Conceptions and dimensions of health and well-being for Métis women in Manitoba

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ABSTRACT

Because of the continuing poor health status of Aboriginal populations in Canada, along with increasing opportunity for Aboriginal designed health surveys, it is argued that policies and programs, and the research from which they are derived, should be more solidly grounded within Aboriginal understandings of health and well-being. Survey research for Aboriginal populations usually draws on questions developed by and for mainstream Canadians. This paper stems from the author’s master’s thesis study that elicited adult and elder Métis women’s description of ‘what constitutes health’ and ‘what constitutes well-being’. Outlined are descriptions of Métis women’s Conceptions of Health and Conceptions of Well-being, as well as Dimensions of Well-Being that should be included in health survey research.

Keywords: aboriginal, interview, social status

INTRODUCTION

Aboriginal peoples often utilize the terms spiritual, emotional, physical, and mental (or intellectual) to describe their perception of health and well-being (3, 4, 10, 12, 21, 23, 24). Little or no academic work has been done to either clarify Aboriginal perception(s) of health and well-being or to explore the four terms noted in italics above. Most currently utilized survey research questions have not been validated with Aboriginal populations to determine congruency with cultural understandings. It is timely to consider the inclusion of Aboriginal meanings of health and well-being in the development of culturally appropriate survey questions. This work explores the meaning of health and wellbeing from the perspective of adult and elder Métis women in Manitoba, Canada. Such meanings should be utilized to develop culturally grounded survey questions.

Literature Review

A literature search was conducted utilizing databases from ERIC (1994-1998/06), PsycLit (1974-1998/06), MEDLINE (1994-1998/06), CINAHL (1982-1998/06), HEALTHSTAR (1974-1998/08), and Sociofile (1974-1998/06). Subject headings included "Indians North America", "Métis", "Aboriginal or Native", "Canada", "Health", and "Culture". Previous literature reviews for papers on ‘Aboriginal Health and Smoking’, ‘Health Promotion and Population Health’, and ‘Aboriginal Concepts of Healing’ were accessed for relevant references. Numerous documents prepared for the Royal Commission on Aboriginal Peoples were reviewed, as were relevant provincial and federal reports for demographic, socioeconomic and health status information.

METHODS

A quasi-phenomenological tradition (11) of enquiry was utilized for the study. The term 'quasi' is used because data collection was achieved through focus groups rather than the usual phenomenology in-depth interview approach. Additionally, the study began with a conceptual framework, which is not the usual approach in phenomenology (11), which was being explored for its potential to become a culturally grounded conceptual framework for survey research. It is beyond the scope of this paper to articulate this
conceptual framework, but it is important to note that although utilized as the contextual basis for the research, it was not described to participants. An initial hypothesis - based on the literature noted above and the researcher’s observations over years - was that Métis women would describe their perception of health and well-being as being holistic. Specifically is was postulated that the terms *spiritual, emotional, physical and intellectual/mental* would be used to describe this holistic perception; and that the terms would arise spontaneously in the discussion of one or both of the terms health and well-being. Focus group questions were constructed and posed in a manner to ensure that participants’ descriptions were not biased by the existence of the underlying conceptual framework.

A participatory research approach engaged personnel at three large urban Aboriginal organizations who provided advice on the proposal and research questions, along with respondent recruitment support. Seventeen Métis women participated in three focus groups stratified into two age groups (’25-54’ and ’55+) and length of residence in an urban setting (’1st generation’ and ’2nd or more generations’). The 1st generation group (i.e. recent move to urban environment) was intended to be representative (or proxy) for rural Métis women. Demographic results showed that all 1st generation adults were in fact rural residents who had temporarily relocated to an urban environment to attend a program of studies. Based on the above, it is argued that the study results can be valid for both urban and rural adult Métis women. As well, it was determined that a 2nd generation elders group could not be recruited, since Aboriginal populations have not resided in this urban setting for a sufficient period for there to have been an urban born and raised generation of elders. All elders in the study were born and raised in rural communities, but lived most of their adult life in this urban setting. Thus it is argued that the results can be valid for urban and rural elder Métis women.

