Akotióhkwa*. The planting group formed as part of the Kahnawake Schools Diabetes Prevention Project and is demonstrative of a First Nations led initiative which embeds traditional ceremony and teachings into all its activities. "*Leiénthos Akotióhkwa* found common interests in aligning the health and well-being of the community through food production, practicing the spiritual cycle of ceremonies, preparing and eating food through activities that promoted culture, language, positive family relationships, and caring for the environment" (Delormier & Marquis, 2019, p. 28). These acts move beyond serving the Indigenous community alone but show promising practices of how all of mankind can move forward in a more balanced way in the area of health and wellness.

Discussion- Returning to Centre

Interpretations of the Integrative Review

As we return to the centre of our wheel, we can now examine the M'pisun from this centred place. At the outset of the review, as we began our walk through these doorways, our intentions were to determine what policies and programs can be found by searching academic databases that support reconciliatory practices in health settings in Canada today. We also questioned by what means do these programs and policies support reconciliatory efforts. Lastly,

we wondered how have Indigenous knowledges and ways of being informed the healthcare policy or program? What we found is that a variety of interventions came together to meet at the centre of our M'pisun. It is here at the centre where we can see that the seemingly disparate interventions, when measured as a whole, are coming together to support reconciliation in Canada.

In the East, we learned that engagement and meaningful inclusion of Elders and Healers into health services, saw the biomedically-based health system's acknowledgement of Indigenous rights to access traditional medicines as part of their care (Drost, 2019). Mundel and Chapman (2010) discussed how embedding Indigenous ceremony into health promotion activities positively affected program outcomes and deliverables. This is where the benefit of a two-eyed seeing approach sits and is first introduced to reconciliatory process. Much of these articles discussed positive outcomes not only for participants, but also for program administrators and practitioners involved with the projects. The seeds planted in this doorway, show promise for change and further acknowledgement of the strength and connection that Indigenous healing modalities can bring to the health of all Canadians.

As we moved to the South, we see the results of the efforts our ancestors and their historical struggle for Indigenous governments to be considered on equal footing and equal step with decision making within the dominant system. It is in this doorway where we acknowledge that, "We are not a conquered people" (A Tribe Called Red, 2016).

> Struggle is a tool of both social activism and theory. It is a tool that has the potential to enable oppressed groups to embrace and mobilize agency, and to turn the consciousness of justice into strategies for change. Struggle can be mobilized as resistance and as transformation. It can provide the means for working things out 'on the ground', for

> identifying and solving problems of practice, for identifying strengths and weaknesses, for refining tactics and uncovering deeper challenges (Tuhiwai-Smith, 2012, p. 199).

In this doorway, we hear the whisperings of nation-to-nation planning efforts and collaborations. We see public health authorities looking to the expertise of our own Indigenous governments to support public health interventions (Long et al., 2019; Williams et al., 2019). The struggle continues here, as we seek to balance power dynamics at this table and move towards the sovereignty found in the Western doorway.

In the West, *organizations* such as the BCFNHA demonstrate the power of Indigenous self-determination over health service delivery (Gallagher, 2019; O'Neil, 2016). Through this foundational agreement of Indigenous Sovereignty as an inherent right, we can truly engage in reconciliatory processes and thus achieve reconciliation as an outcome. Although only in its early years in British Columbia, the devolution, and the transfer of health services, is likely to continue to grow and spread throughout Canada. Articles such as the UNDRIP as well as the TRC (2015) *Calls to Action*, are unlikely to be a passing phase as political landscapes continue to shift through Indigenous advocacy that seeks to claim inherent rights and thus, responsibilities to our lands and our communities.

Finally, as we move North, we see how interventions based on Indigenous ways of knowing, such as land-based healing (Danto & Somerfield, 2020; Delormier & Marquis, 2019) and decolonizing space (Conner, 2011; Saskamoose & Snowshoe, n.d.) hold the promise of healing, not only for Indigenous people, but how shifting connections to land and space can support changes in perceptions with regards to what health and healing systems can look like. This change in perception and sharing of knowledges shows the power of true reciprocity and

serves as an exemplar to what reconciliation in action can look like. By privileging Indigenous epistemologies, we see that there is room for both Indigenous and Western interventions.

Moving forward from here- Implications of the Review's Findings

This interpretation of each doorway allows us to centre ourselves in the middle of the M'pisun and see how *all* actions found in *each* doorway, serve as a map, a compass, or a teaching tool with how to move forward with reconciliation. Efforts of these health leaders, scholars, and Elders demonstrate the many ways that we can come together and meet at a centred place. It is the cumulative impact of these efforts which strengthen the process of reconciliation. There is no *one right way*. The variety of methods allows Indigenous and non-Indigenous health leaders, in collaboration with community partners to select which will be most appropriate based on current readiness, desired impact, or types of health interventions they are looking to achieve. For some, incorporation of Elders into an acute care setting, as an example of an intervention that would be placed in the Eastern doorway may be most appropriate. Conversely, funders may wish to support Northern doorway activities, for example, the construction Indigenous led healing centres, where Indigenous healing is central and serves as an institution to educated allopathic practitioners on Indigenous healing modalities. By using this framework to analyze the current activities to support reconciliatory efforts in the modern Canadian Health context, we can see future possibilities. What could another turn around the Wheel look like as we move towards reconciliation in health service delivery together?

Furthermore, as many of these interventions deal with complex systems change, there is no telling where they will move to or land in the future. We have no crystal ball; however, time will teach us if the best laid intentions result in tangible outcomes for Indigenous people in Canada. Moving forward, it will be essential that Indigenous methods support evaluation of

these interventions and that they are equally tied to population-level health outcomes. If interventions that support Indigenous sovereignty are lacking, it is important that we critically examine which factors, especially those influenced by the dominant health system impacted or led to that result. As discussed, if we accept that the process of reconciliation supersedes the outcome, evaluation of the process of health service devolution will be just as critical as outcome-focussed evaluations. Reviews such as this should be carried out regularly to ensure that information related to the success of failure of reconciliation in healthcare in Canada is available for those who continue to undertake this tireless work.

Limitations of the Integrative Review

Because most of the articles reviewed were published post-TRC (later than 2015), it is unclear what the long-term impacts of these interventions will have on reconciliation in our current context. Although we were quite successful in meeting the objectives of this review, there were still many limitations. Specifically, because we chose only to focus on 3 academic databases, as well as *Google Scholar,* it is likely that many initiatives currently being carried out by grassroots Indigenous organizations were missed. Additionally, much Indigenous knowledge is communicated through spoken-word, and therefore considerations to include video and audio recordings should be given in the future. Inclusion criteria were quite narrow for the purpose of this review. As discussed, articles that focussed on promising practices in relation to healthcare provider education, or as stand-alone position statements (Arkle et al., 2015) were excluded from the review. New and exciting perspectives are emerging in relation to theory development (Sasakamoose et al., 2017) and research practices which also support reconciliatory efforts in Canada, but remain outside of the scope of this review.

Recommendations for Future Reviews

This review focused primarily on Western sources to determine what the current landscape of reconciliation in Canada looks like. As such, many activities, especially those tied to Indigenous activism and grassroots interventions remain undocumented. Another review which privileges Indigenous knowledge-sharing platforms is merited. For example, we know that much of Indigenous knowledge is shared through spoken word, outside the realm of academic databases. A thorough search of social media platforms such as *Facebook, YouTube* and *TikTok*, would be more apt to capture the wide array of ways in which Indigenous communities are taking ownership over their own health services.

Conclusion

The aim for this integrative review was to examine efforts towards reconciliation, and thus, Indigenous self-determination over health service administration in the modern Canadian context. Through our review of relevant materials, we have a clearer understanding of what policies and intervention exist supporting reconciliatory practices in healthcare in Canada today and by which mechanism, which also shines light on spaces that are un-silencing Indigenous knowledges and ways. By placing these interventions into our framework, we have simultaneously deepened our understanding of the M'pisun which we are co-creating as we move through this research project. This will allow for us to share a similar lens and base-understanding as we move towards the research at-hand.

The TRC (2015) has shaped the way that we speak and think about Indigenous self-determination in Canada today. The results of this integrative review have been promising in terms of the breadth and scope of projects, policies and interventions that have been undertaken which support reconciliation in today's health systems. By analyzing our findings through the

lens of the *M'pisun*, we were able to conceptualize how each doorway housed certain reconciliatory efforts and show that each work in concert with one another to meaningfully move towards reconciliation in Canada today. Findings from this integrative review show that embedding Indigenous ways of knowing and being into current health system, partnerships with Indigenous leaders and stakeholders, devolution and transfer of healthcare administration, and decolonizing space found either within western institutions, or within ourselves, as integral to achieving health and wellness at a systems level. It is through the experiential process of forming relationships and partnerships aimed at rectifying the emotional impact that historical settler-colonial relations have had on current health systems and health outcomes, where we will truly begin to capture the process of reconciliation. Self-determination of healthcare administration has been identified a necessary perquisite for changes to health disparities faced by Indigenous people (UN General Assembly, 2007). Having a holistic healthcare system, guided by Indigenous knowledges could dramatically change the way that we define, fund and administer health services in Canada.

Chapter 4- Methodology

> Indigenous methodologies are often a mix of existing methodological approaches and Indigenous practices. The mix reflects the training of Indigenous researchers, which continues to be within the academy, and the parameters and common-sense understandings of research which govern how indigenous communities and researchers define their activities (Tuhwai-Smith, 2012, p.144)

This project was no different. In this Chapter, we will continue to co-create our M'pisun. As discussed, our framework will also be synonymous with our findings. The methodology outlined herein, shows how our storytellers have been engaged in the research and how their stories have been placed within this framework to continue to grow our Medicine Wheel. From a Western perspective, we can say that this study is a qualitative phenomenological research study adapted to Indigenous ways of knowing and doing. It is this methodology that has allowed us to make meaning of their stories that help us address our research objectives. As discussed in the introductory chapter, Indigenous methodologies that contributed to the research purpose, study design, and research methods are claiming, storytelling, and Indigenizing and Indigenists processes. Indigenous methods which supported data collection and analysis were Kovach's (2010) *Conversational Method,* and *Sharing Circles,* as described by Lavallee (2009). From there, rigor and ethical considerations will then be addressed from both Western and Indigenous perspectives.

Research Objectives

As discussed, this study aimed to explore the present-day effects of colonialism influencing healthcare leaders within Manitoba. There were two research objectives:

i. To gather Manitoba health leaders and listen to their stories of promoting reconciliation, decolonization, or Indigenous self-determination within health service delivery; and

ii. To use medicine wheel teachings to extend our understanding of these stories and consider medicines to move forward in balance while working within colonial structures.

In this study, health leaders located themselves within the work of engaging with the TRC (2015) *Calls to Action,* or other activities meant to advance Indigenous self-determination in healthcare service delivery. I then invited interested health care leaders to share their perspectives, feelings and meaning associated with the work itself. The emphasis being placed on where they may have felt out of balance and what, if any tools have supported them to walk in-balance while working within colonial structures.

Methodology

In qualitative phenomenological research, the researcher asks the participants, to provide a description of their experiences through open-ended dialogue. Then, the researcher determines the underlying structures of an experience by interpreting the participants' narratives based on reflective analysis and interpretation of their accounts (Giorgi, 1985). The aim was to determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it.

Using the *Conversational Method* (Kovach, 2010), we were guided to ask open-ended questions about our participants' or storytellers' experiences of promoting reconciliation, decolonization, or Indigenous self-determination within health service delivery. Through an analysis of their experiences, we were able to place key components into the structure of our framework, the Medicine Wheel, to see where and how imbalance occurs while engaging in this work. From there, we held a Sharing Circle to explore what it *means* to walk in balance while

promoting self-determination and reconciliation within health system leadership by exploring what medicines are required to do so. Lavallee describes Sharing Circles as, "Circles are sharings of all aspects of the individual- heart, mind, body and spirit- and permission is given to the facilitator to report on the discussions" (2009, p. 29). Research principles cited by both Indigenous methodologists are relationships, respect, reciprocity, and spiritual realms which have guided all aspects of this study.

Study Participants (Storytellers)

A purposive sampling of health leaders working in healthcare within the past five (5) years at a community, regional, provincial, or federal level in the province of Manitoba was undertaken. Recruitment largely took place through word of mouth and by email invitation, with a total of eight (8) storytellers participating in the study. Inclusion criteria for the study sought storytellers who were actively working towards meaningful reconciliatory, decolonizing, or Indigenous self-determination practices, in the health sector through policy, research, or workplace activities in Manitoba. They could be working in any level of government, either at the community, provincial, or federal levels. They could be working for an Indigenous-led or non-Indigenous led organization. Storytellers could be any gender and any age, above the age of 18 years. Exclusion criteria would be anyone not meeting the inclusion criteria as outlined above. A sample of both non-Indigenous and Indigenous health leaders was sought. In many instances, participants were already known to the research team, however, none were in a professional reporting relationship, and none were colleagues found from within the same workplace as me or members of my thesis committee. Given that the *Conversation Method* (Kovach, 2010) is an appropriate method when the researcher is in-relation to the participants, this did not prove to be

a conflict of interest to undertaking this research project. A template for the email invitation utilized for participant recruitment, approved by the University REB can be found in *Appendix B.*

Data Collection

Storytellers were invited via email to participate in one-on-one interviews, where Kovach's *Conversational Method* (2010) was used to gather stories. By adhering to Indigenous protocols and practices, as well as University policies tied to the REB process, ethical space was honoured during the interview process. This included the offering of tobacco, as protocol dictates, to acknowledge and agreement of reciprocity between researcher and storyteller from the beginning of the study. This also included review of the consent form (*Appendix B*) and an opportunity was provided for each storyteller to ask questions. Kovach (2010) acknowledges the relationality between researcher and storyteller, which allows stories to be co-created during the interview. In this way, the researcher is active in telling of the stories, "both parties become engaged in a collaborative process in which the relationship builds and deepens as stories are shared" (Kovach, 2010, p. 43). The conversational method aims to produce highly contextualized stories and a balance between confidentiality and researcher-participant power dynamics is continuously questioned and addressed (Kovach, 2010).

For each interview, a similar pattern was followed, as set-forth by the semi-structured interview guide (*Appendix B*). This guide served more to support me as a novice researcher and to ensure that sufficient information was captured to support the analysis. In many instances, stories and discussion would venture away from the research objectives and this guide served as a tool to bring these objectives back to the forefront of the discussion. For each interview, storytellers were asked to introduce themselves and locate themselves. This included providing information such as their name, spirit name, clan, profession, familial roles, and background

including ethnicity, home community etc. The information disclosed was entirely voluntary and was based on what the storyteller felt moved to share with me. As this research is not meant to be representative, demographic data was not explicitly collected.

After introductions, conversation then turned to asking storytellers about their visions for reconciliation and their feelings about reconciliation around the time of the release of the TRC (2015) report and its *Calls to Action*. They were then asked to reflect upon implications that this report had on their current work and contrast past feelings about reconciliation with current ones (4-5 years after the document was published). Conversations were focused more on feelings and on personal experiences in relation to the work, rather than the outcomes of the work itself. Each interview found a natural end point, where what needed to be said was agreed upon by both the participant and me. Storytellers were encouraged to add anything that may have been missed in relation to the interview.

As part of the consenting process, contact information was gathered for the storyteller to be invited to participate in the optional and voluntary Sharing Circle, which would serve as ceremony to close the project in a good way and corroborate the study's findings. The interviews were captured via voice recording which were stored on a password protected computer and then sent to a transcription service to be transcribed verbatim into a password protected, electronic document for analysis.

Conversations held during the sharing circle were not captured due to the ceremonial nature of the work. However, learnings and insights gained by the researcher through ceremony, will be included as part of the study's discussion.

Data Analysis

Moustakas (1994) states, "[t]he understanding of meaningful concrete relations implicit in the original description of experience in the context of a particular situation is the primary target of phenomenological knowledge" (p. 11). Therefore, methods of analysis for *empirical phenomenological* research as outlined by Giorgi (1985) were appropriate to meet the research objectives and support the Indigenous ontology of meaning in relationality. These methods were as follows:

1. Transcripts were read in their entirety by me to get a sense of the whole.
2. Transcripts were read a second time, more in depth looking for meaning in each of the storytellers' experiences, resulting in a series of meaning units or constituents.
3. Redundancies were then eliminated, and I elaborated and clarified for the meaning of each unit as they related to each other and how they provided a sense of the whole.
4. I then reflected on each unit and came up with the essence of that situation for the storyteller.
5. Findings were then synthesized and insights from the research are then integrated to achieve a consistent description of the structure of the experience in question.

For this study, the steps outlined above were coupled with Indigenous protocols to support the study's rigour and the connection to spiritual realms. They were undertaken by a group of researchers to support discussion, reflection, and relationality of the work and to temper the researcher's biases as much as possible from the study's findings. Transcripts were prayed over and were read in their entirety several times by me to gain a sense of the whole and to identify key themes, teachings, and meanings. Tobacco and sage were offered to ask for the support of the ancestors to ensure correct meanings were being seen and understood. Key quotes or units

were then extrapolated from each transcript and entered on a spreadsheet (*Appendix C- Storyteller Data*). This spreadsheet was reviewed and reflected upon collectively to make meaning of the interviews and to answer the research questions. Some thesis committee members- Dr. Annette Schultz, Dr. Moneca Sinclaire and Elder Dr. Mary Wilson supported Stephanie, by each reading one selected interview transcript individually, and one collectively. Then, working with the spreadsheet, supported in ceremony by Elder Wilson and using the framework of the medicine wheel- imbalances of the four doorways and potential medicines to help regain balance within each of the storytellers' experiences were identified and summarized by the four research team members. These medicines were then shared back, in reciprocity, with the study participants and the entire committee members through a sharing circle held on the Spring Solstice, March 21st, 2021.

