BRINGING THE MESSAGE HOME:
Enabling urban Aboriginal families for wholistic health

by

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Abstract

BACKGROUND: The health of Aboriginal children and families has been negatively influenced by existing social and economic disparities, dramatic lifestyle disruption, social marginalization, inactivity, dietary change, and lower rates of educational attainment (in comparison with non-Aboriginal populations). Interventions to reduce these risks should emphasize a wholistic approach, consistent with indigenous understandings of the interconnectedness of physical, spiritual, mental and emotional wellbeing. Some positive effects have been seen in family based interventions promoting health, however researchers do not yet know how best to leverage the influence of family through these interventions. This study takes a community-based participatory approach and ecological perspective to develop tailored strategies and resources to engage families in supporting wholistic health messages received through AKWE:GO (a community-based outreach program for at-risk urban Aboriginal youth).

PURPOSE: To discover what activities families (i.e., parents and children) associate with wholistic health, as well as any barriers, facilitators, and competition faced when attempting to engage in health behaviours. Findings will be used to inform the development of take-home packages for AKWE:GO families promoting wholistic health.

METHODS: Fifteen women and 4 men (most are parents of AKWE:GO participants), and 13 girls and 10 boys involved in the AKWE:GO program at the Native Friendship Centres in Kingston and Owen Sound participated in one of 6 sharing circles (4 in Kingston, 2 in Owen Sound). Adults and children attended separate circles, which were facilitated by the AKWE:GO coordinators. Sharing circle questions were centered on wholistic health and based on principles of social marketing. Discussions were recorded and subsequently transcribed. Inductive and deductive content analysis was performed, supported by NVivo 8 software.
RESULTS: Findings from deductive analysis indicate that AKWE:GO families consider engagement in physical activity, traditional activities, healthy eating, budgeting, and meaningful conversation with significant others to be conducive to wholistic health. Inductive analysis of parent discussions revealed differences in community readiness between Kingston and Owen Sound.

CONCLUSION: Results highlight the importance of considering population needs and community-readiness when developing health promotion strategies and resources for a given population.
Acknowledgements

The findings from this study are centered on the concept of “support”, which is appropriate given that this project would not have possible without support from a number of different sources, both academic and personal.

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Prologue

This report was written with three audiences in mind: 1) the AKWE:GO families and the staff and members of the Katarokwi Native Friendship Centre, 2) the Heart & Stroke Foundation, and 3) the academic community of Queen’s University. I tried to compose this dissertation, especially when reporting project findings, in a way that was respectful and useful for all involved. It was important that I show consideration for the community members who participated in the project and to recognize the funding provided by the Heart & Stroke Foundation. The literature review was written in a more academic fashion to comply with Queen’s University requirements for a Masters thesis.

This report will be viewed by members from all three audiences.
Chapter 1

Introduction

Life expectancy for Aboriginal Peoples living in Canada continues to fall below the current national average (Spurr, 2007). This may be attributed to the history of inequity and oppression, the legacy of residential schooling (Ajzenstadt & Burtch, 1990; Health Canada, 1994; Warry, 1998), and the resulting negative impact on social determinants of health (e.g., low income, low educational attainment, insufficient housing) of Aboriginal Peoples (Barton, Anderson, & Thommasen, 2005). Unfortunately, negative health outcomes are appearing more frequently in Aboriginal youth as demonstrated by the increasing rates of suicide (Kirmayer et al., 2007), obesity, and diabetes in this population (Spurr, 2007).

In Aboriginal cultures, health is often viewed as “wholistic”, reflecting the interconnectedness of physical, spiritual, mental and emotional wellbeing (Antone, Gamlin, & Provost-Turchetti, 2003). Initiatives to enhance the health of Aboriginal populations should reflect this wholistic outlook of health. The importance placed on family in Aboriginal cultures (Cheah & Nelson, 2004) and evidence supporting the use of family-based interventions to enhance healthy lifestyles (Salmon, Booth, Phongsavan, Murphy, & Timperio, 2007; Teufel et al., 1999), indicates that promoting health at the family level may be an effective way to convey health messages to Aboriginal children. Research findings that show links between social structures and health outcomes (Gauvin, Lévesque, & Richard, 2001) provide support for the use of an ecological approach to health promotion that considers influences that reach beyond the individual into the social and physical environments to impact health behaviours (Stokols, 1992).

Indeed, if we are to understand ‘healing as the rebuilding of nations’ and as a process
of de-colonization, then we must find ways by which health can be effectively articulated at the levels of the individual, family, community, and nation. (MacKinnon, 2005; Warry, 1998; as cited in Adelson, 2005, p. 47)

The AKWE:GO program for urban Aboriginal youth seeks to improve the health and wellbeing of at-risk children aged 7-12 years by providing opportunities for physical activity, healthy eating, self-esteem building, and homework assistance. Funding was provided to the AKWE:GO program at the Katarokwi Native Friendship Centre by the Heart & Stroke Foundation of Ontario (HSFO) in the form of an Advocacy Planning Grant intended to promote health among AKWE:GO parents and children. Using a community based participatory approach, ecological perspective, and social marketing framework, this study explores strategies and resources to promote wholistic health in the home setting by involving families who participate in the AKWE:GO program.

Before a social marketing campaign to promote health could be developed and implemented, it was necessary to assess AKWE:GO families’ perceptions of the current barriers they face in engaging in health behaviours and to gain an understanding of current views among this population in relation to wholistic health.
Chapter 2

Background Information & Framework

2.1 Friendship Centres

During the 1950s, many Aboriginal people relocated to the more urban regions of Canada hoping to find an improved quality of life (National Association of Friendship Centres [NAFC], 2006). Specialized agencies, named “Friendship Centres”, were soon developed to address the needs being expressed by growing urban Aboriginal communities (NAFC, 2006). Originally reliant on volunteers, donations, and grants, Friendship Centres eventually evolved into leading providers of social services. The centres were recognized by the Canadian government in the early 1970s (NAFC, 2006).

The National Association of Indian Friendship Centres (NAFC) is a non-profit organization that was established in 1972 to provide national representation for the increasing number of Friendship Centres appearing across the country. The mission of the NAFC is “to improve the quality of life for Aboriginal Peoples in an urban environment by supporting self-determined activities which encourage equal access to, and participation in, Canadian Society; and which respect and strengthen the increasing emphasis on Aboriginal cultural distinctiveness” (NAFC, 2006).

Programs and services offered through Friendship Centres are numerous and wide-ranging and include opportunities for counseling, skill development, recreation, and healthy living (NAFC, 2006). Although the focus of these programs is on Aboriginal wellness, they are made available
to people of all ages, races, religions, incomes, and nationalities (NAFC, 2006). There are currently 114 Friendship Centres and seven Provincial Territorial Associations (PTA) across the country whose programs and services are accessed by over 750,000 people each year (NAFC, 2006).