Data handling included two stages - first synthesis, and then analysis. Synthesis consisted of coding transcribed data, grouping coded statements, creating a narrative for groups of coded statements, developing summary term narratives and finally developing summary group narratives. Synthesized group narratives were sent to respective participants to elicit feedback on the accuracy of descriptions, resulting in a couple on non-substantial edits. These summary group narratives were then processed through the analysis stage. Analysis consisted of developing code words until a saturation point in new code words was reached. A three-step analysis process was utilized to ensure internal coding consistency. If a coding mismatch became apparent, the actual participant quotes were reviewed to determine which of the codes was more representative of the intent of the quotes. This process was completed for all three groups of Métis women, and the coding was consistent across groups. This analysis resulted in eight descriptors that contextualize descriptive narratives on Métis women’s perspective well-being, and will be articulated in a later publication. This paper presents only the synthesis stage descriptions of the meanings of health and well-being.

**RESULTS**

**Participant Demographics**

First and 2nd generation adult Métis women’s age was not significantly different at 36 ± 4.2 years and 31 ± 3.6 years, respectively. Elder Métis women’s mean age was 59 ± 2.7 years. Elders and 1st generation women had a higher income range than 2nd or more generation (median $20,001-30,000 vs. $10,001-20,000). Second generation or more adult women and elders appear to have significantly less education than 1st generation women. This difference may be somewhat exaggerated since all 1st generation women were full-time university students. Confusion may have arisen since education categories were listed for both ‘completed some university or college’ and ‘completed university or college’. It is possible that those who chose the ‘some university/college’ did so because of their current student status. If this is the case, this group may actually fall within the ‘completed grade 11 -12’, or less category.
First generation adults (60%) and elders (67%) were more likely to be divorced or separated than 2nd generation adults (17%). Eighty-three percent of elders were employed full-time and the remaining 17% were employed casually. Second generation adults were more likely to be either unemployed or underemployed (66%) or homemakers (33%). Although the demographic data show there may be differences between the 1st generation and elder, and the 2nd generation Métis women, study results do not reveal significant differences in Métis women’s conceptions of health and well-being.

Conceptions of Health were similar for all groups and described as being inclusive of 1) function and sustenance of the physical body; 2) caring for dietary needs of others, especially children; and 3) an understanding/acceptance of disadvantage and functional decline with age. Interestingly, these conceptions of health seem to be in line with current health system approach of focusing on the physical body. Conceptions of Well-Being were also similar across groups and described as inclusive of 1) nurturance and balance; 2) a sense of existence as part of a collectivity rather than individuality, and 3) balancing of the spiritual, emotional, physical and mental/intellectual aspects of an individual. It is important to note that only three women articulated the later four terms in describing health, while most presented these in describing well-being. Such conceptions are fundamentally important since they are not currently incorporated into the design of health and social service policy and programs for Métis women.

Overall, the synthesis results revealed that essentially all of the descriptive points that arose in discussion of the term ‘health’ could be re-allocated to one or more of the components of ‘well-being’. Specifically, the majority of points articulated for health also arose, often in greater detail, in discussion of the terms physical and emotional. Thus, one might simplify the overall components of ‘health and well-being’ into the Dimensions of Well-Being.

**Dimensions of Well-Being**

The terms spiritual, emotional, physical and mental/intellectual (The terms intellectual and mental were used interchangeably by the women, and clearly both terms were used in relation to thinking,

| Table I. Dimensions of Well-Being. |
|-----------------------------------|
| **Spiritual** | **Emotional** | **Physical** | **Intellectual/Mental** |
| Adult Gen 1 | belief in God or a ‘higher power’ with whom one may seek guidance | feelings such as anger, sadness, and joy, and physical symptoms of nervousness, stress and anxiety | good nutrition & physical activity, feeling good in your own body, having the energy to undertake basic daily activities, optimum functioning of the body | being about thinking, learning, reading and keeping one’s mind active |
| Adult Gen 2 | practice of spirituality through the Creator in order to gain strength | feelings such as hurting happiness, sadness and anger | healthy diet and physical activity, and being as active as possible | being intelligent or smart, and learning new things each day through education or life experience to accomplish goals and help others |
| Elder | belief in a Creator or God who provides strength, courage & a sense of being looked after | feelings such as anger, sadness, grieving, and ‘feeling sorry for one’s self’ | appropriate diet, being in good physical shape, getting regular exercise, caring for the body through rest and avoidance of stress | being about the maintenance of inquisitiveness or curiosity about life, and about learning new things on a regular basis |
learning and the functioning of the mind) were clearly and spontaneously described as important components of health and well-being for Métis adult and elder women. These terms were much more prevalent in relation to the meaning of well-being than for the meaning of health. Commonality of core descriptions of these dimensions of well-being, documented in Table I, shows high consistency across groups. Details of meanings for each term are documented below.