Inviting in Spirit

During the analysis meeting, spirit was explicitly invited to participate in the analysis of interview transcripts. In addition to medicines being offered to the work, Elder Mary Wilson invoked spiritual realms directly into the analysis. This allowed for inferences to be made between the data and the Medicine Wheel and supported meaning-making of the storytellers' experiences. During the analysis ceremony, much was considered including historical and personal experiences of the research team members. This analysis ceremony supported not only the analysis, but also myself as a researcher and began to allow me to conceptualize where I sat and how, I made up the centre of the M'pisun. Although details of the ceremony cannot be provided, it is important that I highlight the contribution of spirit and intuition which led the research team to the study's findings.

Ensuring Rigour

Unlike quantitative research, qualitative research is not evaluated for reliability or generalizability of the study's findings; however, that is not to say that with a foundation of sound methods, trustworthiness of the research findings cannot be held to account (Noble & Smith, 2015). Trustworthiness is inherently supported by the Indigenous protocols undertaken throughout the lifespan of this study; however, we can also evaluate trustworthiness of the findings from a Western lens. By locating myself and my positionality throughout the study design and thesis itself, personal biases that may have influenced findings were either overtly stated or have otherwise been made transparent for the reader. Records of the participant transcripts and coding will be kept per approved REB protocol. . The spreadsheet with key learnings and quotes from participants is available for review in *Appendix C.* Thought processes to arrive at the study's findings have been evidenced throughout the thesis. Other members of the research team have been asked to add to, and corroborate findings, which were then shared back with the study's participants, who then validated that the final themes and concepts adequately reflected their experiences.

Ethical Considerations

Ethical considerations for this study were two-fold as the researcher is accountable to both University Research Ethics Board (REB) protocols for conducting research, and from an Indigenous epistemology to the Indigenous and non-Indigenous members of the health leadership community throughout the province of Manitoba. This community is not only made-up of the study's participants, but anyone who serves to benefit from the study's findings. To ensure relational accountability to the participants or storytellers, all written and oral accounts of this project were shared with them. Additionally, storytellers, and more broadly, Indigenous,

and non-Indigenous health leaders in Manitoba will be invited to attend the thesis defense. This will allow for community validation of the study's protocols, findings and recommendations generated by this project.

For institutional ethical requirements, following the methods as outlined in this chapter were paramount in ensuring the trustworthiness of the study's findings and that appropriate protocols were followed as approved by the University of Manitoba REB. The informed consent form was provided to each participant to read and sign, generally ahead of their interview times and as discussed, opportunity for the storytellers to ask questions was provided prior to each interview. The risks to human subjects associated with this study were minimal. Meeting these criteria qualified them as participants in this study. Participation in the Sharing Circle was voluntary, and each participant consented to not discussing elements of the ceremony, including other participants, during the initial consent process of the study. Sharing Circle participants who were not considered storytellers and not part of the University faculty, were asked to sign confidentiality agreements.

Summary

The intent of this chapter was to outline the methodology employed to achieve our study's objectives. By reviewing the applicable methodologies and protocols, we successfully demonstrated where Western and Indigenous epistemologies have intersected and supported one another in creating a study design which effectively answered our research questions. Tuhiwai-Smith (2012) asserts, "Indigenous methodologies tend to approach cultural protocols, values and behaviours as an integral part of methodology. They are 'factors' to be built into research explicitly, to be thought of reflexively, to be declared openly as part of the research design, to be discussed as part of the final results of a study and to be disseminated back to the people in

culturally appropriate ways and in language which can be understood" (p. 16). The *Conversation Method* (Kovach, 2010) proved to be the appropriate tool to elicit data that ultimately allowed us to gather Manitoba health leaders and listen to their stories of promoting reconciliation, decolonization, or Indigenous self-determination within health service delivery. By incorporating Indigenous elements of ceremony, claiming, and storytelling, this study proved effective at Indigenizing *qualitative phenomenological* research in a way which supported the use of Medicine Wheel teachings to extend our understanding of these stories and consider medicines to move forward in balance. In the next chapter, we will discover what those medicines are and how we arrived to them by employing the methodology as described here.

Chapter 5- Findings

"Our first teacher is our own heart."- Cheyenne Saying

In this chapter, we will discuss how the methodology as outlined in Chapter 4, has helped us to meet our study's objectives. As outlined in the previous chapter, storytellers met one-on-one with the researcher and using the conversational method (Kovach, 2010), stories of meaningful engagement with the TRC (2015) calls to action were gathered and then transcribed verbatim. These stories allowed me and members of the thesis committee to take a third turn around our medicine wheel. Key themes that emerged during our conversations, have been placed within the framework of the M'pisun. These themes were then shared back with the storytellers and other members of the thesis committee during our Sharing Circle ceremony, which, effectively, from a spiritual perspective, closed the project for the study's participants. Teachings from that ceremony have supported the fourth turn around the medicine wheel, which we will examine in the next chapter, where the discussion will support us to make meaning of the study's findings.

Who were the Storytellers?

Although demographic data was not explicitly collected, there are several ways in which we can discuss who the storytellers were, based on what they shared during their conversations with me. As discussed, storytellers were identified by members of the research team as health leaders who were leading reconciliatory efforts in Manitoba. All storytellers met the study's inclusion criteria- they identified both as Indigenous (Status and non- Status First Nations n= 4; Inuit n=1; and Metis n= 2) and non-Indigenous (n=1) peoples in Manitoba, who were actively working towards meaningful reconciliatory, decolonizing, or Indigenous self-determination practices, in the healthcare sector. Workplace activities centered on a mix of the following, with

some participants working in more than one category: policy (n= 6), research (n= 3), and health service delivery (n= 3) in Manitoba. Storytellers were health leaders who worked at every level of government- either at the community/regional (n=2), provincial (n=5), or federal levels (n=1). One worked for Indigenous-led organizations (n=1), while the majority worked within the dominant system, colonial structures (n=7). From a gender-based analysis, most participants, self-identified as women (n= 5), some men (n=2), and one as Two-Spirit (n=1). Although, not meant to be a representative sample, the backgrounds and work experiences were varied enough to provide several perspectives on activities aimed at reconciliation or Indigenous self-determination over health service delivery in Manitoba.

Overview of our Data Analysis

Data analysis was guided by *empirical phenomenological* research methods as outlined by Giorgi (1985). Data analysis was done by reading transcripts in their entirety to get a sense of the whole. Then transcripts were read a second time and third time, more in-depth looking for meaning in each of the storytellers' experiences of engaging with the TRC's (2015) *Calls to Action*. Several common experiences and perceptions were shared by the storytellers. Direct quotes which highlighted these shared experiences from each participant was placed on a spreadsheet *(Appendix C*) and shared with Elder Wilson and Drs. Schultz and Sinclaire, along with samples of the participants' transcripts. A facilitated group discussion about the spreadsheet and transcripts followed, and a sense of key meanings as they related to the shared experiences of our storytellers began to emerge. These units came together to constitute each doorway of the Medicine Wheel and further a holistic understanding of our M'pisun. The discussion amongst the research team allowed for insights to be shared which cultivated an understanding and appreciation for the medicines which would support Manitoba Health Leaders to walk in balance

while working within colonial structures, engaged in this work. The medicine wheel and the medicines were shared during the Sharing Circle, attended by our storytellers and other research team members who did not participate in the analysis process. The Sharing Circles was the means in which the findings were validated and honoured in ceremony.

Meanings (Units) and the Medicine (Wheel)

Several key concepts, or meaning units emerged during the initial analysis. Meaning attributed to each concept could either be empowering and in-support of balance or could detract from power and create a sense of imbalance, dependent on the context as described by the storyteller. For example, if we consider a concept such as *voice*, in some stories that were heard, the tellers recounted times in which they felt impactful and that their voice was heard, had a place, and allowed them to move forward with reconciliation in a good way. Conversely, storytellers with experiences of being silenced, felt that *voice* could be used to disempower and create imbalance within the work of reconciliation in Canada's healthcare sector. In addition to *voice*- evidence that supports the identification of key concepts such as: *claiming; dismantling systemic oppression; roles and life calling,* will be explored in this section. To make meaning of these constituents and to continue co-creating our Medicine Wheel, these meaning units have been placed in the doorways of our framework. We will now move through the third turn of the medicine wheel from East to South, to West, to North, exploring the key concepts that support this framework. We will then, return to the center of our medicine wheel, to support a holistic understanding of the meanings derived from experiences that describe individual health leaders' engagement with the TRC's (2015) *Calls to action*. It is from this center, where we can explore what medicines will support our storytellers, and other health leaders, to walk in balance while supporting reconciliatory practices.

Eastern Doorway- Voice

Voice sits in the Eastern direction. It is here where one is born. It is the doorway, where one says, "I am alive, and I am here." Storytellers used the concept of *voice* as a metaphor to highlight their roles as they related to engaging in policy work. Their voice could be representative of Indigenous Peoples in Manitoba while working on large-scale provincial health initiatives, aimed at improving health outcomes for Indigenous persons, for example, as Storyteller 1 introduced themselves and their work to-date, as it relates to reconciliation:

> *I've sat on a number of policy initiatives through the years, in 2010 I sat on a (anonymized) health task force for the province of Manitoba. And in that role, I was the* ***voice*** *of (anonymized) for Indigenous women and families and had advocated for system changes at that level. (ST1)*

Conversely, the same Storyteller, used the metaphor of *voice* to describe their experiences of working within the confines of colonial structures, where she felt silenced by the same system:

> *Again, like I'm just, I guess just to put it in a nutshell,* ***I had no voice****, I had no change. I did work in the federal government for six years before I came over here at the regional level. ... You don't have it over there, you have your particular file, your silo, and that's your area. And then when you want to* ***talk*** *system change, they really don't have that knowledge of the bigger system, right? What does it mean, what does self determination mean? Why is that tied to our health and wellbeing? They don't get it, you know? They are so caught up in their own particular file and managing their own particular budgets and contribution agreements and so on and so forth. (ST1)*

The same storyteller eventually decided to move on from working within the provincial and federal systems and is currently working for an Indigenous-led organization within the province.

There, she has not only found her voice, but also found her place within advancing efforts for Indigenous self-determination over health service delivery. We will revisit her story once we arrive at the Northern doorway and again when we move to the centre of our M'pisun.

When we look at the meanings derived from the concept of *voice* from another storyteller, we gain a different sense of the power of voice as it relates to reconciliation in Manitoba's healthcare context. Storyteller 5 was our only non-Indigenous participant. Their story highlights the complexity of how voices are privileged at policy tables and shared a keen awareness of who was at the table, who was not, and that their own voice could be used to both detract from, and advance reconciliatory efforts.

> *And partly because of this issue because they're a colonial organization working in Indigenous territory and it just feels wrong; I didn't … You know you have to start to look at being a part of it, like are you complicit in it, you know? There's that: are you complicit? The other side is leaving doesn't necessarily help either, like* ***then you're taking a voice away*** *from the table that maybe help to talk about reconciliation. So anyway, so there have been low moments, for sure. (ST5)*

Storyteller 5 goes on to discuss barriers to meaningful inclusion and engagement of Indigenous stakeholders. They discuss how acuity can impact certain situations, and how the system is set-up to respond to those situations, makes for less-than-ideal conditions to include Indigenous voices at the table.

> *"But I don't think we really actioned them. Well, I can say that personally I don't feel good about the way that that happened. So,* ***we wanted to include some Indigenous voices*** *at the table. I was keen to not have one person because of the token Indian comment that I've heard from a lot of my colleagues and friends. So, we wanted more than one person and I*

called the tribal council and they said 'we can't send anyone, we're too busy.' And in the heat of the moment, we just lost the focus on that." (ST5)

As we move on to Storyteller 6, their experiences reflected on the importance of finding one's voice. Their focus was on what it meant to speak up and to speak out against oppression found within the healthcare setting.

"And one of the things that I've noticed is the nurses now that come to our, that are part of our group, our circle, they are ***speaking up and speaking out*** *and there's one in particular who was very oppressed, I think and I mean she had taken time off work a while ago and she was having real issues coping and struggling and she's a different generation, she's a little bit older and so she was used to* ***not speaking out*** *and stuff like that. And now the lady* ***has found her voice*** *and I'm just like go, go. I tell her all the time****, I'm so proud of her for finding her voice*** *and now she's found it. So things like that give me hope." (ST 6)*

This excerpt is not only indicative of the Eastern doorway as a locus for finding one's own voice. For announcing one's presence and one's values to the world, but also centers us in the notion of hope, of the vision for the future and how change is possible. This is exemplary of the Eastern doorway meaning in our framework, where hope and visions of the future intermingle to show us, collectively what is possible.

Southern Doorway- Claiming

Claiming serves as a supportive methodology for the entirety of the project. Claiming is when Indigenous scholars, persons, or groups make claims that assert Indigenous rights which are already inherently there but that are denied by colonial institutions and dominant system governments (Tuhwai-Smith, 2012). *Claiming* involves speaking the *truth* with regards to not only historical contexts, but modern-day realities when asserting Indigenous rights to self-

determination over health service delivery. It is through the acknowledgement and acceptance of these claims that form the foundation of the types of *relationships* which will make reconciliation a possibility in our modern-day context. It is for this reason, that we have placed meaning units which highlight *claiming* in the Southern doorway. The theme of claiming was derived from stories about *rights, recognition, truth, relationship,* and *responsibility*. As one storyteller indicates:

> *"And you have to start with* ***recognition****, because if you don't have people understanding the* ***truth****, and then understanding what happened, and then a* ***recognition*** *that we all have a part, like, we're all treaty people. You know, that we all have a part. So****, recognizing our collective responsibility****, so it's not just one-sided, it's a commitment to that renewal of that* ***relationship****." (ST4)*

This lack of recognition of Indigenous rights, engendered frustration amongst our storytellers-

> *"When it (the TRC) first came out, for me, I remember feeling like, wow we need another document to help settlers and other people like really* ***recognize*** *what the issues are, like how many times do we have to say the same things and give the same messages about what we as Indigenous people should* ***have a right to*** *anyway? So there was that. And what quickly came to mind was the fact that like we continuously heard over and over, "Reconciliation, reconciliation, reconciliation" but I actually didn't see much action from the people that we needed to see action from, so that got a little bit tiresome again" (ST8)*

As the above storyteller points out, lack of meaningful action from governing bodies placed towards reconciliation, becomes tiresome. Many storytellers have moved away from the term *reconciliation* altogether. In the mind of Indigenous peoples, *reconciliation*, if done correctly

involves recognition of Indigenous rights to self-determination over health service administration:

> *And I find that to be a very – it's funny because I did include reconciliation and talked a little bit about reconciliation in my proposal …and they, or the one individual, the trusted individual that I shared it with, said to me why are you using that term, you know? And I explained to them, you know, all the good things about reconciliation and they said, that's a government term. Can you change that, like* ***can you just say that it's our right versus it's being done for reconciliation? It's being done because this is our right****. So, I did change that (ST2).*

Therefore, it is here in the southern doorway, where we not only make-meaning of *claiming* Indigenous rights in the modern Canadian health context, but also, we discover what reconciliation truthfully means. This doorway serves as the locus where recognition of claims to rights of Indigenous sovereignty meets the truth. It is this meeting place where reconciliation occurs. It is named so in the ***Truth*** *and Reconciliation Commission* report (2015).

Western Doorway- Dismantling Systemic Oppression

> *"And so some of the things in the health system, or any systems, they must have a lot of these things we've already talked about, right; the reparation, the recognition, renewal, respect, and that responsibility. Like, I don't have anyone in our system asking, you know, what can we do for indigenous people?* ***But they need to be asking, what can we do to change the system?****" (ST4)*

As we move into the Western Doorway, this is where our storytellers along with the *Truth* from the Southern Doorway meet the weight and oppression of current colonial structures.