The Katarokwi Native Friendship Centre, located in Kingston ON, was established in 1992. As a member of the NAFC and the Ontario Federation of Indian Friendship Centres (OFIFC), it provides a place for Aboriginal community members to converse with others and participate in programs and events; it also welcomes non-Aboriginal community members to come and learn more about Aboriginal cultures and traditions. The centre offers a number of programs that address a variety of needs: Aboriginal Prenatal Nutrition Program, Aboriginal Healthy Babies, AKWE:GO Program (for children ages 7-12 years), Aboriginal Youth Program (for youth ages 15-24 years), Aboriginal Healing & Wellness Program, and the Life Long Care Program (Ontario Federation of Indian Friendship Centres, 2004). While a healthy, active lifestyle is promoted in all programs, sport and recreational activities are particularly important components to the children and youth programs.

### 2.2 AKWE:GO

The AKWE:GO Urban Aboriginal Children’s Program was launched in December 2005 and aims to provide at-risk children aged 7-12 years with the necessary social support, skills, and understanding to improve their knowledge and ability to make healthy life choices. It is funded by the Ontario Government and administered by the Ontario Ministry of Children and Youth, in partnership with the OFIFC. The program seeks to promote healthy development while also
taking into consideration respect for cultural backgrounds and traditions (Ontario Ministry of Children and Youth Services, 2007). It features after-school programming including peer support and help with homework, as well as opportunities for physical activity (PA) and recreation consistent with traditional Aboriginal activities and teachings (e.g., hiking, swimming). While PA is a large component of this program, other topics such as sexual and mental health are addressed, given that reduced health in one area can hinder one’s ability to lead an active lifestyle. The children enrolled in this program often live in low income situations and lone parent homes, placing them at higher risk for health problems (personal communication, W. Prue, April 19, 2007). Each child enrolled in the program receives a personalized plan of action, referrals to community resources and agencies, and access to various health resources (Ontario Ministry of Child and Youth Services, 2007). AKWE:GO is available in 27 Native Friendship Centres across Ontario.

2.3 Heart & Stroke Foundation Kidfit™ Community Advocacy Fund

The goal of the Heart & Stroke Foundation of Ontario (HSFO) Community Advocacy Fund is “to enable school and community groups to advocate for increased children’s access to physical activity and healthy foods” (The Heart & Stroke Foundation of Ontario [HSFO], 2008, p.2). The Community Advocacy Fund provides support to school and community groups through Advocacy Planning ($2,000), Advocacy Development ($5,000), and Community Action ($25,000) Grants. Advocacy Planning Grants are available to assist with the development of community partnerships and the early planning of advocacy efforts involving key stakeholders, while Advocacy Development Grants and Community Action Grants are available to assist advocacy campaigns in the later stages (HSFO, 2007).
Successful grant applications must outline sustainable initiatives to increase the physical activity levels (HSFO, 2007) and/or increase access to healthy foods (HSFO, 2008) for children aged 4-13 years. Advocacy efforts should be aimed at influencing policy, building coalitions, raising awareness and education, and/or mobilizing the community (HSFO, 2008). Priority is placed on projects that will engage child populations who may find it more difficult to engage in physical activity due to increased barriers (HSFO, 2007), and projects involving Aboriginal, African/Caribbean, South Asian, or Chinese populations (HSFO, 2008). The HSFO is increasing efforts to address the needs of diverse populations, with initial plans directed at these four diverse populations (personal communication, B. Collins, May 8, 2007).

2.4 Project Development

I have been working closely with Ms. Willow Prue, the coordinator of the AKWE:GO Urban Aboriginal Youth Program at the Katarokwi Native Friendship Centre, since February 2007. In my initial meetings with Ms. Prue, she expressed concern that the health messages children received while attending her program were not being supported in the home setting. She was interested in finding a way to increase the children’s exposure to wholistic health messages by ensuring that these messages were consistent between AKWE:GO and home. We felt that this was an issue that could be supported by the HSFO Community Advocacy Fund.

With HSFO funding secured, Ms. Prue, myself, and a colleague took on the task of designing an advocacy campaign for the AKWE:GO program. Campaign aims were to: 1) increase community stakeholder awareness of the AKWE:GO program, 2) recruit volunteers, and 3) engage families living on low incomes to support wholistic health messages received by AKWE:GO regarding
healthy living in the home setting. This project is the result of our efforts to carry out this campaign and focuses on the third objective to bring wholistic health messages into the homes of AKWE:GO families.
Chapter 3

Literature Review

3.1 History of Inequity in Aboriginal Canada

Aboriginal people today continue to suffer as a result of attempts by government to colonize and assimilate the Aboriginal population. When examining the current health status of Aboriginal Peoples, it is important to take into consideration the significant historical events that led them to their existing state of oppression. As Adelson (2005) states, “…we must appreciate the individual effects of the collective burden of a history of discriminatory practices, unjust laws and economic or political disadvantage” (p. 46).

Colonization and the ensuing creation of residential schools have taken a devastating toll on Aboriginal cultures. When European settlers arrived in North America, they violated the Aboriginal people and intruded on their way of life. Colonization was devastating to Aboriginal cultures and resulted in great losses for Aboriginal Peoples including a loss of lands, resources, and independence (Health Canada, 1994). With the creation of the reserve system, Aboriginal Peoples were forced to move to new and unfamiliar lands and Aboriginal children were removed from their homes and communities and placed in residential schools (Ajzenstadt & Burch, 1990; Warry, 1998). Children sent to residential schools faced increased exposure to physical, sexual, and emotional abuse and removal from their families deprived them of exposure to positive parenting (Indian and Northern Affairs Canada [INAC], 1996).
3.2 Demographic Profile & Social Determinants of Health for Aboriginal Peoples

3.2.1 Demographic Profile

According to NAHO (2003), “‘Aboriginal Peoples’ is a collective name for the original peoples of Canada and their descendants” (p. 1). This term may vary from country to country as there exists no single term to define Indigenous Peoples (NAHO, 2003). When simply talking about
more than one Aboriginal person, as opposed to “a collective group of First Nations People” (p. 1), the term ‘Aboriginal people’ is used (NAHO, 2003). The Aboriginal population living in Canada continues to grow and migrate to the more populous areas of the country. In 2006, Aboriginal people, including First Nations, Inuit, and Métis made up 3.8% of Canada’s total population, growing from 3.3% in 2001 and 2.8% in 1996 (Statistics Canada, 2008a). At the same time, children and youth aged 24 years and under made up almost one-half (48%) of the Aboriginal population, with children ages 0-4 years representing 9%, and children ages 5-10 years representing 10% of the Aboriginal population (Statistics Canada, 2008a). According to Statistics Canada (2008a), only 31% of the non-Aboriginal population is under the age of 24 years. In Kingston, 2,360 of the 117,207 residents claim Aboriginal identity, and approximately 36% of Aboriginal residents are aged 24 years and under (Statistics Canada, 2008e). These numbers may under-represent the actual population because they are based on self-identification. With an increasingly younger population, ensuring the development of healthy lifestyles and enhancing opportunities and resources for health for Aboriginal youth are especially critical given the potential influence of these factors upon life long health.