Description of the term spiritual revealed that most indicated prayer as the primary method of practicing spirituality. Some women described a period of alienation from spirituality due to early life religious experience, followed for some by confusion as to whether, as Métis, they could utilize indigenous historical ceremonial activities. Ultimately most came to understand that the method of spiritual practice was not as important as becoming spiritually well and that no single spiritual approach is superior. Elder Métis women did not experience this type of confusion, and saw traditional spiritual practice as a powerful way to connect with one’s inner peacefulness. Spiritually well individuals are described as those who show strength and resistance to adversity in difficult circumstances; are supportive, accepting, and non-judgmental; and care for the spiritual needs of children, including giving them choice.

Description of the term emotional revealed that most reflected that no one is perfectly emotionally balanced, and quickly releasing negative emotions was seen as essential. Being emotionally well meant that one can identify feelings and understand their sources; accept emotions as part of the self; manage and control emotions in daily life; and understand that emotional well-being can only truly arise within one’s self. Emotionally well individuals are said to be spiritually well also, and practice traditional activities.

Description of the term physical seemed to be the source of the greatest stress and anxiety for most participants. For adult Métis women, there were feelings of discouragement and a general dissatisfaction with body image due to obesity and loss of youthful vitality. Most of the adult, but not elder, women did not consider themselves physically fit, and admitted to having lifestyle practices that were thought to be harmful, such as smoking. For elder women, motivation was considered one of the most important aspects of maintaining physical well-being, and fear of loss of independence through progression of a physical disability was a clear motivator to increase physical activity.

Description of the term intellectual/mental was revealed as having to do with the mind, learning, and remaining curious about life. There was no perceived connection between age and the conceptualization of intellectual well-being. Remaining intellectually active was seen as a life-long activity, and increased age was not to be used as an excuse for allowing interest in life to lapse or for becoming intellectually inactive. Intellectually well individuals are those who learn from reading and reflecting each day; have an attitude of openness to new ideas or ‘out of the box thinking’; and respect for the views of others. They are also advanced and at ease in both their thinking and abilities; rapidly adapt to circumstances and respond with creative ideas; and attain higher education despite difficult life experiences. Some stated that elders who can teach and learn both old and new information are intellectually well.

In considering the dimensions of well-being, one should be cognizant that, once the terms were tabled, data were collected and reported on the basis of these four terms, thus introducing what might described as ‘coherence artifact’. Although the women did clearly state that the component parts of well-being included these terms, it is less likely that their daily living or reflections on life progress in such a systematic manner. Thus, caution is advised such that one does not conclude a level of coherence in the study results that may be misleading. Yet, this should not detract from utilizing the meanings of the terms to develop survey questions that will elicit information on Métis women’s well-being. Additionally, this statement about the introduction of a ‘coherence artifact’ is not meant to imply that the women do not have critical thought about their
lives – it was very apparent that they do reflect deeply on the circumstances of their lives. Several differences were apparent between groups in description of health and well-being.

Relative to health:
- 2nd generation adults and elders described a need to eliminate negative behaviours;
- 1st generation adults and elders had more income than generation two; and
- 2nd generation adults alone described that health is impacted by lack of education and a job.

Relative to well-being:
- elders described well-being as including a level of self-understanding and acceptance;
- 2nd generation and elders included a clean home and safe environment for children’s play as important to physical well-being; and
- 2nd generation adults alone indicated that responsibility for others can impact on caring for one’s own well-being.

One might argue that the difference in self-understanding and acceptance expressed by elders might simply be a reflection on age. Second generation differences could be attributed to the fact that they may be living in greater poverty conditions than the other two groups of women.

DISCUSSION
Aboriginal populations in Canada continue to suffer significantly from the hardship of living in poverty conditions (5), have disproportionate levels of morbidity (14,20,25), continue to have twice the infant mortality rate (6), and are still lagging behind the general population in terms of life expectancy (7). More often than not general population (and sometimes Aboriginal) researchers, policy makers, and program providers, and society in general, perceive and describe Aboriginal populations only from the perspective of having poor health status. There has been a pervasive tendency to personify Aboriginal peoples only from a deficit perspective as resource-poor victims who lack capacity to address problems (15,19). Little effort has been put into understanding and describing the essential substance of Aboriginal communities; substance that has supported them to remain vibrant and future-oriented despite the many challenges. The meaning of health and well-being from an Aboriginal perspective, and the strengths of Aboriginal peoples are not often drawn upon for incorporation into health and social service delivery approaches.