It is in this doorway where the tension between the hope of the Eastern Doorway and the subsequent lack of action is keenly felt-

> *Yeah, I felt very hopeful and actually at that time I was working with, my office was located with Indigenous health programs which was very convenient. So there was a lot of, I was able to collaborate a lot with just the people there walking by. …* ***I don't know where it's at, but definitely there was hope that hey this is something that we can, but every time something comes out I'm hopeful right****. Like even the Missing and Murdered Indigenous Women report, even the Tina [Fontaine] and all these reports that have come out. The one about the child welfare system, that report.* ***And these reports come out and you're like ok, there's stuff in here, but then it's like it goes nowhere****. (ST6)*

In this doorway, the frustration regarding the stagnancy of the status quo weighs heavy. Some storytellers attributed lack of action, or misguided action to the lack of Indigenous representation at policy tables, as described by Storyteller 3-

> *But I see we have very little indigenous health leadership. So the policy level is still so colonized. I mean they work on biases, they work on the things that they've learnt and the expectations and – There isn't a lot of like* ***"Let's think out of the box for how we could run this programming differently that might actually help Indigenous people."*** *It's like "Well, we just have to help all Manitobans" and that doesn't create health equity on that bigger policy level, right? (ST3)*

Others attributed system expectations and quality measurements to be driving persistent health inequities for Indigenous people throughout the province, "*But the outcomes that the government, like provincial, federal governments and the health authorities and stuff are looking at are different than what needs to be looked at" – (ST8).* What the Western Doorway shows us

is that, once we have embraced the teachings of the Southern Doorway, many storytellers were able to describe a moment where they realized that we needed to move away from activities solely designed to change relationships within Canada's health system, but that the system, founded on colonial structures, is what needed to change:

> *"But also that there's a recognition that this is the only way. When you get into recognizing that this is the only way, then you lose so much, because if we – you know, in the leadership program that I went to, we saw the way – like, yeah, I go to Mohawk country, right, we're in [Kwasaasni], and when you hear the stories of the Wampum belt, then you know that European and Indigenous relationships were not always at one time equal. Because you hear the story of the Wampum belts, that's the history. … And that's just one example of one way,* ***because there are so many examples of different ways of how we know. And so decolonization means it's taking action, right, towards dismantling the current structures****, not just, how many public servants have we told about residential schools. Because that's not enough; I've seen lots of public servants get lots of knowledge, and still ask, what are we doing this for?" (ST4)*

Northern Doorway- Roles & Life Calling

In the Northern Door, the question, *"What are we doing this for?"* Takes on a different connotation and, and therefore, the answer is different. In this doorway, we discover that many of the storytellers had a sense *life calling* when engaging in this work; *"I remember sitting there thinking like* ***this is what I'm supposed to be doing****, but I'm* ***supposed to be doing it for my own Indigenous people****." (ST3)* This could be centered on the notion that as Indigenous people, there is a belief that everyone has gifts, and that these gifts support their purpose.

> *"I feel that I have these, like I think we're all given gifts and that it's our responsibility to share those gifts, that's what I've been told by some Elders that you have gifts and that's your responsibility, you have to share that. And so I try to do that. I especially do that like I think my approach is very different than my colleagues." (ST6)*

From an Indigenous ontology, these roles also are relational and the reason they are meant to be shared, is for their contribution to society. This outlook is rooted in culture and in tradition, as one participant described it-

> *"And so I kind of look at it that way and so when we are in the group of community members* ***there's lots of us that have different skills or roles to play****. So in my community you would have the hunters, you would have the sewers, right, … So, when we look at sort of these kinds of traditions I try to look at those in the same way that I would consider how I would approach, you know, being a researcher and working in the community kind of thing. And so I just kind of go back to a place where maybe I'm considered a knowledge keeper or some other form of like helping, like a helper person, right, or a teaching person." (ST2)*

Because of the inherent relationality and collective responsibility, we return to Storyteller 1, they describe their role in relation to the role of others. Collaboration with others, who too, also have roles to play based on their own unique gifts. The power of open collaboration is found in this doorway and so when asked to think about what is working well, Storyteller 1 responded:

> *"So we all have our particular* ***roles****, I have research, we have a floor upstairs that does policy, we have our grandmother's circle, council, and we also have our knowledge keepers. We all have our particular* ***roles*** *but we also know how to* ***come together and work on a particular issue.*** *" (ST1)*

For another storyteller, being Métisand thus, bi-cultural, meant, that there were obligations to both Manitoba's Indigenous community, but also to the dominant system culture. As opposed to allowing this to create internal conflict, this position, was seen to carry its own gifts and contributions:

> *"And, you know what's interesting – maybe you feel the same – I feel, like as a Métis person, we are a bridge. I don't know that I would say this to First Nations or Inuit – I haven't ever said it to anybody else who's not Métis, but I feel like we have this unique position to like kind of bridge between the certain mainline society and Indigenous values." (ST3., p. 4)*

Working within the dominant system however, as described is not without its challenges. Being the voice for change is also an isolating experience. Many of the storytellers discussed how they were thankful for the opportunity to discuss what it means to feel a calling to advancing Indigenous sovereignty in a system which opposes it. As one storyteller describes:

> *"I think one of the things that's really – I guess feels great is, you know, being able to sort of discuss these things with someone like yourself who I think just even the questions you've asked me kind of give me a sense that you've got a good idea of, you know, what some of the issues are. And what I think is really important is there's almost like a group of individuals that we can – a network because if we're trying to do this work together I think we really – one of the things that I think would really help the system is if we kind of know who we are, right, so that we can kind of pull together."* (ST2)

Many feelings of frustration that arose in the other doorways, here in the North, the struggles are understood to be a necessary part of what it is that we, as Indigenous people, need to prioritize to advance reconciliation in Canada today. The work is often hard, but it is still necessary:

> *"And it's like I told the group a while ago because they're all like well you know they're all kind of oh this is so hard and why do we have to do this. And they're kind of complaining about how hard it is and the things that they see and why are we doing this and kind of complaining. And I said you know what, I was there before too, but I said* ***if you think about what your ancestors went through for you to be here you don't get to put this down****. We don't get to put down this work, we don't. We've got to keep on going and we can cry and we can be pissed off and can hate it, but we don't get to put it down." (ST5)*

Returning to Centre, Returning to Self

In Chapter 2, during our first turn of the Medicine Wheel, we spoke about the center of the *M'pisun.* As Elder Mary Wilson (2019) describes it, "you will hear talk of the doorways and what directions they hold or lead to. All directions- East, South, West, and North hold their own teachings. They all meet in the middle at a center point." It is here at the centre, where the medicines that support walking in balance are found. All elements from each doorway are required. *Voice; claiming; dismantling systemic oppression; roles and life calling* all intersect at this middle-point where the self sits. A change in one, indicates a change in the other and thus a change in ourselves:

> *I'm thinking about the medicine wheel when you're describing, and one of the Elders, when I was struggling in my 20s said, you know, the first thing that you have to do is working on having a strong heart and a strong body and a strong mind and making yourself whole and figuring out the things you need in life to be strong. Then you can work on having a strong family and that support system around you, then you can work on having a strong community. But you can't be effective in helping the community until you have helped yourself. And I thought that was very wise, because I think in your 20s*

> *sometimes you feel like "I'm going to take on the world" and you don't know how to do it and you don't have the right mental stamina to know that. So, my self-care, my relationships with my family and the community that I have, I think are, for me, the foundation of all the strength that I have and all the ability to be a health leader. (ST3)*

And so, to walk in balance, we must continuously return to ourselves. To the sound of our own heart, our own drum-

> *And then it wasn't until I was older that I was actually at the [unintelligible 00:34:37] and I heard the drum and I was like what is that that's happening right now. I'm getting goose bumps just thinking about it. I just felt this weird like I was like what is this that's happening to me right now. And I remember I was with a friend of mine who is Indigenous and I told her that. I said, this is really weird because I just feel something.*
>
> Interviewer: *It's your heartbeat.*
>
> Storyteller: *Yeah. And she had told me at that time because she was adopted and she had the same kind of experience the first time she heard a drum and she said that an elder had told her, he said those are blood memories and those exist and that's what that is. And she said that you're having a blood memory. And I'm like what the hell is a blood memory? And then she explained it to me and she said that's what that is. You remember, your cells remember.* (ST6.)

Through each of us remembering who we are, we can remain balanced in this work. This is as true from a systems' perspective as it is from an individual one. With this knowledge we are better able to move forward, "our first teacher is our own heart" (Cheyenne saying, n.d.) From an Indigenous epistemology, knowledge is relational. It is not the realities in and of themselves that are important, it is the relationship that one shares with reality (Wilson, 2001). From this centre

point, a new reality can be created, based on a change in relationship to the doorways, and thus, a change in relationship with ourselves.

Findings from our Sharing Circle

On March 21st, 2021, some storytellers and thesis committee members gathered in ceremony to discuss the study's findings, the centre point of the heart as the place where *voice; claiming; dismantling systemic oppression; roles and life calling* meet. There is a well-known saying by Quanah Parker, war leader of the *Kwahdi* (Antelope) band of the Comanche Nation, who was later named Principal Chief of the Comanch Nation by the US Federal Government (Wikipedia, n.d.). With regards to ceremony, Chief Parker (n.d.) is credited with saying, "We do not go to ceremony to talk about God. We go into ceremony to talk to God." Sharing circles are a form of ceremony and are no different. Lavallee (2009) reminds readers that when employing the Sharing Circle as methodology that the spirits of our ancestors and the creator are present in the circle and that they guide the process. She goes on to state that energy is created in the circle by the people involved. This is the rationale for not capturing the circle by voice or video recording, understanding that all those who were meant to be there, were present.

Blacksmith, David (2021) *Medicine* [Acrylic on Paper] Winnipeg, Manitoba, Canada

As an alternative means to capture learnings from the Sharing Circle, ceremonial leader, Elder David Blacksmith was commissioned to commune with the ancestors to capture the spiritual elements of this project in a painting. The painting entitled *Medicine* (2021) serves as the cover art for this thesis. The first thing that we notice is that the doorways themselves are not found within a wheel. According to Elder Blacksmith, a Medicine Wheel does not exist as a thing outside of ourselves. The circle of the Medicine Wheel is the circle of life (personal communication, June 2021). Each doorway houses an animal. In the case of this painting, the eagle sits in the East, the world in the South, the bear in the West and the white buffalo in the

North- reminding us of the many depictions and many teachings of the M'pisun. Accompanying the animals, the entrance to each doorway is guarded by a pipe. This reminds us of the spiritual nature and sacredness of these teachings- according to Elder Blacksmith, "it's because you need a pipe to enter each doorway" (personal communication, June 2021). The shape of the structure can be seen as a square, but if we look closely, is also a pyramid. This is representative not only of the sacred nature of the path which we are walking, but also as a reminder of the structures which limit the ways in which we are able to co-create this framework, and so too, limit the ways in which we are able to speak of, and advance reconciliatory efforts. I would encourage each reader to spend some time with this work. What speaks to you? What are your key takeaways? How does this painting help you to understand and integrate the study's findings? This will allow you to be a part of the sharing circle as well.

Summary

What can be spoken about with regards to the Sharing Circle ceremony is that the findings found herein this Chapter were validated by the study participants. Strong medicine was gifted as thanks for supporting this project and was gifted back in reciprocity by the study participants. It was only through this circle, that the final shape of our M'pisun could emerged and come fully into view. In the following chapter, we will place the findings into our final framework. In this way, the framework and the findings will be synonymous. What we have created will be a Medicine Wheel which supports both the process and the outcome of reconciliation as it relates to Canada's modern-day healthcare context.

Chapter 6- Discussion

> The Red Nation shall rise again, and it shall be a blessing for a sick world; a world filled with broken promises, selfishness, and separations; a world longing for light again.
>
> I see a time of Seven Generations when all the colors of mankind will gather under the Sacred Tree of Life and the whole Earth will become one circle again.
>
> In that day, there will be those among the Lakota who will carry knowledge and understanding of unity among all living things and the young white ones will come to those of my people and ask for this wisdom. I salute the light within your eyes where the whole Universe dwells. For when you are at that center within you and I am that place within me, we shall be one. –Chief Crazy Horse, 1877

It is said that the longest journey one will ever make, is the one that travels from the head to the heart. As we enter the last leg of our journey, the final and fourth turn of our M'pisun, we aim to pull everything that we have learnt together. As discussed with regards to the Medicine Wheel, all is interconnected, everything is relational- a change in one doorway, will be felt in the others. This is as true for our framework, as it is for the relationship that you, as a reader, have formed to this thesis; and the relationship that I, as a writer, have formed not only to this work, but also to you. We are in relation.

This chapter weaves together the threads from the previous turns of the M'pisun. Thus, this chapter not only offers an interpretation of the study's findings but demonstrates their interconnectedness with the teachings from of our literature review and from the *Indigenous Health Research Symposium* (2020). In this way, our findings reflect the final framework based on the context of this research. In walking through the last turn of our M'pisun, the implications

and therefore, the meaning of the research will be proposed. Limitations of this project and recommendations for future ones will also be shared.

The purpose of this study was to move discussion in the modern Canadian healthcare context beyond the examination of the roots of health inequities experienced by Indigenous people, and towards a common understanding of reconciliation and the next steps which will lead us to a more balanced and equitable future. We have undertaken this by exploring the present-day effects of colonialism influencing healthcare leaders within Manitoba, through our study's two research objectives:

i. *By gathering Manitoba health leaders and listening to their stories of promoting reconciliation, decolonization, or Indigenous self-determination within healthcare administration and service delivery.*
ii. *Using medicine wheel teachings to extend our understanding of these stories and; by considering medicines to move forward in balance while working within colonial structures.*

Through meeting these objectives, we found that the concepts of *voice; claiming; dismantling systemic oppression;* and *roles and life calling* intersect at the center of the Medicine Wheel to support balanced and meaningful engagement with the TRC (2015) *Calls to Action.*

Pulling it all Together- Interpreting the *M'pisun*

The task now becomes interpreting the findings of the interviews and weave them together with those found in the literature review, married with the original concepts of our framework. That tapestry will ultimately be representative of our fourth and final turn of the M'pisun. We will, once again move from East to South, to West, to North; before returning finally to the centre, where the study's implications will be addressed. As we have discussed, an

Indigenous ontology is one that is relational, with an emphasis on non-human relationships (Kovach, 2010; Lavallee, 2009; Wilson, 2001). By walking together in ceremony, we have honoured this relationship. In this fourth and final turn of our Medicine Wheel, we aim to foster a collective understanding of reconciliation within our current context. So please now- join with me in our final walk around the M'pisun, which will culminate the journey we have undertaken- the one that travels from our heads to our heart.

Eastern Doorway

The sun rises in the east. It represents the dawn of a new day and in the case of the modern Canadian healthcare context, it could be perhaps, representative of a new era of health service delivery. From the refereed literature, we see that implementation of traditional medicines alongside those of our current biomedically-based health system is leading to improved health outcomes for Indigenous Peoples in Canada (Hadjipavlou et al., 2018; Mundel & Chapman, 2010). This holistic approach to health service delivery is no longer seen as a revolutionary act and is increasingly being recognized by administrators in the dominant system health services as an integral part of caring for Indigenous clients (de Leeuw, 2017). In large part, this could be attributed to the concept of *voice* which was the theme given to the Eastern doorway during the analysis of the narratives as told by our storytellers. By Indigenous health leaders and their allies, speaking up and speaking out at policy tables, to physicians, and to funders, advancements in the Canadian healthcare system which are inclusive of Indigenous health and healing practices, are emerging.

Hope sits in the Eastern doorway. Love sits here. The future, our children, and those seven generations beyond us sit here. It is up to us, as a collective, to come from this place, to ask the Eagle to help us foster a shared vision of our future healthcare systems. The concept of

voice extended beyond colloquial understandings. Storytellers recognized how *voice* can birth power for Indigenous people. Power dynamics, reflected by whose voices were not only privileged, but present, at policy and planning tables were identified. Feelings of frustration were keenly felt with storytellers who have been silenced by the system, whose power had been supressed. It is this silencing of Indigenous voices which often, perpetuates systemic racism which leads to health inequities (McGibbon, 2019; McNally & Martin, 2017). More care is needed to tend how we address power at planning tables in Manitoba. As planting seeds which address these power dynamics will allow for more Indigenous voices to be present. These seeds which we plant now, are for the future, and will one day blossom- once they reach the South doorway.

Southern Doorway

Claiming as defined by Tuhwai-Smith (2012), characterized the Southern doorway for our storytellers. The act *Claiming* is synonymous with truth-telling. The turtle sits in the Southern doorway and the turtle represents Truth. It was in this doorway, where the truth as it relates to Indigenous sovereignty was located for both our storytellers and, so too, was found in the literature. This doorway which speaks to the passion, the desire, and the drive often marked characteristics of adolescence, continues to push forward the responsibilities of the Canadian government to uphold agreements made with the Indigenous people of Turtle Island. This doorway is representative of the struggle for partnerships and relationships and is also representative of the truth on which those partnerships and relationships stand. In the case of nation-to-nation partnerships, we can look back as far as the original agreements made and documented with two-row Wampum belts (Long et al., 2019). It is these agreements upon which the very fabric of the Canadian nation was founded. Many of our storytellers have been

passionately advocating for Indigenous health and healing throughout their careers. They are representative of a larger group, who tell a similar story.

If we look to where we are stuck in relation to reconciliatory efforts in Canada, often times we find that we are stuck here in the Southern doorway. The frustration which marked the narratives of many storytellers, echoed the inability for many Canadians to accept historical truths. These truths not only speak of the trauma suffered by our ancestors, or the present-day health disparities experienced by our people. These truths are rooted in the fact that the Canadian nation was founded on systems designed to, "get rid of the Indian problem" (Duncan-Campbell Scott, as cited by the TRC, 2015). Without recognition of this truth, partnerships formed to work together to address systemic health disparities and systemic racism will not move forward. Much of the passion of the southern doorway, aims to dismantle structures which are holding these systems in place. Without a plan to rebuild, however, many of these efforts fall short to disrupt ongoing colonialism in Canada today (McAdam, 2015; McGibbon, 2019).