The aim of this project is to positively impact the health of Aboriginal children by promoting healthy activities to their families. Preventing today’s health inequalities from plaguing future generations is especially important in Aboriginal cultures where “each new generation is responsible to ensure the survival of the seventh generation” (Clarkson, Morrissette, & Régallet, 1992, p. 3). Many Aboriginal people choose to focus on the seventh generation, which is beyond their lifetime, to ensure the prosperity of their people (International Institute for Sustainable Development, 2000). Actions taken today must include consideration of the effect that they will have on the seventh generation (Clarkson et al., 1992).
Over the past ten years, the Aboriginal population has continued to migrate to urban centers (Statistics Canada, 2008a). According to the 1996 Census Dictionary, an urban area contains a minimum population of 1000 and minimum population density of 400 persons per square kilometer (Statistics Canada, 1999a). All other areas are considered rural. In 2006, 54% of the Aboriginal population reported living in an urban area, up from 50% in 1996; however, compared with non-Aboriginal people, urban Aboriginal people are less likely to live in large urban centers (Statistics Canada, 2008a). Reasons for migration include: getting away from violent, racist, and volatile environments, seeking improved economic opportunity, and escaping the environmental devastation that has abolished previously traditional lifestyles (Clarkson et al., 1992).

3.2.2 Social Determinants of Health

The social and economic conditions that exist in a person’s day-to-day environment are considered their social determinants of health (Public Health Agency of Canada, 2007). Many social and cultural, factors contribute to negative health outcomes in the Aboriginal population. Social factors include: poverty/low income, insufficient housing, low educational achievement, and reliance on social assistance. Distress from residential schooling experiences is a cultural factor specific to Aboriginal Peoples (Barton et al., 2005). Closer examination of the income, housing, and education situation of Aboriginal Peoples living in Canada reveals the magnitude of the barriers many must overcome in order to improve their health status.

While there still remains no international definition of poverty, Statistics Canada has developed a set of measures known as the Low Income Cut-Offs (LICO). These measures do not necessarily
indicate absolute poverty (Statistics Canada, 1997), instead they are relative measures of the after-tax income below which Canadians must spend a considerably higher proportion of their income on food, shelter and clothing (Statistics Canada, 2008d). In 2006, approximately 3.4 million (10.5%) Canadians, including 760,000 (11.3%) Canadian children aged 18 years and under, and 633,000 (7.0%) Canadian families, lived in low-income situations (Statistics Canada, 2008d). The number of urban Aboriginal people living on low incomes in Census Metropolitan Areas (CMAs) in 2000 was more than double the national average for CMAs (Statistics Canada, 2004). Low income rates of 41.6% among Aboriginal people in CMAs were substantially higher than the overall average of 17.7%; likewise, in CMAs Aboriginal people represented 1.6% of the total population, but 3.7% of the low-income population (Statistics Canada, 2004). Having Aboriginal heritage and having a low income are two risk-factors linked with having two or more chronic diseases (Canadian Institute for Health Information, 2006). Similarly, Aboriginal people who live in low-income households are more likely to be obese (Statistics Canada, 2008f). Negative health outcomes may also be influenced by inadequate housing, which includes homes that are crowded and/or in need of major repair. According to Statistics Canada (2008a), in 2006, Aboriginal Peoples were four times more likely than the non-Aboriginal population of Canada, to live in a home that was crowded (more than one person per room), and three times more likely to live in a home in need of major repair. However, Aboriginal people in Montreal, Ottawa-Gatineau, Toronto and Vancouver were actually less likely than their non-Aboriginal counterparts to live in a crowded residence (Statistics Canada, 2008a). In Ontario, only 2.1% of occupied private dwellings, and 1.8% in Kingston, had more than one person per room (Statistics Canada, 2008e). Of the 1,415 private dwellings occupied by Aboriginal residents of Kingston, 1,130 were constructed prior to 1986, and 190 require major repairs (Statistics Canada, 2008e).
Finally, low educational achievement is another important social determinant of health. As of 2006, 34% of Aboriginal people aged 25-64 years had not completed high school, 21% had high school diplomas as their highest level of educational attainment, and 44% had post-secondary education (trade credentials, college diploma, or university degree) compared with 15%, 24%, and 60% of the Canadian population respectively (Statistics Canada, 2008c). In addition, 8% of the Aboriginal population had a university degree, compared with 23% percent of the non-Aboriginal population (Statistics Canada, 2008c).

Therefore, the social and economic conditions present in the day-to-day lives of many Aboriginal people make it exceptionally challenging to achieve and maintain a positive health status. This is difficult to address directly through programming; however programs can attempt to make or encourage small changes to alleviate some of the negative health consequences associated with low income, insufficient housing, and low educational attainment. Ideally, health status would be enhanced by direct improvement of the social determinants.

3.3 Mortality & Health Disparities among Aboriginal Peoples

In general, life expectancy is a reflection of overall health and wellness and healthier populations tend to enjoy longer life spans. Life expectancy for Aboriginal Peoples continues to fall below the national average and the health of Aboriginal children and families has been negatively influenced by existing social and economic disparities (Spurr, 2007). Despite an increase in the life expectancy of Aboriginal people since 1980, from 60.9 to 70.4 years for men, and from 68.0
to 75.5 years for women, non-Aboriginal Canadians could still expect to live 6.6 years longer than the Registered Indian population in 2001 (Indian Affairs and Northern Development [IAND], 2005). While there are many factors that influence the health outcomes of a given population, it is worth noting that higher rates of employment and educational attainment have been found as common characteristics among health regions (i.e., administrative areas of regional health boards or areas of interest for health authorities) with higher life expectancies (Statistics Canada, 1999b). This further highlights the connection between the social determinants of health and the current health status of Aboriginal Peoples living in Canada.