Neither has significant academic effort been put into research on the meaning – conceptions and dimensions – of health and well-being from an Aboriginal perspective. Thus most program approaches are boilerplate replicas of programs developed for majority populations. For example, the mainstay approach to addressing diabetes mellitus has been the provision of counseling on physical aspects of the disease – diet and exercise, and screening and treatment for physical complications. Little attention is directed toward spiritual, emotional and intellectual impacts that diabetes has on individuals and their families. Nor have resources that might be drawn from Métis strength in these areas been integrated into or applied as the basis for approaches to addressing such disease entities. This research shows that attaining and maintaining physical well-being presents a significant stress for Métis adult and elder women. The research also reveals that Métis women have developed significant insight into and strength in the spiritual, intellectual and emotional aspects of their lives. One must question why the health system continues to focus its efforts toward the changes in the physical body if Métis women might perceive this change as unachievable. Could a focus on spiritual, emotional and intellectual strengths, away from the most stressful physical area, over time, result in improved physical well-being? Basic psychological development has demonstrated that positive reinforcement will result in more positive outcomes than negative reinforcement. These ideas should be explored and tested.

It is also clear from this research that for Métis adult and elder women a major motivating factor in attaining and maintaining well-being is grounded within a sense of collectivism rather than
individualism. Yet, health promotion continues to focus on an individualistic approach that does not meet the needs of Métis women’s collectivist orientation to life. Unless alternatives approaches are put forward and tested the usual health promotion and health education approaches (22) will continue to function as social marketing tools directed toward ‘at risk’ Aboriginal populations (1). To date, few alternatives have been offered, nor unfortunately have important critiques of health education and health promotion (17) resulted in a shift away from social marketing. Some provincial governments are now utilizing important health determinants (13), population health (8), and population health promotion (16) frameworks in planning for health and social services (18). These demonstrate the increasing understanding that both agency (the individual) and structure (the society) must be considered in addressing the health of populations (2). Yet, Aboriginal populations still live in with poverty (5), have high unemployment (9) and few education opportunities. The sources of these difficulties are as often structure, as agency (26). At the same time our health and social service sector continues to focus primarily on the agency side of the equation. This is perhaps not because of lack understanding that individual behaviour alone is not the sole cause poor health, but could be due to feelings of helplessness to do anything about societal structures that continue to act as barriers to well-being for certain parts of a population.

Exhaustive Royal Commission on Aboriginal Peoples research revealed the many systemic barriers that prevent Aboriginal populations from achieving prosperity (20). Yet, the current health promotion approach, with its focus on agency, still does not take into consideration the systemic barriers that many, if not most, Aboriginal populations face on a daily basis. Health promotion unfortunately remains embedded within an ‘at risk’ approach that can feel to some like a ‘blame the victim’ orientation. One woman in expressing her defiance and disgust at how poor people are judged by society powerfully stated;

"Because we’re on assistance or because we’ve had troubles in our life, don’t begrudge us and look down on us - and think that we’re no good, and we’re never going to amount to anything. You know, like I’m always proud of my accomplishments. I don’t care whether people like it or not. You have to be proud of what you’re doing.”

Generally Canadian society and its health system grounds the concept of health within a disease or absence of disease approach. Some elder Métis women did speak of physical disability that interfered somewhat with daily function, and health problems for which they should follow their doctors’ advice - even so, these were not stated in terms of disease. Of particular importance, the Métis women in this study did not articulate disease or even absence of disease as being a component of either health or well-being - a fact that must be further explored.

Finally, the 1990 Evans & Stoddart ‘determinants of health’ model interestingly, and I believe with some prescience, includes a box titled ‘Well-Being’ (13). More than a decade later, and despite the significant increase in utilization of the term well-being in the health field, the lack of literature on this subject reveals the obvious - researchers have not taken up the challenge of attempting to define the content of this Well-Being box. This research attempts to remedy this by documenting the Métis women’s Dimensions Of Well-Being that should be included in Aboriginal (Métis) survey research. This research also presents a Métis women’s perspective on health and well-being that provides a counterbalance to sometimes ubiquitous negative descriptions of Aboriginal health. The health sector can also play a role in beginning to remedy negative description by, at minimum, providing context appropriate and culturally grounded services, programs, and research.

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