Western Doorway

The art of rebuilding is the work of the Western doorway. It is where both Indigenous and non-Indigenous health leaders face their wolf teaching, where they are humbled. It is only through this humility which one can put aside their ego and preconceived notions of how things need to be based on past lived experience. and allows us to dream about how things *could* be. It is here, where the sentiment of needing a new system, of reforming and rebuilding current structures which oppress and sustain health inequities, as echoed by our storytellers, sits. The dismantling of the ego can be seen on par with dismantling of the healthcare system through devolution and transfer of health services. Both the ego and Canadian health systems are likely, equally colonized. Both are challenged when asked to make decisions for the common good and

asked to let go of the illusion of power and control. It is only here where we can truly begin the act of reconciliation in earnest. Where both the process and the outcome of reconciliation are focused outside of the self and towards a common good. In this way, dismantling and building are synonymous and can occur concurrently in the West.

Through our literature review, we noted that there are some healthcare systems' leaders in this doorway have already begun this process. New Indigenous health delivery models, such as the *Wilp Wa'ums Nisga'a Health Center* in British Columbia (Kelm, 2004), and the BC First Nations Health Authority (O'Neil et al., 2016) show what is possible for Indigenous sovereignty over delivery of healthcare programs. Conversely, in Manitoba, it still appears that often, we are looking into the Western doorway from the outside. Despite Indigenous people comprising 18% of Manitoba's overall population (Statistics Canada, 2016), we are not leading in efforts which would support our Indigenous community to meaningfully engage in reconciliation in this province.

This was a sentiment felt by many of our storytellers who described a heaviness and a weight to oppressive colonial structures which support healthcare administration throughout our territoryConsistently, it was noted by the study's storytellers that it was not more education or awareness that was required to shift health outcomes for Indigenous people. What was nearly unanimous was the awareness and recognition that the system itself is what needed to be changed. Some narratives of the storytellers reflected the first steps towards this already being taken. However, there remains an apparent lack of readiness that permeates throughout Manitoba's healthcare system to meaningfully engage in this restructuring in a way that does not continue to privilege a Western epistemology. For our storytellers, reconciliatory efforts should disrupt the dominant, colonial system. Without recognition that the structures themselves need

to be changed, we are effectively, hoping that forced assimilation of Indigenous ways of being into the dominant system, might at one point be successful. Historically, we have seen the impact of this belief. It is not enough to talk about health equity. What needs to be the focus moving forward is Indigenous sovereignty over health service delivery.

Northern Doorway

The Northern Doorway traditionally represented as the doorway to the next world and the doorway to our ancestors, in the case of our M'pisun has represented a place of wisdom and generosity. This generosity stems from the understanding that it is here from which we have came and to here, we shall return. It is bordered by the humility of the West and the unconditional love found in the East. Humility and love intersect here in the North and extend as a love for all that is, and all that is to come. When Crazy Horse (1877) spoke of the *Seven Generations* and of unity amongst all nations, it is from this doorway that he received his vision, it came from the ancestors who gifted him the wisdom of that message. He spoke those words shortly before surrendering to General Crook at the Red Cloud Agency in Nebraska on May 6, 1977 (Britannica, n.d.). The wisdom of the Northern door fosters not only a freedom, but a purpose.

The study participants or storytellers described a sense of roles, life calling and of a desire to be of service that were integral and inherent to their identities. It was this part of their identities that encouraged them forward. They continued to meaningfully engage in work that supported reconciliation in the Canadian healthcare context, despite how hard the work was and the barriers which they faced. In this doorway, sacrifice, is replaced by a sense of generosity and open sharing that is elicited from recognizing one's life path. In addition, in this doorway, there is an understanding of our responsibilities, not only to our life path but also to each other. It is

this Indigenous ontology where rights are equated to responsibility. Although all the storytellers described themselves as health leaders, it was not power which motivated their actions, but a sense of duty to the next seven generations. We are reminded here in the North of what our ancestors suffered for us to engage in this work. It is in this doorway where we are reminded that seven generations ago, our ancestors prayed for us. It is here where we pray for seven generations from now. They are the reason that we move forward. That we take another turn around the wheel.

In the literature, we see glimpses of what healthcare could be for our children's, children's, children's, children's, children's, children's children. In Canada, spaces, both inner and outer, are being decolonized. In some cases, it means a return to the land, and thus, to our mother. In other cases, modern buildings are being erected based on traditional teachings and Indigenous knowledge. These spaces, like the *Nanatawihowikamik Healing Lodge and Wellness Clinic* at the University of Saskatchewan, will hopefully still be in existence seven generations from now and will serve as a reminder of how far we have come. It is possible that 150 years in the future, we will have moved from incorporating Indigenous healing practices into Western health systems, towards incorporating allopathic medicine into a system representative of holistic health and healing. A true example of reconciliation will be when we have come together to make a new whole, co-created and in-tune with our mother Earth, which serves to deliver health equity not only in the present, but considers its impact, seven generations into the future. Led by this Indigenous ontology, we serve all beings.

Standing at the Centre of the M'pisun

We have just completed a fourth turn of our medicine wheel where we have travelled one last time, clockwise, from the East to the North to describe our M'pisun, and so we find

ourselves back in the centre- both our starting and ending place. Just as our framework is synonymous with our findings, the place from which we began and have travelled to, are the same. Like any good journey, when we return home, things look a little different. This is not because home has changed so drastically in our time away, but rather, we find that it is us, who has gained a new perspective. The above section addresses one possible interpretation of a Medicine Wheel as applied to reconciliation in healthcare in the modern Canadian health context. This journey from start to end of the thesis, as stated in the introduction, has required blind faith. It is a journey that began by following a thread, brought to me by a raven, which vibrated ever so softly, and which whispered, "follow me". It is a thread which has brought me closer to my ancestors, and thus closer to my own heart. It has informed me of the next steps that I can take to support myself as an Indigenous health leader, and has offered me insight on what balance looks like while advancing Indigenous sovereignty. Most of all, it has taught me that the self is inseparable from this work. A Western paradigm which seeks to remove the self, and thus the heart, from the matter at hand, will not be successful in this context. Each one of us must stand in our truth to move things forward.

As readers, and thus witnesses to this journey, you have come with your own biases and preconceived notions, which have perhaps, also shifted, changed, and grown in concert with your own relationship that you have formed to this work. This project aimed to apply a decolonizing lens to research practices. This research, situated within an Indigenous Paradigm- where at its core there is a relational understanding and accountability to the research. This paradigm has allowed us to co-create, not only our framework, but has served as a centering place from which we can locate ourselves and our own unique contributions towards reconciliation in healthcare. If anything, through this process of decolonization, we can see how integral the self is in relation

to it. We all have our own unique purpose and contributions to make. It is my hope that the decolonizing principles, as outlined by Kovach (2010), have guided not only the study's methodology used to meet our objectives, but have served to demonstrate the power and connection of relationality in research.

Study Limitations

"Indigenous research is not objective, nor does it see itself as unbiased" (Lavallee, 2009, p. 23). Together, we have gained many insights, however, the purposeful subjective nature of this research, have only allowed us to further examine our own truth. Because this study is phenomenological, it does not seek to inform how we should go about reconciling and implementing the TRC (2015) *Calls to Action.* It can, however, inform how we can support ourselves as health leaders throughout the process, and how to root ourselves in right actions which will move things forward in a good way. The framework, and thus our findings are tied only to our current context. More research is needed to determine the widescale applicability of the study. Furthermore, given the nature of the framework, a change in one doorway, results as a change in the whole. Therefore, this research is not replicable. Different experiences, new interventions and changes in self will inform each doorway while using the Medicine Wheel. With the ever-changing health landscape, along with the changes to the roles and functions of health systems and health leaders, current findings will shift as well. This study and the resulting insights and discussions serve only as a snapshot to the meaning derived from this place and this time.

Where do we Journey from Here? -Recommendations for Future Research

What should carry forward however, is the relationality and thus, reciprocity in which this research was undertaken. Many storytellers during the sharing circle and one-on-one

interviews expressed how meaningful this project was for them on a personal level. Storyteller 5 as a non-Indigenous storyteller, during the interview referred to the conversation as therapeutic. Storyteller 6 discussed how nice it was to connect to someone with similar experiences. Often, it can feel like we are engaged in solitary work, despite the collective nature required to advance reconciliatory efforts from within our modern context. Research projects examined during the review of the literature, often described efforts in isolation, rather than part of a growing movement. Arguably, it is this lack of relationality, designed to promote objectivity, in both research as well as healthcare service administration, which puts us at a deficit. For reconciliatory efforts to be impactful, they must also be recognized for their collective, rather than individual impacts they have on improving Indigenous health throughout Canada. As much as the doorways of the M'pisun are interconnected and interdependent, so too, are our efforts. Many of the articles currently being published in the refereed literature, continue to privilege a Western ontology that fits within a Western paradigm. This paradigm continues to divide and separate us within not only the health sector, but on our own lands and territories.

Conversely, an Indigenous research paradigm, based in Indigenous epistemologies which promote a relational understanding not only of our efforts, but of ourselves in relation the work, supports individual and collective responsibilities for addressing health inequities and improving overall functioning of our health systems. Academic institutions and health faculties would benefit from research which fosters an Indigenous paradigm. Publishers wishing to support reconciliatory efforts need to include not only publications from Indigenous researchers, but emphasizing projects which actively advance the science of Indigenous methodologies. From this place, Indigenous ontologies will continue to permeate the academy and impact future healthcare systems' leaders, and their efforts to advance reconciliation in Canada.

Conclusion

Together we have made four turns around our Medicine Wheel. By employing an Indigenous paradigm, we were able to conduct research that was not only relational and rooted in spiritual realms, but also nonlinear. The purposeful decision to utilize a circular framework, which supported a circular discussion, allowed for experiential learning. The spiral created by the four turns the medicine wheel allowed for a deeper understanding of our storytellers' experiences. During the framework chapter, I shared a teaching gifted to me by Elder Wilson during my time in Aotearoa. During that teaching I was told that a wheel is a circle which has 360 degrees. Each degree of the 360 degrees of the M'pisun, contains another wheel. The Medicine Wheel is often represented as a circle, divided into four quadrants. Another way to conceptualize our framework, is to see the quadrants as a birds-eye view of two intersecting helixes,much like our DNA. The study found that the medicine to help us walk in balance and make-meaning of the Eastern, Southern, Western and Northern doorways as they relate to our research purpose, was the medicine of centering ourselves in our own heart, in the middle of the M'pisun. The activities undertaken to support engagement with the TRC *Calls to Action,* placed in each doorway, intersect here, with us at the centre. We found that much like our DNA; the medicine was a part of us all along. Not to be sought as an external journey where reconciliation is a destination outside of ourselves. Reconciliation is only found as we journey within. This journey begins with the first teaching found in the Eastern doorway: Love. Universal Love. That is decolonization, and it is love which connects our heads to our heart.

Epilogue- Father of The Blue Waters

I can see you as I breach the water, be gentle with the life.

I am the Father of the sea.

Breathe the moist air, heal your lungs.

This moment in the great abyss, where the sun creates diamonds in the early morning rise.

I call to the nations, my brothers and sisters, to tell them, take care of the waters.

What has been and what is to come.

My song is heard as I ripple through the waves, I am the holder of the knowledge.

I share with you.

Raise your shaker, call to your spirit, as your ancestors wait for your request.

In the lines in my face, I will teach you compassion.

I will help you map the stars with the turn of my tail,

Understand the universe.

Do not underestimate the rhythm of the sea.

Our survival is your survival, respect the deep waters.

My sister the dolphin, my brother the seaweed, our gentle auntie the shark is old like me.

My song speaks to the heart of all nations, listen closely. My song, your own translation, resonates to the sounds to your soul.

Our mother is shared, she is the great circle of life.

My songs are from 1000 years ago and will be sung until forever.

Be in peace with the water, with me.

To all your nations be peaceful.

Take care of your water, she will take care of you.

My song can travel where you wander.

I send my love.

Your Father of Blue Waters, come and grow with me.

Written by
Mary Wilson,
Sung by Father Whale,
Location, where the water meets the shore.

References

Adelson, N. (2000). Miyupimaatisiiun: 'Being Alive Well'. In *Being Alive Well': Health and the Politics of Cree Well-Being*. (pp.59-98). Toronto: University of Toronto Press.

Adelson, N. (2005). The embodiment of inequity: health disparities in aboriginal Canada. *Canadian Journal of Public Health, 96(2),* 45-61.

Al-Husseini, Khansaa. (2019). Re: What is the difference between scoping and integrative literature review? Retrieved from: https://www.researchgate.net/post/What_is_the_difference_between_scoping_and_integrative_literature_review/5c390af136d235330d63cf5a/citation/download.

Andrews, M. (2015). *Decolonizing the colonizer.* [Video file]. Retrieved from: https://vimeo.com/132494877

Arkle, M., Deschner, M., Giroux, R., Morrison, R., Nelson, D., Sauvé D., Singh, K., (2015). Indigenous Peoples and Health in Canadian Medical Education CFMS Position Paper. Retrieved from: https://www.cfms.org/files/positionpapers/2015_indigenous_people_in_canadian_med_ed.pdf

Arksey, H., O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19-32.

Bagelman, J., Devereaux, F., Hartley, R. (2016). Feasting for Change: Reconnecting with Food, Place & Culture. *International Journal of Indigenous Health 11*(1). 6-17.DOI:10.18357/ijih111201616016

Bar-Tal, D., Bennink, G.H. (2004). The Nature of Reconciliation as an Outcome and as a Process. In Bar-Siman-Tov, Yaacov. (ed). *From Conflict Resolution to*

Reconciliation. USA: Oxford University Press. Retrieved from: http://www.myilibrary.com?ID=56032

Beiser, M., Stewart, M.S. (2005). Reducing Health Disparities: A Priority for Canada. *Canadian Journal of Public Health, March-April.*

Benbow, S., Gorlick, C., Forchuk, C., Ward-Griffen, C., Berman, H. (2016). Ontario's Poverty Reduction Strategy: A Critical Discourse Analysis. *Canadian Journal of Nursing Research, 48*(3-4), 100-109.

Blacksmith, David, personal communication, February 15, 2021.

Blacksmith, David, personal communication, June 24, 2021.

Bloomfield. (2006). *On Good Terms: Clarifying Reconciliation.* Berlin: Berghof Research Center for Constructive Conflict Management.

Bourque-Bearskin, L. (2015). Message from The President. *The Aboriginal Nurse; Summer 2015,* 3-5.

Chiang, Y-C., Lee, H-C., Chu, T-L., Han, C-Y., Hsiao, Y-C. (2016). The impact of nurses' spiritual health on their attitudes toward spiritual care, professional commitment, and caring. *Nurse Outlook, 64*(3), 215-224.

Chiefs of Ontario (n.d.). Understanding First Nation Sovereignty. Retrieved from: http://www.chiefs-of-ontario.org/faq , February 20, 2021.

Chinn, P., Kramer, M. (2015). *Knowledge Development in Nursing: Theory and Process* (10th ed.) Elsevir, Inc.

Connor, H. (2011). *Culture is Healing: A design for youth suicide prevention in northern Manitoba* (Thesis) Retrieved from: http://hdl.handle.net/1993/4490

Crazy Horse (1877). Retrieved from: https://www.californiaindianeducation.org/famous_indian_chiefs/crazy_horse/

Danto, D., Walsh, R., Somerfield, J. (2020). Learning from Those Who Do: Land-Based Healing in a Mushkegowuk Community. *International Journal of Mental Health and Addiction.*

Di Lallo, S. (2017). A call to follow through on relationship building. *Canadian Nurse, Nov/Dec2017; 113*(6), 36-36.

de Leeuw, S (2017). Putting calls into action Treating aboriginal patients in collaboration with Indigenous healers and elders. *Canadian Family Physician 63*.

Delorier, T., Marquis, K. (2019). Building Health Community Relationships Through Food Security and Food Sovereignty. *Current Developments in Nutrition, 3,* 25-31.

Doucette, J., Bernard. B., Simon, M., Knockwood, C. (18 June, 2004). The Medicine Wheel: Health Teachings & Health Research. Presented at the 2nd annual Cape Breton Health Research Symposium; Cape Breton University, Sydney NS.

Drost, J.L. (2019). Developing the Alliances to Expand Traditional Indigenous Healing Practices Within Alberta Health Services. *Journal of Alternative and Complementary Medicine* 25(S1), S69-S77.

Encyclopedia.com. (2018). Sperm Whalle, In: *Encyclopedia.com*, from: www.encyclopedia.com/plants-and-animals/animals/vertibrate-zoology/sperm-whale

Flood, J., Minkler, M., Hennessey Lavery, S., Estrada, J., Falbe, J. (2015). The Collective Impact Model and Its Potential for Health Promotion: Overview and Case Study of a Healthy Retail Initiative in San Francisco. *Health Education & Behavior, 47*(5), 654-668.

Firestone, M., Syrette, J., Jourdain, T., Recollet, V., Smylie, J. (2019). “I feel safe just coming here because there are other Native brothers and sisters”: findings from a community

based evaluation of the Niiwin Wendaanimak Four Winds Wellness Program. *Canadian Journal of Public Health, 110*(4), 404-413.

Gallagher, J. (2019). Indigenous approaches to health and wellness leadership: A BC First Nations perspective. *Healthcare Management Forum 32*(1), 5-10.

Giorgi, A. (1985). *Phenomenology and psychological research.* Pittsburgh, PA: Duquesne University Press.

Hadjipavlou, G., Varcoe, C., Tu, D., Dehoney, J., Price, R., Browne, A.J. (2018). "All my relations": Experiences and perceptions of Indigenous patients connecting with Indigenous Elders in an inner city primary care partnership for mental health and wellbeing. *CMAJ, 190*(20), E608-E615.