The shorter life expectancy of Aboriginal Peoples is most likely linked to their overrepresentation in chronic condition and disease categories. Health regions with high percentages of Aboriginal residents were found to have higher rates of mortality due to major chronic disease (Statistics Canada, 1999b). In 2001, the potential years of life lost (PYLL) due to injury, digestive problems, endocrine dysfunction, respiratory trouble, infectious diseases, nervous system problems, mental illness, and musculoskeletal dysfunction were all higher for the First Nations population than for the Canadian population in general (IAND, 2005). Rates of obesity and diabetes among Aboriginal populations are especially troubling (Katzmarzyk, 2008).

Excess weight continues to be a contributing factor in the development of chronic conditions. Obese children and adolescents are more likely to become obese adults and are more likely to suffer from hypertension, high cholesterol, type 2 diabetes, and atherosclerotic lesions - all of which are risk factors for cardiovascular disease (Jolliffe & Janssen 2006). Findings from the 2004 Canadian Community Health Survey: Nutrition [CCHS] indicate that a staggering 41% of
off-reserve Aboriginal children aged 2-17 years were overweight or obese\(^1\), with 20% being obese. In Canadian children these numbers drop to 26% and 8% respectively (Statistics Canada, 2005b). Sixty-seven percent of off-reserve Aboriginal adults are considered overweight or obese, with 38% of this group being obese (Statistics Canada, 2008f). Obesity is considered to be one of the greatest risk factors in the development of type 2 diabetes (Felber, Acheson, & Tappy, 1993).

Non-insulin dependent diabetes mellitus (type 2) is a leading cause of morbidity and mortality among Aboriginal Peoples in North America (Barton et al., 2005). People with type 2 diabetes do not produce enough insulin to meet their needs, or their bodies do not respond properly to the insulin that is produced (Canadian Diabetes Association, 2008). Deaths attributable to diabetes in the Aboriginal population are six times the national average (Barton et al., 2005) and the incidence of type 2 diabetes, previously referred to as adult-onset diabetes (Canadian Diabetes Association, 2008), continues to increase in Aboriginal children and adolescents (Spurr, 2007). Several investigations involving female Aboriginal adolescents have found a 4% prevalence rate of diabetes in this population (Fagot-Campagna, 2000).

Physical inactivity is a major risk-factor in the development of obesity and diabetes, as well as other chronic conditions. According to the 2004 CCHS, 56% of the Aboriginal and non-Aboriginal adult populations reported being inactive, however 50% of Aboriginal respondents who reported being inactive were obese, compared with 23% of the non-Aboriginal respondents (Statistics Canada, 2008f). Today many more children are spending their free time engaged in

\(^1\) The Centers for Disease Control and Prevention (2007) uses the terms ‘at-risk for overweight’ and ‘overweight’ in place of ‘overweight’ and ‘obese’ when referring to children and teens due to the difficulty in determining healthy weight ranges in this population.
sedentary activities such as watching television, playing video games, or sitting at the computer (National Aboriginal Health Organization [NAHO], 2005).

The shorter life expectancy of Aboriginal populations is also related to additional factors including addictions, violence, and suicide. All of these reaffirm the devastating effects of the historical injustices imposed on Aboriginal Peoples (Lafrenière, Diallo, Dubie, & Henry, 2005). Like obesity, diabetes, and inactivity, these factors appear to be more prevalent in Aboriginal communities (Chansonneuve, 2007). The significantly high rates of addiction, violence, and suicide contribute to the dysfunction in families, fetal alcohol syndrome, mental illness, and homicide among the Aboriginal population (Sanchez, Plawecki, & Plawecki, 1996).

Addictions can take a devastating toll not only on individual health, but on the health of families and communities as well. According to the National Native Addictions Partnership Foundation Inc. (2000), in the Aboriginal population, alcohol use causes almost twice as many deaths (43.7 per 100,000), and illicit drugs nearly three times as many deaths (7.0 per 100,000) as they do in the general population. The abuse of drugs and alcohol also increases risk for accidents, illness, disease, and violence (Chansonneuve, 2007) and is often a factor in spousal homicide cases (Statistics Canada, 2005a).

Like addictions, family violence continues to take a toll on Aboriginal Peoples. The consumption of alcohol is often a factor in violent episodes towards women (Brownridge, 2003) and Aboriginal women are three times more likely than non-Aboriginal women to report spousal assault (Statistics Canada, 2006). In 2004, 21% of Aboriginal people reported being victims of spousal violence, which is three times the percentage reported in the non-Aboriginal population
(Statistics Canada, 2006). According to Straus (1992), physical violence amongst parents is witnessed by 23-36% of children with two-thirds of these children being exposed on more than one occasion. Forty-five to 70% of the time children who witness violence involving parents are also abused themselves (Prescott & Letko, 1977; Straus, 1980).

Finally, suicide rates among Aboriginal populations continue to exceed rates in the general population (Kirmayer et al., 2007). In an examination of health regions with Aboriginal populations of more than 20%, suicide rates were found to be 1.5 – 2.9 times the Canadian rate (Statistics Canada, 1999b). Rates among youth are especially troubling with at least one out of every three deaths among Aboriginal youth attributable to suicide (Kirmayer et al., 2007).

### 3.4 Need for Culturally Relevant Solutions in Health Care & Health Promotion

History, culture, and personal beliefs all play a role in influencing an individual’s daily actions. Like all people living in Canada, the actions of Aboriginal Peoples are greatly influenced by their cultural beliefs (Sanchez et al., 1996). Culture can be seen as the values, norms, practices, and ways of life that are passed on from one generation to the next (Betancourt & Lopez, 1993; Hughes, Seidman, & Williams, 1993; Orlandi, Landers, Weston, & Haley, 1990). Showing respect and understanding for various cultures is especially important for persons working in the areas of health care and health promotion because a lack of cultural awareness can negatively influence the effectiveness of their services.
Ideally, health-care providers should have an appreciation and respect for Aboriginal cultures in order to provide this group with effective health care (Sanchez et al., 1996). When the Aboriginal model of healing and the priorities of main-stream health-care are out of sync, the health of Aboriginal people can suffer (Adelson, 2005). Therefore, it is important for health-care providers, who do not come from the communities they serve, to seek indigenous knowledge and to develop an awareness of Aboriginal views and traditions so that relevant and meaningful communication can take place (Sanchez et al., 1996). Community members and health-care workers who understand and appreciate Aboriginal cultures are able to work together to develop appropriate strategies to promote and maintain wholistic\(^2\) health in the Aboriginal population.

Similar to the development of relationships between healthcare workers and Aboriginal patients, health promotion strategies must be developed with an appreciation and respect for Aboriginal cultures to ensure meaningful promotion strategies for Aboriginal Peoples. The most widely accepted definition of health promotion is “the process of enabling people to increase control over, and to improve, their health” (World Health Organization, 1986). Health related behaviours within a given cultural group may be linked with any number of social and cultural characteristics (Pasick, D’Onofrio, & Otero-Sabogal 1996). Such characteristics may include “familial roles, communication patterns, beliefs relating to personal control, individualism, collectivism, and spirituality” (Triandis et al., 1980, as cited in Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003, p. 133). There is a growing body of evidence to suggest that health interventions and materials that are made relevant to the cultural norms of the intended audience

\(^2\) Wholistic is spelled with a “w” to reflect the concept of wholeness when the four areas of health: physical, emotional, mental, and spiritual, are in balance as per the definition provided by Antone, Gamlin, & Provost-Turchetti (2003)
are more successful (Bechtel & Davidhizar, 2000; Brach & Fraser, 2000; Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999).

3.5 Wholistic Health

Perceptions and worldviews may vary according to cultural beliefs and values. While there exists no over-arching definition of Aboriginal perspectives (Simpson, 2000), the wholistic foundation of Indigenous knowledge suggests that sources of understanding (e.g., religion, art, science) should be examined together as their meanings are often intertwined or interconnected (Battiste & Henderson, 2000; Cajete, 1999, 2000; as cited in Hart, 2007). As defined by Antone and colleagues (2003), the term “wholistic” refers to Aboriginal philosophy where all things are interconnected through common origins and the sharing of an environment. A person is considered to be whole when he or she is mentally, physically, spiritually, and emotionally one – as an individual, with his or her family and extended family, and people, and within sacred relationships (Antone et al., 2003; Kelm, 1996).

The Medicine Wheel (Figure 3-1) is a sacred symbol in Aboriginal cultures. Medicine Wheel teachings are based on the seven directions; North, East, South, West, Father Sky, Mother Earth, and Centre, which form the wholistic base of human behaviour and interaction (Teya Peya Productions, n.d.).
Many nations use the Medicine Wheel to represent their thoughts on health and well-being, however it is not a universal symbol (Hart, 2002). Each nation and group is unique and may express their identities through their own symbols (Cargo, Peterson, Lévesque, & Macaulay, 2007). For some groups, the colours in the image above represent the colours of humanity (i.e., yellow race, red race, black race, white race) and may also be correlated with a specific direction, season, birth order, element, etc. (Teya Peya Productions, n.d.). Often, the wheel is divided into four sections representing four areas of the self: spirituality, emotionality, physical, and social (Montour, 2000). Again, these categories are not universal and in some instances, the mental (Lavallée, 2007) or intellectual (Mussell, Cardiff, & White, 2004) realms are included. The Medicine Wheel is a symbol that represents ideas of balance, interdependence, and wholistic
health (Mazzola, 1988), and if any one of the areas of self is out of balance, so is one’s health.

While there exist no over-arching descriptions defining the different areas of self, Montour (2000) provides some insight as to what the areas of spiritual, emotional, physical, and social health might encompass. According to Montour (2000):

Spirituality is the part of the self that believes in the connection of all things, a sense of connectedness that allows for an inner awareness of the unity of all things, either animate or inanimate. Emotionality is the part of the self that touches all other things through feeling. The physical dimension is the aspect of self that recognizes and nurtures the body and the environment. The social dimension concerns the social relations that one has through interactions with others in the greater circles or networks of relationships of which they are a part such as family (including extended family), the community, and the broader social systems and natural environment. (as cited in Cargo et al., 2007, pp. 89-90)

Living out of balance is believed to have a negative impact on overall wellness. While no one behaviour can resolve all issues, stemming from the social determinants, that impact one’s health, certain behaviours can be adopted to improve overall health and wellbeing. Physical activity and healthy eating are two behaviours that have been shown to provide significant health benefits relating to the various areas of self.

Regular physical activity is associated with numerous physical, emotional, intellectual, and social benefits. Physically active youth enjoy lower levels of adiposity (Janssen et al., 2005), increased muscular strength and endurance, higher bone density, and improved flexibility (Côté & Hay, 2002; Wankel & Berger, 1990), which in turn result in a decreased risk of chronic disease. Emotional benefits of regular physical activity include lower levels of stress (Haugland, Wold, & Torsheim, 2003) and an improved mental state (Mutrie & Parfitt, 1998), while intellectually, regular physical activity can result in improved academic performance (Dwyer, Sallis, Blizzard,
Lazarus, & Dean, 2001). Sport and physical activity settings provide a social environment for adolescents to connect with friends and adults who model active behaviours (Wankel & Berger, 1990).

Healthy eating habits have also been shown to provide numerous health benefits. Children and adolescents who maintain a healthy, nutritious diet will also maintain a healthier body weight and decrease their chances of developing type 2 diabetes as adults (Rinderknecht & Smith, 2004). Additionally, healthy eating is associated with weight control, which can help to prevent chronic disease (Rinderknecht & Smith, 2004).

3.6 Factors Influencing Wholistic Health in Aboriginal Youth & Families

Achieving and maintaining wholistic health and wellness, as an individual or as part of a family is an intricate process that is dependant on a number influencing factors. According to the Fraser Valley Aboriginal Wellness Steering Group (2002):

Wellness describes a condition of optimal wellbeing. Children who enjoy wellness reflect family health. Members of healthy families possess personal purpose, value family membership, seek information, offer assistance, make choices, experience humility, have a sense of humour, believe in an optimistic future, identify with family heritage and possess a relatively secure personal identity. Wellness is balancing the physical, emotional, intellectual, and spiritual aspects of life. (as cited in Mussell et al., 2004, p.13)

Many health interventions and health education efforts have traditionally focused on the individual, however there are multiple levels of influence that can shape behaviour (Sallis & Owen, 2002). According to Stokols (1992), using an ecological framework that recognizes these multiple layers of influence helps to shift the focus from the individual level to also include
higher levels of influence that involve other aspects of the person’s environment. Researchers who use ecological models recognize five levels of influence on health-related behaviours. These five levels can be leveraged as targets for intervention programs: (1) intrapersonal characteristics, (2) interpersonal processes and primary groups, (3) institutional factors, (4) community factors, and (5) public policy (McLeroy, Bibeau, Steckler, & Glanz, 1988). Family would be considered an interpersonal level of influence (i.e., primary group). Evidence strongly suggests that health problems are clearly linked with social structures and conditions, and therefore lack of success in any given behaviour change attempt is not always the result of failure at the individual level (Gauvin et al., 2001). The ecological model helps to highlight complexities in the relationships between humans, their health, and the environment by broadening the vision of the determinants of health beyond the individual (Gauvin et al., 2001).