Hamber, B., Kelly, G. (2004) *A Working Definition of Reconciliation*. Belfast: Democratic Dialogue.

Hammarberg, K., Kirkman, M., de Lacey, S. (2013). Qualitative research methods: when to use them and how to judge them. *Human Reproduction, 31*(3), 498-501.

Health Canada (2018) https://www.canada.ca/en/public-health/services/publications/science research-data/key-health-inequalities-canada-national-portrait-executive-summary.html

Hunter, L.M, Logan, J., Goulet, J-G., & Barton, S. (2006). Aboriginal healing: Regaining balance and culture. *Journal of Transcultural Nursing 17*(1), 13-22.

Jackson, L.R., Ward, J.E. (1999). Aboriginal health: why is reconciliation necessary? *The Medical Journal of Australia, 170(9),* 437-440.

Kelm, M.-E. (2004). Wilp Wa'ums: Colonial encounter, decolonization and medical care among the Nisga'a. *Social Science and Medicine 59*(2), 335-349.

Kovach, M. (2010). Conversational Method in Indigenous Research. *First Peoples Child & Family Review, 5*(1), 40-48.

Larkin, J., Flicker, S., Koleszar-Green, R., Mintz, S., Dagnin, M., Mitchell, C. (2007) HIV risk, systemic inequalities, and Aboriginal youth: Widening the circle for HIV prevention programming. *Canadian Journal of Public Health, 98*(3), 179-182.

Lavallee, L. (2009). Practical Application of an Indigenous Research Framework and Two Qualitative Indigenous Research Methods: Sharing Circles and Anishnaabe Symbol Based Reflection. *International of Qualitative Methods, 8*(1), 21-40.

Levac, D., Colquhoun, H., O'Brien, K. (2010). Scoping studies: advancing the methodology. *Implementation Science, 5*(69), 1-9.

Little Bear (2000). *Jagged worldviews colliding.* (M. Battiste, Ed.), *Reclaiming indigenous voice and vision* (pp 77-85). Vancouver, BC: UBC Press.

Long, R., Heffernan, C., Cardinal-Grant, M., (…) Janvier, D. (2019). Two row wampum, human rights, and the elimination of tuberculosis from high-incidence indigenous communities. *Health and Human Rights, 21*(1), 253-265.

MacDonald, C., Steenbeek, A. (2015). The Impact of Colonization and Western Assimilation on Health and Wellbeing of Canadian Aboriginal People. *International Journal of Regional and Local History, 10*(1), 32-46.

Martin, D. H. (2012). Two-eyed seeing: A framework for understanding indigenous and non -indigenous approaches to indigenous health research. *CJNR (Canadian Journal of Nursing Research),* **44**(2), 20– 42.

Martin, D., Murdoch, E., Rieger, K. (2016). Walking side by side on a journey of reconciliation. *Canadian Nurse, May.*

McAdam, S. (2015). *Nationhood Interrupted: Revitalizing Nehiyaw legal systems.* Toronto, ON: Purich Publishing, Ltd.

McGibbon, E. (2019). Truth and reconciliation: Healthcare organizational leadership. *Healthcare Management Forum 32*(1), 20-24.

McNally, M., Martin, D. (2017). First Nations, Inuit and Metis health: Considerations for Canadian health leaders in the wake of the Truth and Reconciliation Commission of Canada report. *Healthcare Management Forum, 30*(2), 117-122.

MMIWG. (2019) *Reclaiming Power and Place: the Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. Canada.

Mohatt, N.V, Thompson, A.B., Thai, N. D., Tebes, J.K. (2014). Historical trauma as public narrative: A conceptual review of how history impacts present-day health. *Social Science & Medicine,* 106, 128-136.

Moustakas, C. (1994). *Phenomenological Research Methods.* Thousand Oaks California: Sage Publications.

Mundel, E., Chapman, G.E. (2010). A decolonizing approach to health promotion in Canada: The case of the Urban Aboriginal Community kitchen garden project. *Health Promotion International 25(*2), 166-173.

New Bedford Whaling Museum (n.d.). *Whales and Hunting.* Retrieved from: www.whalingmuseum.org/learn/research-topic/whaling-history/whales-and-hunting/

Noble, H., Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence Based Nursing, 18*(2), 34-35.

O'Neil, J., Gallagher, J., Wylie, L., Bingham,B., Lavoie, J., Alcock, D., Johnson, H. (2016). Transforming First Nations' health governance in British Columbia. *International Journal of Health Governance 21*(4), 229-244.

Richmond, C., Cook, C. (2016). Creating conditions for Canadian aboriginal health equity: the promise of healthy public policy. *Public Health Reviews, 37*(2), 1-16.

Royal Commission on Aboriginal Peoples. (1996). *People to people, nation to nation: Highlights from the report of the Royal Commission on Aboriginal Peoples.* Ottawa: Minister of Supply and Services Canada.

Sasakamoose, J., Bellegarde, T., Sutherland, W., & Mckay-Mcnabb, K. (2017). Miýo pimātisiwin Developing Indigenous Cultural Responsiveness Theory (ICRT): Improving Indigenous Health and Well-Being. *International Indigenous Policy Journal, 8*(4), Retrieved from: https://doi.org/10.18584/iipj.2017.8.4.1

Saskamoose, J., Snowshoe, A. (n.d.) *The Nanatawihowikamik healing Lodge and Wellness Clinic.* Saskatoon: University of Saskatchewan Newsletter.

Simonds, V., Christopher, S. (2013). Adapting Western Research Methods to Indigenous Ways of Knowing. *American Journal of Public Health, 13*(3), 2185-2192.

Skewers, M. (n.d.) *Anishinaabe Medicine Wheel.* Retrieved from: http://www.montana.edu/reachlab/

Soares, Cassia. (2020). Re: What is the difference between scoping and integrative literature review? Retrieved from: https://www.researchgate.net/post/What_is_the_difference_between_scoping_and_integ

Statistics Canada. (2017). *2016 Census topic: Aboriginal peoples.* Retrieved from: https://www12.statcan.gc.ca/census-recensement/2016/rt-td/ap-pa-eng.cfm

Thurman, W., Pfitzinger-Lippe, M. (2017). Returning to the profession's roots: Social justice in nursing education for the 21st century. *Advances in Nursing Science, 40*(2), 184-193.

Torraco, R.J. (2005). Writing Integrative Literature Reviews: Guidelines and Examples. *Human Resource Development Review, 4*(3), 356-367.

Tribe Called Red, A. (2016). *The Virus Ft. Saul Williams, Chippewa Travellers.* Retrieved from: https://www.youtube.com/watch?v=4_5VAKdHMek&index=6&list=RDEMG2dSuVrS7dzFlpLRGXQ28w

Truth and Reconciliation Canada. (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Winnipeg: Truth and Reconciliation Commission of Canada.

Tuhiwai Smith, L. (2012). *Decolonizing Methodologies, 2nd ed.* Dunedin: Otago University Press.

UN General Assembly. (2007). *United Nations Declaration on the Rights of Indigenous Peoples: resolution/ adopted by the General Assembly.* Geneva: UN General Assembly.

Webber, J. (1999). Native Title as Self-Government. *U.N.S.W.L.J., 22*, 600-603.

Wenger-Nabigon, A. (2010). The Cree medicine wheel as an organizing paradigm of theories of human development. *Native Social Work Journal* (7), 139-161.

Whalen, K. (n.d.). *Indigenous Religious Traditions.* Retrieved from: https://sites.coloradocollege.edu/indigenoustraditions/sacred-lands/bighorn-medicine wheel-wyoming/

Williams, K., Potestio, M.L., Austen-Wiebe, V. (2019). Indigenous health: Applying truth and reconciliation in Alberta health services. *CMAJ (191)*, 544-546.

Wilson, M (2019-2020). Personal communication, winter of 2019 - Fall 2020)

Wilson, S. (2001). What is an Indigenous research methodology? *Canadian Journal of Native Education*, *25*(2), 175.

Wilson, S. (2008). *Research is Ceremony: Indigenous Research Methods.* Black Point, Nova Scotia: Fernwood Publishing.

Whallen, K. (n.d.) Bighorn Medicine Wheel Wyoming. Retrieved from: http://sites.coloradocollege.edu/indigenoustraditions/sacred-lands/bighorn-medicine-wheel-wyoming/

Wikipedia (n.d.). Quanah Parker. In *Wikipedia*. Retrieved Feb 16, 2021, from: https://en.wikipedia.org/wiki/Quanah_Parker

Appendices

Appendix A- Chapter 3 Tables and Figures

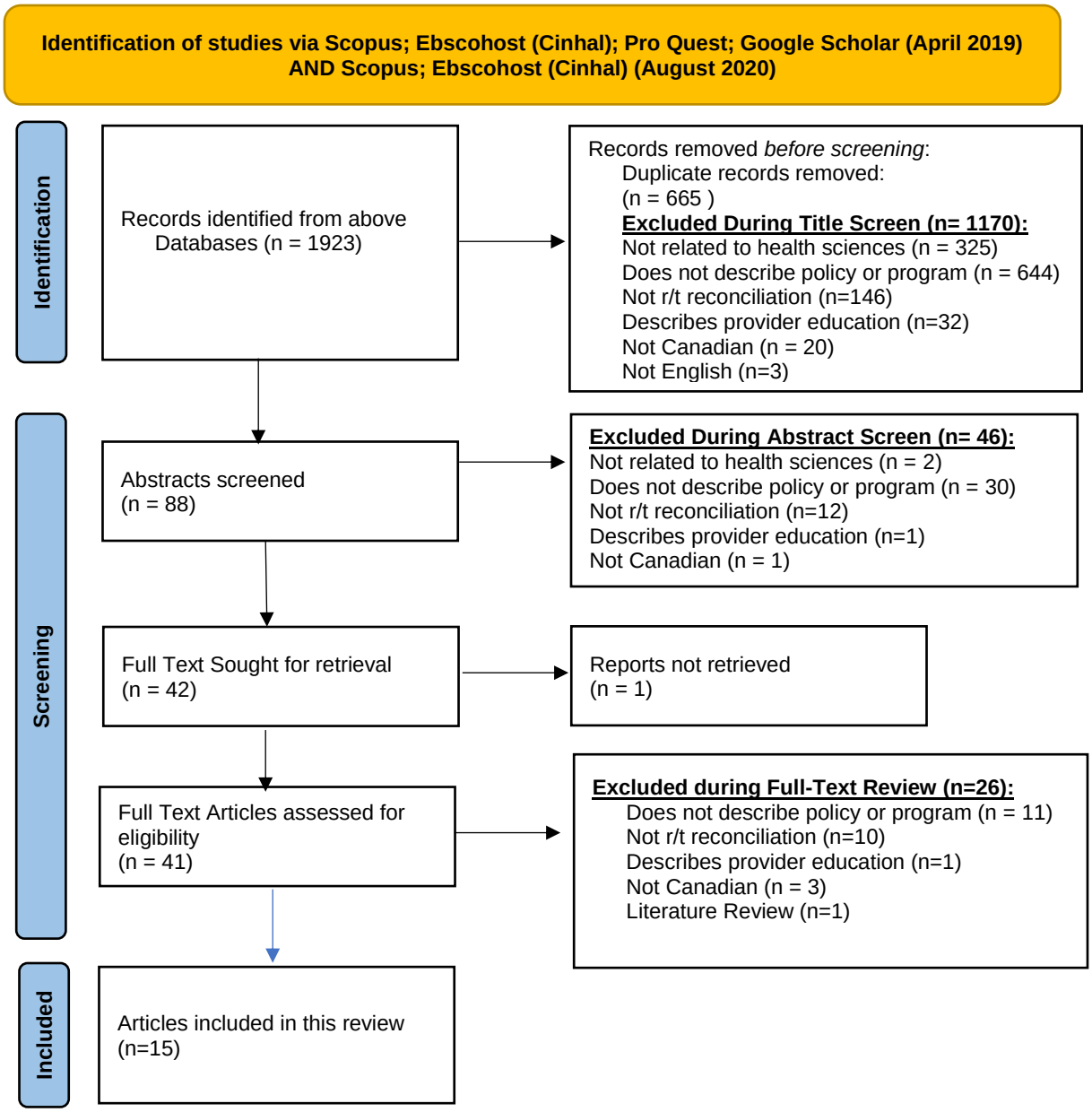
Table 1
Search Terms and for Scopus, Ebscohost (Cinhal), Pro Quest and Google Scholar Databases, April 2019

Search Term	Boolean		Boolean	Qualifier	Filters
					Canada, English, 1996-present
"Truth and Reconciliation"	AND			Health	
	AND			"Health Policy"	
	AND			Nursing	
	AND			Healing	
Decolonization	AND			Health	
	AND			"Health Policy"	
	AND			Nursing	
	AND			Healing	
"Indigenous" OR "Inuit" OR "First Nation" OR "Native American" OR "American Indian" OR Metis	AND	Self-determination	AND	Health	
	AND	Self-determination		"Health Policy"	
		Self-determination		Nursing	
		Self-determination		Healing	

Table 2
Search Terms for Scopus and Ebscohost (Cinhal), August 2020

Search Term	Boolean			Qualifier	Filters
"Indigenous" OR "Inuit" OR "First Nation" OR "Native American" OR "American Indian" OR Metis	AND	"Health"	AND	"Reconciliation"	Limit to: Canada, English, 1996-present; Medicine; Social Sciences; Health Professionals; Nursing; Psychology
	AND	"Health Policy"	AND	"Reconciliation"	
	AND	"Nursing"	AND	"Reconciliation"	
	AND	"Healing"	AND	"Reconciliation"	
"Indigenous" OR "Inuit" OR "First Nation" OR "Native American" OR "American Indian" OR Metis	AND	Health	AND	Self-determination	
	AND	"Health Policy"	AND	Self-determination	
	AND	Nursing	AND	Self-determination	
	AND	Healing	AND	Self-determination	
"Indigenous" OR "Inuit" OR "First Nation" OR "Native American" OR "American Indian" OR Metis	AND	Health	AND	Decolonization	
	AND	"Health Policy"	AND	Decolonization	
	AND	Nursing	AND	Decolonization	
	AND	Healing	AND	Decolonization	
"Indigenous" OR "Inuit" OR "First Nation" OR "Native American" OR "American Indian" OR Metis	AND	Health	AND	Reconciliation	

Figure1- Prisma Flow Diagram



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Table 3- Integrative Review Findings- Summary of Interventions

Author(s)	Article/ Study Name	Publication Year	Intervention Name	What means are used to support reconciliation	Summary
Drost, J.L.	Developing the Alliances to Expand Traditional Indigenous Healing Practices Within Alberta Health Services	2019	Alberta Health Services	Embedding traditional Indigenous Healing within the modern medical system. There were several objectives to the study: increasing efforts to expand traditional Indigenous healing practices within AHS, giving rise to the primary study theme: Expanding Traditional Indigenous Healing Practices within AHS. Several subthemes emerged in support of this primary focus, including the following: (1) enhancing cultural competency and safety training among leadership and employees; (2) adhering to tradition and protocol; (3) establishing meaningful partnerships; (4) strengthening organizational facets of program delivery; and (5) need for additional financial, human, and logistical resources. Ideal outcome of nation to nation partnerships: First, teams of stakeholders may effectively assess community priorities and system readiness for traditional Indigenous healing practices programs to be implemented. Second, in contexts where readiness has been established, Elders, Knowledge Keepers, and Healers may define and assert Indigenous rights to traditional medicines and healing practices within the healthcare system. Third, such partnerships would support ongoing consultation aimed at protection and preservation of the integrity of traditional Indigenous healing practices from exploitation and misappropriation (p. S75) How to do it: It is clear that there are various organizational requirements needed to successfully create space for traditional Indigenous healing practices within healthcare systems. These include the following: leadership, coordination and alignment, partnerships, awareness, delivery, and resources. A comprehensive traditional Indigenous healing practices strategic plan that informs organizational leadership, internal and external coordination and alignment, community partnership development, program awareness and delivery, and resources allocation is needed within healthcare systems.	Discussion and preliminary partnerships that surrounded the possibility of embedding traditional Healing within the modern medical system as a starting place and moving towards nation to nation partnerships. Typically, these partnerships are aimed at activities to take place throughout AHS, but are directed towards Indigenous Clients. These programs state that only after readiness has been established could Elders, Knowledge Keepers and Healers be granted the opportunity to "define and assert Indigenous rights to traditional medicines and healing practices within the health system" (Drost, 2019, p. S75)