Family poverty, living with a lone-parent, and community poverty are all factors in a child’s environment that can potentially decrease their participation in health promoting behaviours. Socio-economic disadvantages at the family level can contribute to the development of adolescent health problems (Wickrama, Conger, Wallace, & Elder, 1999). Decreased access to resources for health, such as proper food, health services, and recreational facilities, and an increased likelihood that parents will pass unhealthy behaviours onto their children, are all factors associated with family poverty (Fitzgivvon et al., 1997; Wickrama et al., 1999). Aboriginal Peoples and members of lone-parent families are much more likely than the general population to be living on low incomes (Statistics Canada, 2004).

Approximately 58% of Aboriginal children in Canada live with both parents compared with almost 82% of non-Aboriginal children (Statistics Canada, 2008a). Aboriginal children aged 14
years and under are much more likely to live with a single parent than their non-Aboriginal peers (Statistics Canada, 2008a). Twenty-nine percent of Aboriginal children live with a lone mother and 6% with a lone father (Statistics Canada, 2008a). In Kingston, of the 1540 Aboriginal adults in census families, 145 were lone parents, and 115 of these were lone mothers (Statistics Canada, 2008e). Of all the major economic family types defined by Statistics Canada, lone-parent mothers continue to have the lowest median income (Statistics Canada, 2008b). According to Statistics Canada (2004), in 2000, “lone-parent family persons comprised 7.3% of the population but 19.3% of the low income population” (p. 29). Aboriginal youth have a very high likelihood of living in lone-parent families, experiencing family poverty, and being exposed to all the associated negative health consequences.

Community poverty also has an impact on adolescent health and contributes to the accumulation of undesirable health-outcomes such as substance use and chronic disease (Auchincloss & Hadden, 2002; Wickrama, Wickrama, & Bryant, 2006). Some of the factors related to community poverty that may contribute to negative health outcomes for adolescents include: limited availability of health resources (Sorenson, Emmons, Hunt, & Johnston, 1998); erosion of community norms and values (Wickrama & Bryant, 2003); lack of positive role models promoting health among youth (Kowaleski-Jones, 2000); and erosion of social trust and cohesion among residents (Wickrama et al., 2006). In poor communities, negative health behaviours are hard to control due to a lack of collective efficacy (Browning & Cagney, 2004). In 2000, “11.7% of Aboriginal people lived in low income neighborhoods” (p.7), and the likelihood of an Aboriginal person living in a low-income neighborhood (11.9%) was more than double that of the overall Census Metropolitan Area (CMA) population (4.4%; Statistics Canada, 2004).
3.7 Influence of Family on Health & Behaviour Change

3.7.1 Family Influence

There are many aspects of family relationships and family structure that contribute to the health and wellbeing of a child. A child’s socio-cultural context, including the family, may be responsible for teaching health-related behaviours (Crossman, Sullivan, & Benin, 2006). Early socialization and child development within the family and community contexts can contribute significantly to the development and maintenance of health disparities into adulthood (Kendall & Li, 2005). “Family health promotion is a critical element of primary health care” (Ford-Gilobe, 1997, p. 205), therefore, it is important that healthy behaviours be promoted in the home starting at a young age.

While the family context lays the foundation for teaching health-related behaviours, the relationship between parent and child also contributes significantly to a child’s overall health and wellbeing. For instance, values and norms about weight promoted by parents have a strong influence on a child and oftentimes the closer children are to their parents, the more likely their parents’ values and norms become their own (Hirschi, 1991). For example, factors that decrease a female adolescent’s risk of becoming overweight as a young adult include having a higher parental educational attainment, a higher self-esteem, and a stronger perception that her parents care about her (Crossman et al., 2006). A child’s eating and exercise habits are strongly influenced by family (Teufel et al., 1999), and parental physical activity levels can influence the physical activity levels of their children (Sallis, Prochaska, & Taylor, 2000).
Epstein, Valoski, Wing and McCurley (1994) suggest that having friend and family support for individual behaviour change assists with the achievement and maintenance of positive outcomes. Specific behaviour-change strategies, like positive reinforcement from parents, may improve the likelihood of a child achieving maximal effectiveness in a behaviour change attempt (Epstein & Wing, 1987). Therefore, including family members in attempts to promote health-related behaviours to children may increase message uptake in this population.

### 3.7.2 Family & Behaviour Change

Consistent with an ecological perspective that considers the interpersonal environment important in influencing the behaviour of a given population (e.g., children), the family is seen as a huge source of behavioural influence for Aboriginal Peoples (Cheah & Nelson, 2004). This is why it is critical to consider the historical trauma of the residential schooling experience that removed children from their families, and thus interfered with the Aboriginal family structure and its cultural foundations (Aboriginal Healing Foundation, Legacy of Hope Foundation, & the National Archives and National Library of Canada, 2003). Residential schools have left behind a generation of individuals who were denied the opportunity to know what it means to be part of a family and who are now struggling to create healthy families of their own (Kirmayer, Simpson, & Cargo, 2003).

Given the significance of family in Aboriginal cultures (Cheah & Nelson, 2004), family members may be especially important for supporting health related behaviours. Children are held in very high regard in Aboriginal cultures; the family unit itself is often large and includes members of the extended family who assist in helping to raise the children (Dilworth-Anderson & Marshall,
Any attempts to influence health behaviours will likely be enhanced by the involvement of the entire family.

3.8 Health Promotion through Families

In a review of the literature surrounding the promotion of physical activity participation among children and adolescents in school, family, primary care, and community settings, Salmon and colleagues (2007) concluded that more evidence was required to support the effectiveness of interventions promoting physical activity in family and community settings. Of the family-based interventions the researchers examined, many were aimed at youth from an ethnic minority or low socioeconomic status. Only three of the nine family-based interventions reviewed by Salmon and colleagues (2007) reported positive outcomes approaching significance, however high levels of cooperation and comprehension were observed in most families. So, while positive effects have been seen in family based interventions, the lack of overwhelming support indicates that researchers do not yet know how best to leverage the influence of family through these interventions.

Research with Aboriginal families by Teufel and colleagues (1999) demonstrates the effectiveness of take-home family-based information packages at increasing health-related knowledge. However, more information is needed on the specific factors that influence health in urban Aboriginal youth, the barriers to engaging in healthy behaviours (Fila & Smith, 2006), and how best to ensure the participation of all family members (Teufel et al., 1999).
3.9 Strategies to Influence Change

3.9.1 Diffusion of Innovation

Rogers (1995) defines diffusion as “the process by which an innovation is communicated through certain channels over time among the members of a social system” (p. 5). Innovations are ideas, practices, or objects that are considered new to members of a social system. They are generally defined by five characteristics that indicate how they relate to potential adopters: 1) relative advantage, 2) compatibility, 3) complexity, 4) trialability, and 5) observability. Adopters are those people who choose to accept an innovation and since innovations are not simultaneously adopted by all people in a social system, adopters are categorized by differences in their innovation-decision period. Generally the uptake of a successful innovation is slow to start, but speeds as people start to see others adopting, and the norms of their social system begin to favour adoption (Rogers, 1995).

Diffusion of innovation has been shown to be a useful framework for designing successful health behaviour interventions by increasing the number of adopters (Oldenburg & Parcel, 2002). This model is especially useful in assisting with the challenges of disseminating effective programs to large audiences (Owen, Glanz, Sallis, & Kelder, 2006).
3.9.2 Social Marketing

Over the past several decades, numerous approaches and strategies have been used when attempting to disseminate ideas for change (Kotler & Roberto, 1989). Developed in 1971, social marketing seeks to change behaviour by using the “best-practices” from several accepted social change approaches (Kotler & Roberto, 1989).

Social marketing is the application of commercial marketing technologies to the analysis, planning, execution, and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of the society of which they are a part. (Andreasen, 1995, p. 7)

According to Kotler & Lee (2008) there are ten necessary steps in the development of a social marketing campaign (Table 3-1).

Table 3-1: *Ten Steps to Develop a Social Marketing Plan*

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Background, Purpose, and Focus</td>
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<tr>
<td>2.0</td>
<td>Situation Analysis</td>
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<tr>
<td>3.0</td>
<td>Target Market Profile</td>
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<tr>
<td>4.0</td>
<td>Marketing Objectives &amp; Goals</td>
</tr>
<tr>
<td>5.0</td>
<td>Target Market Barriers, Benefits, and the Competition</td>
</tr>
<tr>
<td>6.0</td>
<td>Positioning Statement</td>
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<tr>
<td>7.0</td>
<td>Marketing Mix Strategies (4Ps)</td>
</tr>
<tr>
<td>8.0</td>
<td>Evaluation Plan</td>
</tr>
<tr>
<td>9.0</td>
<td>Budget</td>
</tr>
<tr>
<td>10.0</td>
<td>Implementation Plan</td>
</tr>
</tbody>
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(adapted from Kotler & Lee, 2008, p.36)
These ten steps direct social marketers in choosing a defined audience, with a specific need, and in developing, evaluating, and implementing a campaign to sell a product (e.g., behaviour) that fills that need (Kotler & Lee, 2008). Each step builds upon the previous one and helps to inform the next. For example, one cannot determine marketing goals and objectives prior to establishing a profile of the target market, nor can one assess target market barriers, benefits, and the competition without knowing the objectives and goals.

Although social marketing stems from commercial marketing, it differs from the latter in one very crucial way – products are for the most part intangible or non-physical (Lefebvre & Flora, 1988). Social marketing products are ideas, attitudes, and/or behaviours (Lefebvre & Flora, 1988). Campaigns often use the concepts from exchange theory, audience segmentation, competition, and the marketing mix (Grier & Bryant, 2005) to sell products in the form of beliefs, attitudes, values, practices (acts or behaviours), and in some cases, tangible objects (Kotler & Roberto, 1989).

Exchange theory, a core concept of traditional marketing, stipulates that perceived benefits must outweigh perceived costs in order for the intended audience to partake in an exchange (Bagozzi, 1978). This theory has been expanded in recent years to account for situations in which more than one party may be involved in an exchange and that a third party may be the primary beneficiary of an exchange (Bagozzi, 1974, 1978). Audience segmentation is also critical for social marketing success. When contemplating the intended audience of a social marketing campaign, it is important to determine commonalities among audience members while also ensuring the size, access, and perceived receptivity of the group (Kotler & Lee, 2008).
Another concept necessary in a social marketing campaign is the concept of competition, which can be identified as: the behaviours that the intended audience currently prefer over the desired behaviour, the negative behaviours that have become “habits”, and/or the organizations that promote messages that conflict with that of the desired behaviour (Kotler & Lee, 2008). Oftentimes, competition is considered when determining the price, place, and promotion elements of the marketing mix. The marketing mix is made up of four areas of influence referred to as the 4 P’s: product, price, place and promotion (Smith, 2000).

The first P in the marketing mix is “product”. When your product is a behaviour, the benefit of adopting that behaviour is referred to as the “core product”, while the desired behaviour itself is the “actual product” (Kotler, Roberto, & Lee, 2002). The actual product(s) must be specific and identify what needs to be done in order to achieve the benefits stated as the core product (Kotler & Lee, 2008). For a social marketing campaign to be successful, the product must solve a perceived problem or offer a benefit that is of value to the target audience (Grier & Bryant, 2005).

The perceived and actual costs of engaging in the desired behaviour are referred to as the price (Kotler & Lee, 2008). Price is often related to barriers (Kotler & Lee, 2008) and outlines what the intended market must give up in order to engage in the desired behaviour, or to obtain the benefits of the product (Bryant, Forthofer, Landis, & McDermott, 2000). Such costs may be tangible (i.e., monetary) or intangible (i.e., non-monetary) and are always considered from the consumer’s standpoint (Grier & Bryant, 2005; Kotler & Lee, 2008). Intangible or non-monetary costs may be related to time, energy, effort, psychological risk, or physical discomfort (Kotler & Lee, 2008).
The concept of place is largely based on providing the target market with easy access to the desired behaviour (Smith, 2000). Place refers to where the consumer will perform the desired behaviour and/or receive any related goods and services (Kotler et al., 2002; Kotler & Lee, 2008). It also refers to the placement of information regarding the desired behaviour (Bryant et al., 2000).

The last “P”, promotion, focuses largely on disseminating product benefits (Kotler et al., 2002), and is concerned with making the campaign visible to the intended audience (Grier & Bryant, 2005). Decisions regarding messages, messengers, and communication channels are all made when addressing this last component of the marketing mix (Kotler & Lee, 2008). Messages include information regarding the benefits and features of the product, as well as any items or services related to the desired behaviour (Kotler & Lee, 2008).