Hadjipavlou, G., Varcoe, C., Tu, D., Dehoney, J., Price, R., Browne, A.J.	"All my relations": Experiences and perceptions of Indigenous patients connecting with Indigenous Elders in an inner-city primary care partnership for mental health and well-being	2018	Inner City Clinic (name and location not provided)	These findings support the Truth and Reconciliation Commission of Canada's calls to action regarding the inclusion of Elders as a strategy to improve care of Indigenous patients in Canadian healthcare systems. We included 37 participants from at least 20 different First Nations. All but 1 participant described substantial benefits from their encounters with Elders, and none reported being negatively affected. Five overarching themes were identified: experiencing healing after prolonged periods of seeking and desperation; strengthening cultural identity and belonging; developing trust and opening up; coping with losses; and engaging in ceremony and spiritual dimensions of care as a resource for hope. In 2013, the clinic began a partnership program with several Indigenous Elders to provide cultural mentorship to clinic staff and trainees; their roles expanded in 2014 to include direct patient care through one-on-one visits, group cultural teaching circles and seasonal land-based ceremonies. *DESCRIBED AS A "CULTURAL INTERVENTION" (good way to describe one of the doorways)* Access to Elders as part of routine primary care offers one important avenue for meaningful participation in cultural practices that can improve Indigenous patients' care and help reduce inequities. (p. E613)	One inner city clinic, whose name and location was not disclosed, moved one step further towards reconciliation and self-determination over health administration. This study examined the inclusion of Elders as members of the care team as a strategy to improve care of Indigenous patients in Canadian healthcare systems. This study described the initiative as a Cultural Intervention. Five overarching themes related to client experiences were identified: experiencing healing after prolonged periods of seeking and desperation; strengthening cultural identity and belonging; developing trust and opening up; coping with losses; and engaging in ceremony and spiritual dimensions of care as a resource for hope. (Hadjipavlou et al., 2018)

O'Neil, J., Gallagher, J., Wylie, L., Bingham,B., Lavoie, J., Alcock, D., Johnson, H.	Transforming First Nations' health governance in British Columbia	2016	BCFNHA	Devolution of Health Services to create a FNHA (administrative control and oversight over health service delivery). ...Key themes included: partnership and relationships, governance and reciprocal accountability, First Nations perspectives on health and wellness, and quality and cultural safety. ...Today, BC First Nations have assumed responsibility for the design and delivery of First Nations health services, through a transfer of FNIHB-BC operations to the FNHA and collaborative partnerships with the BC Ministry of Health and the province's Health Authorities, to improve provincial health services accessed by First Nations and Aboriginal people (Kelly, 2011) throughout all regions of BC. In addition to this direct service transfer, the Health Partnership Accord (First Nations Health Council, British Columbia Ministry of Health & Health Canada, 2012) outlines a set of principles that encapsulate the shared commitments and vision of the partners to engage in ongoing service improvements, including the responsibility to monitor and evaluate progress through a process of reciprocal accountability (p. 232) ...Co-creation of solutions is a process that requires the development of shared perspectives, and implies building a relationship through dialogue, goal alignment, and reconciliation of differences. In the context of First Nations health governance in BC, processes of negotiations and relationship-building over the past decade have led to many examples of co-created solutions at the strategic level between political representatives of federal, provincial, and First Nations governments, and at the operational and service level through shared health and wellness planning. (p. 233) Respondents acknowledged that the real work of reciprocal accountability was to facilitate the partners taking responsibility to address common issues in First Nations health. This meant dedicated efforts to work together to develop shared actions aimed to meet the common commitments outlined in the partnership accords, and to monitor progress on these commitments made at all levels of the partnership....First Nations people are being "hard-wired" into the decision-making processes, rather than tacked on in a token consultative role: (p.235)	O'Neil et. al. (2016) describe the devolution of provincial and federal health services to create Canada's first Nations Health Authority which grants BC First Nations complete administrative control and oversight over health service delivery. Much of this was done through partnership agreement and in alignment with the provincial and federal health leadership. "In the context of First Nations health governance in BC, processes of negotiations and relationship-building over the past decade have led to many examples of co-created solutions at the strategic level between political representatives of federal, provincial, and First Nations governments, and at the operational and service level through shared health and wellness planning." (O'Neil et al., 2016, p. 233)

Mundel, E., Chapman, G.E.	A decolonizing approach to health promotion in Canada: The case of the Urban Aboriginal Community kitchen garden project	2010	Urban Aboriginal Community Kitchen Garden Project in Vancouver, Canada	Guided by the teachings of the Medicine Wheel, aims to provide culturally appropriate health promotion. By drawing on Aboriginal approaches to healing, acknowledging the legacy of colonization and providing a context for cultural celebration, we suggest that the project can be seen as an example of what decolonizing health promotion could look like	Mundel and Chapman (2010) describe their Urban Aboriginal Community Garden Project. Guided by the teachings of the Medicine Wheel, the project aims to provide culturally appropriate health promotion. By drawing on Aboriginal approaches to healing, acknowledging the legacy of colonization and providing a context for cultural celebration, the authors suggest that the project can be seen as an example of what decolonizing health promotion could look like
Kelm, M.-E.	Wilp Wa'ums: Colonial encounter, decolonization and medical care among the Nisga'a	2004	Wilp Wa'umsNisga'a health center, BC	The devolution of health services- Local administrative control over health service delivery vs. Incorporation corporation (Incorporation is about drawing into indigenous life certain foreign ideas, practices, material culture. European commodities and concepts had their meaning reassigned by indigenous peoples the world over (Sahlins, 1994). In some cases, even the foreigners themselves have been adopted and re-named, reidentified by aboriginal people as known entities or fictive kin) (p. 335)	Kelm (2004) describes one of the first published examples of the devolution of health services with the inception of the Wilp Wa'umsNisga'a health center, in British Columbia. Which highlights the importance of local administrative control over health serves versus the incorporation of Indigenous ideologies, and thus the commodification of Indigenous epistemologies by the dominant health system.
Bagelman, Jen, Dr; Devereaux, Fiona; Hartley, Raven.	Feasting for Change: Reconnecting with Food, Place & Culture	2016	Feasting for Change, Salish Coast BC	Promising practices in promoting health and well-being that emerged from an innovative project, entitled "Feasting for Change". Taking place on Coast Salish territories, British Columbia, Canada, Feasting for Change aimed to empower Indigenous communities in revitalizing traditional knowledge about the healing power of foods. .... It was determined that a "solidaristic" (i.e., undertaken in unity) project could be possible if all events associated with Feasting for Change took leadership from First Nations. In particular, it was determined that Elders would play a leadership role, identifying proper protocol for all activities. (p. 8) Additionally, it was determined that youth should play a role in facilitating and guiding the overall project. (p. 9)	Feasting for Change in Salish BC, "determined that a "solidaristic" (i.e., undertaken in unity) project could be possible if all events associated with Feasting for Change took leadership from First Nations. In particular, it was determined that Elders would play a leadership role, identifying proper protocol for all activities." (Bagelman et al., 2016, p. 8)

Sarah de Leeuw	Putting calls into action Treating aboriginal patients in collaboration with indigenous healers and elders	2017	Sturgeon Lake FN Health Centre	The Truth and Reconciliation Commission also released 94 “calls to action,” the 22nd of which is that “those who can effect change within the Canadian health-system … recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.” (p. 57)	Sturgeon Lake First Nation Health Centre, administered in collaboration with First Nations Inuit Health Branch (FNIHB), recognizes the value of Aboriginal healing practices and uses them in the treatment of Aboriginal patients in collaboration with healers and Elders (de Leeuw, 2017).
Connor, H.	Culture is Healing: A design for youth suicide prevention in northern Manitoba	2011	Youth and Adolescent treatment center in Thompson	Decolonizing Space- Interior design has a role in this intervention because of design’s ability to create highly refined and safe environments while concurrently using creativity to shape space using cultural and spiritual traditions, practices, stories and meanings. While it is obvious that interior design alone cannot solve the issue of youth suicide, a key objective of this practicum is to reveal how interior design can help facilitate healing. (p. 3)	Connor (2011) speaks to the importance of decolonizing space, using interior design methods based in cultural and spiritual traditions, practices, stories and meanings.
Gallagher, J.	Indigenous approaches to health and wellness leadership: A BC First Nations perspective	2019	BCFNHA	The First Nations Health Authority (FNHA) is the operational arm of a new First Nations Health Governance structure created by and for First Nations people, which serves as a leading practice for Indigenous health and wellness services transformation in Canada (p.5)	Gallagher (2019) describe the devolution of provincial and federal health services to create Canada's first Nations Health Authority which grants BC First Nations complete administrative control and oversight over health service delivery. Much of this was done through partnership agreement and in alignment with the provincial and federal health leadership.
Drs. JoLee Sasakamoose and Angela Snowshoe	THE NANATAWIHOWIKAMIK HEALING LODGE AND WELLNESS CLINIC	not stated	THE NANATAWIHOWIKAMIK HEALING LODGE AND WELLNESS CLINIC	Decolonization of Colonial Spaces "The Lodge was designed as a radical departure and disruption of current academic strictures in order to facilitate culturally responsive training and emerging forms of research, particularly those guided by decolonizing methodologies. The process required essential shifts in the university culture," says Sasakamoose. (p.8)	Another article that described the decolonization of colonial spaces was the Nanatawihowikamik Healing Lodge and Wellness Clinic at the University of Saskatchewan. "The Lodge was designed as a radical departure and disruption of current academic strictures in order to facilitate culturally responsive training and emerging forms of research, particularly those guided by decolonizing methodologies. The process required essential shifts in the university culture" (Saskamoose & Snowshoe, n.d., p. 8)

Danto, D., Walsh, R., Sommerfeld, J.	Learning from Those Who Do: Land-Based Healing in a Mushkegowuk Community	2020	Land based healing		Space can also be decolonized by returning to healing on the land itself. A land-based initiative in a Mushkeowgowuk Community describes how youth can be engaged directly to support their own healing and wellness by Elders who bring them out on the land to heal. (Danto & Summerfield, 2020).
Williams, K., Potestio, M.L., Austen-Wiebe, V.	Indigenous health: Applying truth and reconciliation in Alberta health services	2019	Alberta Health Services	A goal of the Indigenous health arm of the Population, Public & Indigenous Health Strategic Clinical Network (PPIH SCN; www. ahs.ca/ppihscn), launched in 2016, is to support AHS' commitment to closing the gap in health outcomes for First Nations, Métis and Inuit in Alberta. One of the missions of the network is to improve the health and wellness of Indigenous peoples by engaging them as equal partners in their own health, wellness and care at the individual, family and community level; exploring, identifying and embedding equitable, holistic and culturally safe health practices; and acknowledging and addressing health inequities rooted in the determinants of health. (p.S44)	AHS's Population and Public Health unit has already begun this work, where the Population, Public & Indigenous Health Strategic Clinical Network (PPIH SCN; www. ahs.ca/ppihscn), launched in 2016, is designed to support AHS' commitment to closing the gap in health outcomes for First Nations, Métis and Inuit in Alberta. One of the missions of the network is to improve the health and wellness of Indigenous peoples by engaging them as equal partners in their own health, wellness and care. (Williams et al., 2019).
Long, R., Heffernan, C., Cardinal-Grant, M., (...), Nokohoo, M., Janvier, D.	Two row wampum, human rights, and the elimination of tuberculosis from high-incidence indigenous communities	2019	TB program	We built a broad coalition of community, government, First Nations and Métis organizations (tribal councils), and other stakeholders, with the scientific team at the University of Alberta and the University of Saskatchewan acting as brokers. By linking all four communities, this coalition builds on real patterns of human mobility and social relationships rather than a patchwork of externally imposed colonial jurisdictions. (p.257) ...Local surveillance and data sharing by government is essential (p.259)	Long et al. (2019) continued in the same spirit of collaboration, building a broad coalition of community, government, First Nations and Métis organizations (tribal councils), and other stakeholders, with the scientific team at the University of Alberta and the University of Saskatchewan acting as brokers for the Two Row Wampum Project.

Delormier, T., Marquis, K.	Building Healthy Community Relationships Through Food Security and Food Sovereignty	2019	The Kahnawake Schools Diabetes Prevention Project (KSDPP) --> Ieiénthos Akotióhkwa (planting group)	The inclusion of Indigenous Peoples' food systems in programs to enhance food security in Indigenous communities is significant and essential for promoting health and nutrition. (p. 26) ...The motivation of Ieiénthos Akotióhkwa (Planting Group) was to build upon efforts that enhance food security in the community of Kahnawake by drawing from lessons rooted in Haudenosaunee knowledge and cultural practices. Ieiénthos Akotióhkwa was formed as an ad hoc advisory group to address food security efforts within the Kahnawake Schools Diabetes Prevention Project – a long-standing health promotion, academic–community partnership. (p. 26) ....Ieiénthos Akotióhkwa found common interests in aligning the health and well-being of the community through food production, practicing the spiritual cycle of ceremonies, preparing and eating food through activities that promoted culture, language, positive family relationships, and caring for the environment. (p. 28) ....The food preservation and preparation workshops have become opportunities to honor the skills and knowledge held by our community members. It has been a valuable space where participants share experiences, stories, and new ideas and plans moving forward. (p. 28) ...*Local health, social service, volunteer, religious and environmental organizations in Kahnawake have been invited, consulted, and involved in the planning and delivery of some of the activities of Ieiénthos Akotióhkwa. Building relationships with formal organizations has value in itself in terms of creating alliances around shared goals, and working toward community vision.* Working collaboratively has helped in terms of sharing resources, and increasing among their employees the visibility of food security and the program of activities that brings people together for well-being (p. 29)	Leiénthos Akotióhkwa, the planting group formed as part of the Kahnawake Schools Diabetes Preven Project, is also demonstrative of a First Nations led initiative which draws directly on traditional knowledge. "Leiénthos Akotióhkwa found common interests in aligning the health and well-being of the community through food production, practicing the spiritual cycle of ceremonies, preparing and eating food through activities that promoted culture, language, positive family relationships, and caring for the environment." (Delormier & Marquis, 2019, p. 28).

Firestone, Michelle; Syrette, Jessica; Jourdain, Tessa; Recollet, Vivian; Smylie, Janet;	"I feel safe just coming here because there are other Native brothers and sisters": findings from a community-based evaluation of the Niiwin Wendaanimak Four Winds Wellness Program.	2019	Parkdale Queen West Community Health Centre (PQWCHC)	A collaborative project with the goal to enhance health and community services for homeless and at-risk Indigenous populations in the downtown mid-west Toronto area .... The Niiwin Wendaanimak Four Winds Wellness Program (Niiwin Wendaanimak program) is guided by the West End Aboriginal Advisory Council (WEACC), which is comprised of service providers, Elders, Indigenous service users, and other community leaders concerned with enhancing services in the West End and with a mandate to provide guidance, oversight, and advice for the program. ... The objectives of the Niiwin Wendaanimak program are to improve primary and harm reduction services for Indigenous populations, to identify and develop pathways to care for Indigenous adults and youth, particularly those who are homeless, living in poverty and at-risk of homelessness, and to provide Indigenous culturally specific healing and psychosocial support which integrates recognition of the chronic trauma caused by genocide and colonization (p. 406) ...Health and wellness for Niiwin Wendaanimak program clients was improved through their access to a range of supports including, for example, access to healthcare, health education, housing, showers, and laundry in addition to access to medicines, ceremony, Elders, traditional healers, and counselors. Food was central to well-being within the Niiwin Wendaanimak program. (p. 410)	Another example of consulting with Indigenous stakeholders was undertaken by Parkdale Queen West Community Health. Firestone et al. (2019) describe a collaborative project where an Aboriginal Advisory Council, comprised of service providers, community leaders, Elders and Indigenous services users come together with the aim of enhancing Harm Reduction services for First Nations clients.

Appendix B- Study Documents

Interview Guide

From Head to Heart: listening to Manitoba healthcare leaders' experiences of structural barriers with meaningful engagement of Canada's Truth and Reconciliation Commission's calls to action

Interview Guide

Semi-Structured Interview Guide – Story Tellers (Administrators and Policy Makers)

- Please tell me about your position and educational background
  - Probes
  - Position title?
  - Which Health Sector do you primarily work for (Provincial/Regional/Community/Federal)?
  - What is your education level?

- Please tell me about how the TRC influenced your vision for policy or program development?

- Now please tell me about reconciliation and what this means to you personally?
  - Probes
  - What are your feelings about the term reconciliation?
  - Examples of reconciliation or efforts towards reconciliation
  - What is one key thing that could support healthcare delivery and system to move forward in a spirit of reconciliation?

- Please tell me about a time when you had the opportunity to promote reconciliatory, decolonizing or Indigenous self-determination, either through policy or activities in the workplace?
  - Probes:
    - Are you able to describe the situation?
    - What was meaningful about this opportunity?
    - What worked well?
    - What were some barriers?
    - Overall was this positive or negative experience for you?
    - Why?
    - What could have been improved?

- You describe this experience as overall, being _____ (positive or negative), what were some of the more personal impacts related to this experience?
  - Probes:
    - What was the effect on your overall mood and general outlook? Can you describe it?
      - What were the effects on your work life?
      - Home life?
      - Personal or professional relationships?

- How did these experiences change your ability to perform and meet the expectations of your job?

- In general, have these experiences changed your perspective of health delivery?
  Probes:
  - Do you have hope for the future health of Indigenous Manitobans?
  - Where would full autonomy/authority assist you in making changes within the current health system?
  - What else needs to change?

- Is there anything else you would like mention?

E-mail Invitation to Storytellers (Administrators & Policy Makers)

Subject: Invitation to participate- From Head to Heart - listening to Manitoba healthcare leaders

Text:

Date: XXX

UNIVERSITY OF MANITOBA

Dear [Name Inserted],

Hello. Tansi. I am writing to invite you to participate in a discussion about your experiences with promoting reconciliatory, decolonizing, or Indigenous self-determination in policy and practice in your workplace.

Despite provincial and federal governing bodies reconciliatory efforts, current policies, procedures and overall function of health structures in Canada remain at odds to disrupt colonialism. Indigenous and non-Indigenous healthcare employees continue to function within and are required to uphold these colonial structures, which often challenge their personal values and beliefs.

By telling your story through a one-on-one interview, lasting about sixty (60) minutes, as well as participating in a follow up sharing circle and feast, hosted by Elder Mary Wilson Grandmother of the Four Direction and myself at a later date, we are better able to understand what is currently working well, and what needs to be re-evaluated, re-worked and repaired, in order to truly begin to reconcile and improve health outcomes for all Manitobans.

For more information or to choose a time to participate, please contact Stephanie Van Haute at xxx-xxx-xxxx or xxxxxxxxx@myumanitoba.ca

Ekosi!

Stephanie Van Haute

Informed Consent Form

UNIVERSITY OF MANITOBA

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

Title of Study: From Head to Heart- listening to Manitoba healthcare leaders' experiences of structural barriers with meaningful engagement of Canada's Truth and Reconciliation Commission's calls to action

Principal Investigator: Stephanie Van Haute, College of Nursing, Rady Faculty of Health Sciences Helen Glass Centre for Nursing, 89 Curry Place University of Manitoba, Winnipeg, MB R3T 2N2 Canada
Phone: xxx-xxx-xxxx; E-mail: xxxxxxxxx@myumanitoba.ca

Co-Investigators:
Elder Mary Wilson;
Donna Martin RN, PhD; Associate Professor & Associate Dean of Graduate Programs; Rady Faculty of Health Sciences; College of Nursing, University of Manitoba
Monica Cyr RD, MSc. HNSC;
Annette Schultz RN, PhD, Associate Professor; Rady Faculty of Health Sciences; College of Nursing, University of Manitoba

Funder: Manitoba Center for Nursing and Health Research (MCNHR)

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in the study and you may discuss it with your friends, family or anyone else before you make your decision. This consent form may contain words that you don't understand or are unsure of. Please ask the study staff to explain any words or information that you do not clearly understand.

Purpose of the Study

The purpose of this study is to explore the present-day effects of colonial structures influencing modern-day leaders of Manitoba's healthcare system. There are two research objectives:

1- To gather and listen to Manitoba's health leaders' stories of system changes to promote reconciliation, decolonization or Indigenous self-determination within health service delivery.
2- To use medicine wheel teaching to extend our understanding of these stories and consider medicines for health leaders to move forward and walk in balance while working within colonial structures.

Storyteller Selection

You are being asked to participate in this study because you have been identified as a policy

makers or administrator working in healthcare within the past five (5) years at a community, regional, provincial or federal level in the province of Manitoba. During which time you have been involved in promoting reconciliatory, decolonizing or Indigenous self-determination, either through policy or activities in the workplace. We expect to involve approximately six (6) to eight (8) storytellers throughout the course of this project.

Study Procedures

If you choose to participate, this means completing a one on one interview lasting about60 minutes (conducted by Stephanie Van Haute), and attending a sharing circle lasting 2 to 3 hours (includes a feast) at a later date (conducted by Stephanie Van Haute and Elder Mary Wilson)

Risks and Discomforts

There are few risks to participating in this study. However, you may find some of the topics discussed during the interviews or sharing circle to be upsetting, emotional, or stressful. You do not have to answer any questions that make you feel uncomfortable. If you need additional help or support during the interview, please let the interviewer know and we will refer you for assistance. If you need additional help or support during the sharing circle, please let one of the facilitators know and we will refer you for assistance.

Benefits

There may or may not be direct benefit to you from participating in the study interview and sharing circle.

Compensation for Participation

As is custom while participating in research grounded in Indigenous methodologies, small offering(s) will be made to participant in order to honour protocols. A digital copy of the artwork created during the sharing circle will be given to all participants as an act of reciprocity for the shared learnings.

Confidentiality

We will do everything possible to keep your personal information confidential if you choose not to waive anonymity. Your name will not be used on the transcripts of your interview or of the sharing circle. Code numbers will be used instead. Your name will not be used in study reports. A list of names and contact information of the storytellers will be kept in a secure file so we can send you a summary of the results of the study. If the results of this study are presented in a meeting, or published, you name or identity will not be used. Please note that, although you will not be identified as the speaker, your specific words may be used to highlight a specific point. The collection and access to personal information will be in compliance with provincial and federal privacy legislations.

All records, transcripts and notes with you name or other identifying information will be kept in a secure and locked area. Only members of the research team will have access to these records. Paper records with your identifying information will be destroyed and electronic files erased, 3 years after closure of the study. The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes. If any of your record needs to be copied to the University of Manitoba Health Research Ethics Board, your name and all identifying information will be removed. No information revealing any personal information such as your name, address or telephone number will leave the University of Manitoba except as necessary to transport information to and from the site of the interviews.

Questions

You are free to ask any questions that you may have about the study and your rights as a research participant/storyteller. If any questions come up during or after the study, please contact the Study's Advisor, Dr. Annette Schultz at: (204) 474-6351. For questions about your rights as a research participant, you may contact the Human Ethics Coordinator at: xxx-xxx-xxxx or xxxxxxxxx@umanitoba.ca

Statement of Consent

I have read this consent form or have had it read to me. I have had my questions answered by Stephanie Van Haute or study staff in language I understand. I have not been unduly influenced by any study team member to provide the information requested. Any relationship (such as employer, supervisor, or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form. I understand that my participation is voluntary and that I may choose to withdraw at any time by contacting study staff. I understand that unless anonymity is waived, information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board, for quality assurance purposes.

By signing this consent form or verbally acknowledging my consent, I have not waived any of the legal rights that I have as a participant in a research study.

Participant signature_____ Date _____
(day/month/year)

Participant printed name: _____

Appendix C- Storyteller Data

Table 5- Storyteller Data Doorways and Discussion Points

East	South	West	North	Frustration/Imbalance (overarching) for discussion?	Where to find balance
"I've sat on a number of policy initiatives through the years, in 2010 I sat on a health task force for the province of Manitoba. And in that role, I was the voice of – for indigenous women and families and had advocated for system changes at that level" (ST1)	"And you have to start with recognition, because if you don't have people understanding the truth, and then understanding what happened, and then a recognition that we all have a part, like, we're all treaty people. You know, that we all have a part. So, recognizing our collective responsibility, so it's not just one-sided, it's a commitment to that renewal of that relationship." (ST4)	"But at those meetings, most of the other players are white men. Like which they recognize, some of them. Their perspective may not be accurate, and I think that's why they ask people like me to come. But a lot of the meeting is spent trying to explain and interpret practically what's happening for people who have obviously large assumptions about practice models that they don't understand." (ST3)	"But also that there's a recognition that this is the only way. When you get into recognizing that this is the only way, then you lose so much, because if we – you know, in the leadership program that I went to, we saw the way – like, yeah, I go to Mohawk country, right, we're in [Kwasaasni], and when you hear the stories of the Wampum belt, then you know that European and indigenous relationships were not always at one time equal. Because you hear the story of the Wampum belts, that's the history. ... And that's just one example of one way, because there are so many examples of different ways of how we know. And so decolonization means it's taking action, right, towards dismantling the current structures, not just, how many public servants have we told about residential schools. Because that's not enough; I've seen lots of public servants get lots of knowledge, and still ask, what are we doing this for?" (ST4)	It's the commitment, right, like how I was saying earlier. But, you know, the thing about the tension is some of these things are really outside of what I can do, I'm only one person. So if I'm talking about policy or, you know, someone is not even aware of the policy or someone that's saying well, we can't do that because like we need to – you know, it really has to come from the top. (ST 2., p. 29)	That's sort of my immediate family life and then like most Métis people I have very extensive, strong relationships with my sister, X, who is in our everyday life and my mom and my brother, X. That's sort of my circle of people and support, which I think have enabled me to do everything I've done professionally because of those family ties and our history as Métis people. I find a lot of strength in that. (ST3., p. 1)

East	South	West	North	Frustration/Imbalance (overarching) for discussion?	Where to find balance
“Again, like I'm just, I guess just to put it in a nutshell, I had no voice, I had no change. I did work in the federal government for six years before I came over here at the regional level. ... You don't have it over there, you have your particular file, your silo, and that's your area. And then when you want to talk system change, they really don't have that knowledge of the bigger system, right? What does it mean, what does self determination mean? Why is that tied to our health and wellbeing? They don't get it, you know? They are so caught up in their own particular file and managing their own particular budgets and contribution agreements and so on and so forth.” (ST1)	“When it (the TRC) first came out, for me, I remember feeling like wow we need another document to help settlers and other people like really recognize what the issues are, like how many times do we have to say the same things and give the same messages about what we as indigenous people should have a right to anyway? So there was that. And what quickly came to mind was the fact that like we continuously heard over and over, “Reconciliation, reconciliation, reconciliation” but I actually didn’t see much action from the people that we needed to see action from, so that got a little bit tiresome again” (ST8)	“But I don’t think we really actioned them. Well, I can say that personally I don’t feel good about the way that that happened. So we wanted to include some indigenous voices at the table. I was keen to not have one person because of the token Indian comment that I’ve heard from a lot of my colleagues and friends. So we wanted more than one person and I called the tribal council and they said ‘we can’t send anyone, we’re too busy.’ And in the heat of the moment we just lost the focus on that.” (ST5)	“So we all have our particular roles, I have research, we have a floor upstairs that does policy, we have our grandmother's circle, council, and we also have our knowledge keepers. We all have our particular roles but we also know how to come together and work on a particular issue.” (ST1)	And so I get I think frustrated because I realize I'm not going to be able to do this on my own and I don't want to be sort of an idealist about this, you know, I want to be very pragmatic somewhere between, you know, that rationalist and that idealist personality type, right? Where I can sort of recognize these things and how they work together but not get too caught up in the [unintelligible [00:53:18] you know, it has to be realistic with what I think not only the system is ready for but also what they can even potentially be able to handle, right? (ST2., p. 30)	But, anyway, so my spirit name is [unintelligible 00:02:08] which means XX. And I think that’s like very descriptive of who I am because my family and my family relationships are the most important thing to me in life. (ST 3., p. 1)

East	South	West	North	Frustration/Imbalance (overarching) for discussion?	Where to find balance
"And one of the things that I've noticed is the nurses now that come to our, that are part of our group, our circle, they are speaking up and speaking out and there's one in particular who was very oppressed, I think and I mean she had taken time off work a while ago and she was having real issues coping and struggling and she's a different generation, she's a little bit older and so she was used to not speaking out and stuff like that. And now the lady has found her voice and I'm just like go, go. I tell her all the time, I'm so proud of her for finding her voice and now she's found it. So things like that give me hope." (ST 6)	And I find that to be a very – it's funny because I did include reconciliation and talked a little bit about reconciliation in my proposal … l and they, or the one individual, the trusted individual that I shared it with, said to me why are you using that term, you know? And I explained to them, you know, all the good things about reconciliation and they said, that's a government term. Can you change that, like can you just say that it's our right versus it's being done for reconciliation? It's being done because this is our right. So, I did change that because I had that right in the abstract. (ST 2., p. 23)	"And so some of the things in the health system, or any systems, they must have a lot of these things we've already talked about, right; the reparation, the recognition, renewal, respect, and that responsibility. Like, I don't have anyone in our system asking, you know, what can we do for indigenous people? But they need to be asking, what can we do to change the system?" (ST4)	"And it's like I told the group a while ago because they're all like well you know they're all kind of oh this is so hard and why do we have to do this. And they're kind of complaining about how hard it is and the things that they see and why are we doing this and kind of complaining. And I said you know what, I was there before too, but I said if you think about what your ancestors went through for you to be here you don't get to put this down. We don't get to put down this work, we don't. We've got to keep on going and we can cry and we can be pissed off and can hate it, but we don't get to put it down." (ST5)	so I thought, oh, reconciliation is great, and I sort of had this warm, fuzzy feeling. And I thought, this is what we've been hoping for all this time. But then I started hearing other perspectives, like, reconcile what? And sort of the Canada 150 side of things, where it's talking about, again – and then just looking at the current situation and thinking, oh, it's really just kind of the same old discourse, to make – you know, what is it? Just to make us feel better as a country, or …? (ST4., p. 7)	**I'm thinking about the medicine wheel when you're describing, and one of the elders, when I was struggling in my 20s said, you know, the first thing that you have to do is working on having a strong heart and a strong body and a strong mind and making yourself whole and figuring out the things you need in life to be strong. Then you can work on having a strong family and that support system around you, then you can work on having a strong community. But you can't be effective in helping the community until you have helped yourself. And I thought that was very wise, because I think in your 20s sometimes you feel like "I'm going to take on the world" and you don't know how to do it and you don't have the right mental stamina to know that. So, my self-care, my relationships with my family and the community that I have, I think are, for me, the foundation of all the strength that I have and all the ability to be a health leader. (ST3., p. 1)**
And you know, am I the voice, you know, and is this, now I'm speaking on behalf of all indigenous people. But then I got into and aboriginal leadership program, and that really helped me to think, well, I'm just going to speak for what I know, and I'm going to speak from my heart, and I'm going to speak from my experience. (ST4., p. 13)		But I see we have very little indigenous health leadership. So the policy level is still so colonized. I mean they work on biases, they work on the things that they've learnt and the expectations and – There isn't a lot of like "Let's think out of the box for how we could run this programming differently that might actually help indigenous people." It's like "Well, we just have to help all Manitobans" and that doesn't create health equity	And so I kind of look at it that way and so when we are in the group of community members there's lots of us that have different skills or roles to play….So, when we look at sort of these kinds of traditions I try to look at those in the same way that I would consider how I would approach, you know, being a researcher and working in the community kind of thing. And so I just kind of go back to a place where maybe I'm considered a	You know, I guess – and just staying kind of line with what you're saying, failing feels bad but you learn from it, so I mean I guess like when this happens again the key thing is that we try not to make the same mistakes. And I can't say that I'm 100% confident that we won't right now. (ST5., p. 13)	and I also started meditating a year ago. I completely changed my brain and how I'm able to focus on what I'm supposed to be doing at that moment and just knowing that I can only do one thing at a time and not apologizing for that and doing the best that I can with what I'm working on, then moving on to the next thing. Then being OK that maybe I can't get everything done. (ST3., p. 14)

East	South	West	North	Frustration/Imbalance (overarching) for discussion?	Where to find balance
		on that bigger policy level, right? (ST3., p. 9)	knowledge keeper or some other form of like helping, like a helper person, right, or a teaching person. (ST2)		
I think that like if you're doing a good job with reconciliation, I think you'll have folks feel comfortable to work in your organization or apply to work in your organization, and in the groups that I work with in the provincial government there's just no indigenous voices anymore (ST5., p. 7)			and I remember sitting there thinking like this is what I'm supposed to be doing, but I'm supposed to be doing it for my own indigenous people. (ST3., p. 3)	**Yeah, I felt very hopeful and actually at that time I was working with, my office was located with indigenous health programs which was very convenient. So there was a lot of, I was able to collaborate a lot with just the people there walking by. … . I don't know where it's at, but definitely there was hope that hey this is something that we can, but every time something comes out I'm hopeful right. Like even the Missing and Murdered Indigenous Women report, even the Tina [Fontain] and all these reports that have come out. The one about the child welfare system, that report. And these reports come out and you're like ok, there's stuff in here, but then it's like it goes nowhere. (ST6., p. 5)**	This leadership coach taught me a lot about transitions. Transitioning into work and transitioning out of work. For me, I find like physical activity really helps me to transition out of work. So I used to come home from being – like going to work in our northern communities, there is just incredible sadness. There are some patients who you see and their stories are sad, but you don't connect with them, right? But there are other people that you see and for whatever reason their story just kind of sits like with me. (ST3., p. 14)

East	South	West	North	Frustration/Imbalance (overarching) for discussion?	Where to find balance
And partly because of this issue because they're a colonial organization working in indigenous territory and it just feels wrong; I didn't … You know you have to start to look at being a part of it, like are you complicit in it, you know? There's that: are you complicit? The other side is leaving doesn't necessarily help either, like then you're taking a voice away from the table that maybe help to talk about reconciliation. So anyway, so there have been low moments, for sure. And then I'd say like, you know, getting funding for the first time ever for people who use substances and a traditional knowledge keeper – a big win. (ST5., p. 15)			And, you know what's interesting – maybe you feel the same – I feel, like as a Métis person, we are a bridge. I don't know that I would say this to First Nations or Inuit – I haven't ever said it to anybody else who's not Métis, but I feel like we have this unique position to like kind of bridge between the certain mainline society and indigenous values. (ST3., p. 4) **I feel that I have these, like I think we're all given gifts and that it's our responsibility to share those gifts, that's what I've been told by some elders that you have gifts and that's your responsibility, you have to share that. And so I try to do that. I especially do that like I think my approach is very different than my colleagues. (ST6., p. 11)** I think so. I think that because I have like honestly before like I said I was lost and I think now that I've sort of found my way back, I feel like I had to find my way back to who I was supposed to be or who maybe who I always was, but just because I grew up in that sort of European dominated culture and I just didn't fit in with my family at all. (ST6., p. 12)	But the outcomes that the government, like provincial, federal governments and the health authorities and stuff are looking at are different than what needs to be looked at – (ST8., p. 12)	Like I always wear my – I bring my medicine bag with me, I don't always show it to patients. Like sometimes I'll just have it my bra or whatever. But I carry that with me all the time. And we worked a lot on how the medicine bag can absorb people's stories, then when I come home, as a part of my transitioning, I do a lot of ceremony now. I smudge my medicine bag and I pray for all the people whose stories I was involved with and I pray for the community that I was just in. And that really helps me to feel like I'm a part of that spiritually, which I think western medicine, you have a hard time – Like I've had a hard time connecting western medicine with my value and this helps me to do that. (ST3., p. 14)

East	South	West	North	Frustration/Imbalance (overarching) for discussion?	Where to find balance
That particular project is – in the end it has, it's been extremely difficult to go through – you know, so I've had some periods of time where I've, you know, kind of questioned, you know, like should be doing this or maybe, you know, as someone who lives in the south, you know, should I be doing this with the Inuit community in the north? You know, and then, you know, getting I guess a sponsor in the community or [unintelligible [00:33:30] the process is that they would require say a – and any outsider could do – I am considered like, you know, even though I'm someone's nephew there or something like that, I don't live there, I'm still an outsider, just like I would be an outsider if I went to do research in [unintelligible [00:33:46] or something, right? Yeah so I'm sort of cognisant of that. (ST2., p. 23-24)	So one of the things I have to say right off the bat when we consider the report from the TRC it is the – a lot folks talk about the different recommendations but I think it's really important to mention the legacy, like the systems and legacy components. And so those need to all be dealt with before we can kind of start considering these other things we need to do. (ST 2., p. 18)	So we managed to come up with a system that would connect both the federal and the provincial systems so that public health would be aware of when the women left the communities. So we ended up with a referral form, OK? And that was ready to go between the two systems. Again, when the provincial government switched over, there was nothing, it just fell under the table. (ST1; P2)	Yeah, I think being more now in a policy role and research role I feel I can do more, I can say more. And sitting at different policy tables I actually feel that I'm heard. (ST1, p. 7)	Do you want to start or me? You want me to start? So when everything was happening and it was coming out, there was a real fear for me that it would just become another document that was, you know, collecting dust and exists on the shelves of wherever or libraries but not enough people know about it. (ST7., p. 4)	Well, again, with the leadership course that I took, I met some indigenous leaders – a lot of indigenous leaders, actually, and also my network of people, and so I find that having that network helps me. I can put it somewhere and talk about it and also, we can share with each other, so you don't really feel quite alone. You feel like, okay, this is happening to others. ... And also to just really tap into, for me, find allies in the system as well, so you know, indigenous or non-indigenous, who are also thinking like I am, that's really helpful. So to connect with others. (ST4., p. 13-14)

East	South	West	North	Frustration/Imbalance (overarching) for discussion?	Where to find balance
I find that working with the community, you know, I don't have a lot of Inuit working with me in the healthcare system. So it's really more I think I can relate to some of the things that are probably universally indigenous that I think, you know, don't have really any boundaries kind of thing. (ST2., p. 25-26)	So to go back to your question I think it's important and I'm excited about it or was excited about it but I also recognize how challenging it is to actually implement some of those things and it can be very tiring. And personally, you know, like I'm very committed to this, I haven't given up on it yet I guess. It can be incredibly disappointing sometimes when, you know, when you'll hear about something that's happening where you have some individuals working on something but they haven't – like I don't know, like I'm not meant to be sort of judgmental or anything but I don't know that sometimes – like some people have really good intentions but if they don't work with the community on these things, I hate to say it, they're not going to work. (ST 2., p. 19-20)	It's very frustrating because that – I sat on both working groups, the travelling for birth working group, and the referral process working group. I sat on both of those working groups and we had met quite intensely at the beginning and then monthly for about 18 months. So a lot of discussion, a lot of effort and policy work had gone into that but the initiatives just fell apart. (ST1; p. 3)	I think that in itself is very, very – it's I wouldn't say – yeah, it contributed to being able to breathe and understand that I couldn't do it all by myself, that we are very interconnected in we rely very heavily on the knowledge of our wisdom keepers, or knowledge keepers, and that we all work together. That's something you do not getting working in the federal government or provincial government for that matter. (ST 1, p. 10)		And then you know, at home I feel like I do – well, I do things for my own – things that are meaningful for my own identity and same with my son, right, it's sort of, like, well, what – you know we are who we are. We don't ever have to justify it when we go anywhere, and there's all kinds of things going on in the world where you have to sort of, you know, are you really Metis? (ST4., p. 14)
I'm Métis and I'm from Winnipeg." And they were like "Oh." I don't know if you ever get this, but people say like "Oh, you're from Winnipeg?" and I was like "Yeah." And I was kind of apologetic. I was like "Oh, yeah, I don't come from a cool community." And a lot of my family is buried in [unintelligible 00:11:42]. So I would say, "Oh, I'm from [unintelligible 00:11:43]. And more recently I'm like "Yeah, this is the homeland of the Métis. I live on my people's land." (ST3., p. 5)	And building trust is I think the way that, the way forward. I think reconciliation is probably a good term when you consider this on a very broad basis but when you break it down at the personal level I think a lot feedback that I've heard about reconciliation is that well, why do we have to do that? (ST2., p. 20)	Yeah. So I was – I needed to – I was suffocating, yeah suffocating. And I think the whole goal of the federal government particularly is to keep things status quo and to control and to cost contain and you can't – I couldn't function in that system. (ST1., p. 9)	I think working in this environment I've had a lot of mentors and we work very closely with our grandmother's council and our knowledge keepers and I think that having that inform the work that we do, the – and having the grandmother circle too to sort of go to for support if needed or for advice, if we need advice for some of the work that we're doing. (ST 1, p. 10)		So and I think that's part of reconciliation is being open to that, open to being corrected or called out, or whatever, and thinking about that. And it's a total process, hey, like it's not like you do a course and you're done. And you said it's an interesting time. I really agree with you. (ST5., p. 19)

East	South	West	North	Frustration/Imbalance (overarching) for discussion?	Where to find balance
Well, I feel like I was initially really interested in justice, because I read the Aboriginal Justice Inquiry and that was a turning point in my life. I was young and I read the Aboriginal Justice Inquiry, and so I was interested in justice. ... But as I started to take that in my degree, and maybe wanting to go to law school, then I learned about the connections, you know, that health isn't necessarily separate from justice, isn't necessarily separate – it's all connected. ... Like if we don't find justice in our lives, then our health suffers, whether that's our physical health or spiritual health, our mental health or emotional health, right. (ST 4., p. 1)	Yeah. I think before we start this education we have to sort of define you know, what it is, like a framework or partnership or some other kind of framework for understanding, you know, goals and what it is we want to achieve together. (ST2, p. 21)	So from a person standpoint it's kind of worrisome because I also know if you don't have the knowledge of systems and structures and things like that and just understanding how difficult it is to get legislation and policy work done it's very – you know, one of the things that we're doing when we're advocating for patients when I was in the community is that we recognize that these individuals don't know the background, they don't have the expertise and yet it's their right, you know, that we're talking about, it's their access to healthcare, it's their universal right in Canada. (ST2, p. 19)	So we all kind of – because healthcare's a complex system so we need to sort of identify who all these stakeholders are. And then people would need different forms of communication depending on what it is, their responsibility was or how in which they were supposed to interact with the system based on what their role is. (ST 2., p. 21)		**I grew up in Northwester Ontario so I grew up very close to nature and I spent a lot of time, my favorite place was to spend time with in the bush with my father. He was a logger. He worked for a logging company. So at Spring Break every other kid's going to Disneyworld, I'm going to the bush to be at a logging camp. And I loved it, I absolutely loved it. (ST6., p. 10)**

East	South	West	North	Frustration/Imbalance (overarching) for discussion?	Where to find balance
Yeah I think that's probably where, from the settler perspective, reconciliation starts is looking at your history and your family, and thinking about your biases and your race, are you racist? Do you have racist thoughts go through your head? I do. I do. I was steeped in a tradition where that was kind of the norm. (ST5., p. 7)	And the community members have constantly have had to, you know, fight this fight. And so when they're asked to be part of a consultation again, you know, it's almost as though OK, they've done this to the point like we all know it's a problem, we all talk about it like, you know, ad nauseam. There hasn't always been a lot of really good changes or solutions that could be sustainable. (ST2., p. 27)	But five years later, you know, there's days when I'm thinking like no one is really caring about this reconciliation thing, you know? And we're not making any changes. And with some of the structural things that have happened just recently in Manitoba I think we could have made some really, really significant structural changes that I don't think have occurred as a result of us not being prepared [unintelligible [00:42:31] So I'm very disappointed to say that, you know, five years ago I would have thought this would be the perfect timing for all this to occur but I don't – I think we haven't necessarily been all that prepared for. And it's not just I'm going to blame the system on it, like the community has to also be ready. (ST2., p. 26)	And it's not so much reconciliation but it's been about like, you know, what is the right thing to do and what is my position on this, right? And how am I approaching this? And I think one of the things that – if others were thinking about this in a way that was sort of complying to, you know, good principles or guiding principles they would ask themselves what's their reason for doing this? (ST 2., p. 23)		**And then it wasn't until I was older that I was actually at the [unintelligible 00:34:37] and I heard the drum and I was like what is that that's happening right now. I'm getting goose bumps just thinking about it. I just felt this weird like I was like what is this that's happening to me right now. And I remember I was with a friend of mine who is indigenous [unintelligible 00:35:04] and I told her that. I said, this is really weird because I just feel something.** **Interviewer: It's your heart beat.** **Respondent: Yeah. And she had told me at that time because she was adopted and she had the same kind of experience the first time she heard a drum and she said that an elder had told her, he said those are blood memories and those exist and that's what that is. And she said that you're having a blood memory. And I'm like what the hell is a blood memory? And then she explained it to me and she said that's what that is. You remember, your cells remember. (ST6., p. 10)**

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And you hear systemic racism but you're not living it, and so you can get over that mindset. And so I think reconciliation is bringing yourself back to – almost like reminding yourself we have big issues and hear the systemic issues that people are living day to day that I don't have to live with. (ST5., p. 8)	Exactly, like, yeah, exactly, it's that truth and knowledge and that we have responsibilities and accountabilities. All people do. That's the, that we're all treaty people-concept, that people have to start asking – you know, stop saying, well, that was a long time ago, and you know, I'm not responsible, versus, what can we all do now and what is my responsibility now? (ST4., p. 5)	I feel like I have a larger degree of comfort with sitting in discomfort than other people – than I view other people do. And because of working in indigenous health – Like I helped to run this interview process for our First Nations, Inuit, Métis for probably 10 years before anybody let me do anything to change it. Even though I thought "Wow, this is not safe." And we created some safety within like what we had with our little committee and we tried our best, but we couldn't change the overall process. (ST3., p. 11)	I think one of the things that's really – I guess feels great is, you know, being able to sort of discuss these things with someone like yourself who I think just even the questions you've asked me kind of give me a sense that you've got a good idea of, you know, what some of the issues are. And what I think is really important is there's almost like a group of individuals that we can – a network because if we're trying to do this work together I think we really – one of the things that I think would really help the system is if we kind of know who we are, right, so that we can kind of pull together. (ST2., p. 30)		So I grew up mostly celebrating our indigenous culture, but in Thunder Bay that's kind of tough, right, because there's a lot of racism there. (ST7., p. 1)
Yeah it is very difficult. I still find it, you know I still find it difficult and honestly I don't know what it is. So I work with an indigenous physician who's great who's been supportive and we wouldn't be where we are as an organization, or as in public health as a program without that leadership, definitely and without having like I feel like she has my back you know what I mean? Interviewer: Yes. Respondent: Which has been so helpful for me and I'm so grateful, thank God she's there. But even then what I find is that because she's a doctor that she has that power too right. She has that power and she has that, it's almost like what she said is more valid than what I would say. So as frustrating as it is sometimes I've learned that I have to use that to my advantage. (ST6., p. 4)	Be accountable for, you know, acknowledging your own privilege or how you've benefitted, and not continuing just to say – what is the story when you keep saying it and it's not true? Like, you know, be responsible for understanding – I guess questioning what you know.	And then if you see some of the after-effects of that, was that without healing in the communities, that redress that came in to people, wasn't able to be used or respected in the way that it needed to be in terms of – the healing processes that needed to happen alongside of it were – you know, they fell short, they were very time-limited and not enough. (ST4., p. 3)	Oh, I was actually – I had found allies in the system, so they would just speak about this, so I had opportunities to be brought to certain tables to speak to management or whatever. But also, I think that it's fallen on deaf ears, or just nothing has changed. Or there could be a sense of being cynical. So I think that it's increased my frustration, and over time I've just become a little bit more and more vocal. And I think that being more vocal though, doesn't change the system, it just increases your sense of frustration in a lot of ways, because you're a lone voice, or there's not – whoever is making the decisions, doesn't get to the – You know, if you're working in a large system, is it getting to the people that need to – to the decision-makers that need to do it? So you might get an opportunity once. (ST4., p. 12)		– and so I'm surrounded by people who are supporting that world view and that way of knowing and doing. We do have – you know, we [out branch 00:18:03] with other people but I think we're at a place now where people – within the university they're more able to understand that this is the way we need to do things and this is how we have to change. I don't have too many networks that don't support my work, so I feel very fortunate that way. I think for Melinda it's different because you work in like the larger healthcare system, so maybe you can talk about that. (ST7., p. 6-7)

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	So the CEO after the last VP Indigenous left, she kind of- she did a lot of collaboration and consultation with First Nations groups in the north about: what should we call this role, of this person, and what should be part of their responsibilities? And so they changed the name to Chief Indigenous Officer (ST5., p. 5)	I remember it at an executive meeting, we brought up the TRC and [Indigenous Lead] was there, and we talked about it and how excellent this was. And then we were tasked by the CEO to come up with a way to incorporate some of the TRC health calls to action into the work of the health region. And it just never got done. And so when I look back at why, I don't know if I could give you one great reason … I think multiple reasons, the VP Indigenous didn't have many staff, he was tasked with doing a lot of other things. And so when we would approach him to say, "Okay, how are we going to work on this?" he was busy. He was busy. He was coming up with an indigenous health strategy for the health region and working with the board on that, and I think the TRC weaved itself in there. But this kind of separate project of trying to focus on a few things in the short-term, medium-term and long-term just didn't get off the ground. (ST5., p. 4-5)	But just being there I knew that that's where I belonged. And then when I came to public health I felt this isn't where I belong. It was really hard. It was so hard because you're sitting in a room and a leadership like you know at these leadership tables and you're the only indigenous person there and everybody's talking and you're trying to absorb all this stuff and nobody comes up for air even like to, it was crazy. And I was like this, I don't belong here, this is horrible. It was really tough. (ST6., p. 3)		Because I did my training back at McMaster, undergrad and postgrad, and through attending those indigenous health conferences and also Indigenous Physicians Association of Canada, so IPAC, we got to build a relationship, they knew me from that. (ST8., p. 2)

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	So what is the goal? And I don't know if anyone's landed on that. I think one of the comments was, it's around trust, and some of the First Nations communities in the north don't trust the health region. And so one of the goals that was banded about was to try and increase trust in people that live in the north. (ST5., p. 6) And it's a great comment, and I think when you step back and take a look at what you should be measuring, some of those process things should be in there if you start looking at what we're … The Nuka folks in Alaska did a nice job of this, I think when they were – the executive team there, I'll never forget this, said that they realized that they were spending – they weren't spending enough time in the community talking to community people. So they set a target for how many hours a day, or hours that they wanted to do that, and then they went about and measured that. (ST5., p. 10)	Sometimes I feel scared, or like I don't want to do harm so I work in a system that still hasn't sorted itself out and they're still doing harm, and I don't want to do that harm. So sometimes I feel scared that I'm actually doing a lot more harm than I know, because we have blinders on. So I have like some anxiety on that. It's not like I don't show up at work because of my anxiety for this, whatever. Or discomfort: to me that's another way of putting it. And so I think so ways to deal with that I'm fortunate I have some colleagues I can talk to about that kind of thing and, you know, that come from the same perspective of if you're not feeling some discomfort then, you know, you're probably not (ST5., p. 18) I think too that things like the TRC report are seen as sort of airy fairy kind of stuff and so people focus more on ok the crisis right now is transformation of the healthcare system and nurses working horrible over time and all this other stuff. So it's sort of that almost that acute, we respond to that acuity and that other stuff just gets pushed to the side because who has time for that? We have to deal with this right now and we just don't feel that there. And they don't, I don't think the people see the connection. (ST 6., p. 6)	It's work for all of us to do together. And then they went the next step and said but indigenization, indigenizing places is for people to stand out of our way and to allow us to do the work that we need to do as indigenous people to actually make it right for us and so your job as a settler, your job as people within our country is to step aside. (ST8., p. 5-6)		

East	South	West	North	Frustration/Imbalance (overarching) for discussion?	Where to find balance
	Yeah. I think that in order to move forward, settlers really need to unpack where they are and why they're feeling this way, understand it's OK to feel this way but there's like opportunity move forward and grow from that. (ST7., p. 11)	It's like you said it's how do we because we can hire more indigenous nurses, but they're working in a colonized system and a system that's oppressive and that is discriminatory and is racist and all those things. So it's not an easy check mark and it's going to take so long to, I think, work at that together. (ST6., p. 7) The reality is I live in both worlds, I have to exist in both worlds, and I'm expected to be successful in both worlds yet there's like so many constraints and timelines and deadlines that I have to work under, and that's very western, that's very colonized. (ST8., p. 7)			