### 3.9.3 Real-world Application of Social Marketing to Physical Activity Promotion

The multiethnic media campaign, VERB™, used a social marketing framework to promote increased participation in physical activities to tweens (i.e., children aged 9-13 years; Wong et al., 2004). The product of this campaign was physical activity, and extensive market research, including focus groups and interviews, was conducted with tweens, parents, adults who work with tweens, and industry professionals, to determine appropriate strategies to address price, place, and promotion (Berkowitz et al., 2008; Wong et al., 2004). This market research was used to guide the creation of strategies for developing, distributing, and evaluating campaign messages to the general audience, while additional market research with four ethnic audiences: 1) African Americans, 2) Hispanics, 3) Asian Americans, and 4) Native Americans, resulted in the
development of culturally-relevant strategies and messages adapted to the preferences of each of these populations (Huhman et al., 2008). Information obtained from audience research was then used to develop a national media campaign (e.g., paid media advertisements) to increase tween familiarity with the VERB™ brand and messages and to conduct smaller community level interventions across the country (e.g., hosting an “activity zone” at existing community events; Wong et al., 2004).

Results from a two year follow-up survey indicated that experience and familiarity with VERB™ messages resulted in increased physical activity levels and positive attitudes towards physical activity in tweens (Huhman et al., 2007). The success of the VERB™ campaign lends support to the idea “that a national media campaign with strong social marketing elements in many communities can have a demonstrable and important impact on physical activity at the population level, nationwide” (Cavill & Malibach, 2008, p. 1).

3.9.4 Summary of the Models

Diffusion of Innovations is generally used to inform large audiences of a new innovation (Rogers, 1995). Typically, the product or message to be disseminated is known before a dissemination plan is developed. By contrast, a Social Marketing framework can be applied at an earlier phase, when the product, message and strategy for diffusion to a particular audience are being developed (Kotler & Lee, 2008). It outlines a procedure for learning about the intended audience in a way that will optimize the uptake of the message or object of diffusion. Therefore, I chose Social Marketing as the framework for this project.
3.10 Research Aim

Given a lack of knowledge about the best way to leverage the influence of family to positively impact wholistic health, this thesis will use a social marketing approach to inform the development of strategies and resources to engage urban Aboriginal families in supporting wholistic health messages received through AKWE:GO (a community-based outreach program for at-risk urban Aboriginal youth). More specifically, the research aim is to use a social marketing framework to gain a greater understanding of AKWE:GO family perceptions of wholistic health, the personal and familial factors that influence AKWE:GO family wholistic health practices, and to develop effective strategies and resources (i.e., a campaign) for wholistic health promotion to AKWE:GO families.
Chapter 4

Methods

4.1 History of Research in Aboriginal Communities

Past experiences with researchers have left Aboriginal Peoples feeling used and has created distrust for the research process (Smith, 1999). The collection, classification, and representation of indigenous knowledge by western researchers was supportive of imperialism (Smith, 1999), and rather than collaborate with communities from the start, researchers would often present completed research designs and anticipate meaningful community involvement (NAHO, 2004). This way of working allowed the researcher to essentially “use” the Aboriginal community for a specified purpose and then leave the community no better than when they had arrived. Many of the problems with Aboriginal-based research are related to who is in control, influencing what gets done, how it gets done, and who knows about it (NAHO, 2004).

With increasing awareness of past research abuse, more and more researchers are interested in alternative methodologies that are respectful of and beneficial to Aboriginal Peoples and communities. Researchers are encouraged to use decolonizing methodologies (Smith, 1999), indigenous knowledge, and relevant teachings and perspectives to help shape the research framework (Lavallée, 2007) rather than imposing westernized approaches and views.
4.2 Research Ethics in Aboriginal Communities

The Interagency Advisory Panel on Research Ethics (PRE) and the National Aboriginal Health Organization (NAHO) have developed ethical guidelines for conducting research with human subjects. PRE, comprised of the Canadian Institute of Health Research (CIHR), the Natural Science and Engineering Research Council of Canada (NSERC), and the Social Sciences and Humanities Research Council (SSHRC) has developed joint guiding ethical principles in the form of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, which are representative of common standards and values among researchers from across disciplines. While Tri-Council funded researchers must abide by these ethical principles, many other research agencies also require researchers to adhere to these ethical principles given that they are generally accepted as the national standard for the proper treatment of human subjects. These principles include: respect for human dignity, respect for free and informed consent, respect for vulnerable persons, respect for privacy and confidentiality, respect for justice and inclusiveness, balancing harms and benefits, minimizing harm, and maximizing benefit (Canadian Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada [NSERC], & Social Sciences and Humanities Research Council of Canada [SSHRC], 1998). Queen’s University General Research Ethics Board (GREB) is mandated to ensure that researchers at Queen’s adhere to the principles set out by the Tri-Council and this project has received ethics approval from GREB.

CIHR and the Institute of Aboriginal Peoples Health (2007) have also developed guidelines for research involving Aboriginal Peoples to address the specific needs that arise when research is conducted in Aboriginal communities. These guidelines promote research processes that are
respectful of Aboriginal values and traditions and the development of research partnerships that encourage mutually beneficial and culturally sound research (CIHR, 2007).

NAHO is a not-for-profit organization, created and controlled by Aboriginal people, that seeks to advance the health and wellbeing of Aboriginal Peoples through the creation, interpretation, and dissemination of knowledge (NAHO, 2007). The principles of Ownership, Control, Access and Possession (OCAP) were developed by NAHO in response to the negative practices of Western researchers in Aboriginal communities; they aim to provide Aboriginal Peoples with more autonomy in the research process (NAHO, 2004). OCAP principles are applicable to all forms of research and information gathering concerning Aboriginal Peoples and continue to evolve (NAHO, 2004). Although communities and researchers are not obliged to adhere to these principles, many do. As per the principle of ownership, the cultural knowledge and data collected from a community is owned by that community and if there is a lack of trust between an Aboriginal community and those in possession of the data, the community may assert the principle of possession to retain the data (NAHO, 2004). Aboriginal communities also have the right to retain control of their lives and institutions and to seek control of any processes pertaining to research or information management (NAHO, 2004). Finally, Aboriginal Peoples have the right to access any information obtained about themselves and their communities and the right to decide who has access to this information (NAHO, 2004). While Ms. Prue and I outlined no formal agreement regarding these principles, it was understood that we would follow them in spirit. Research findings from this project were presented at the Native Friendship Centre and participants were fully informed of the intended use of the information collected prior to partaking in a sharing circle and they were invited to provide active consent. They were also informed that they could request a full description of the results at anytime.
4.3 Research Approach & Conceptual Framework

This project grew out of a collaboration between myself and Ms. Prue when we met to see how I might be of assistance to her and her program. We were cognizant of the negative research history between academics and Aboriginal groups so it was important to establish a basis for collaboration that was mutually beneficial and respectful of Aboriginal cultures. Thus we adopted a Community Based Participatory Approach consistent with an indigenous framework. Ultimately, community-based participatory approaches and indigenous frameworks represent the same ideas of collaboration and respect and are simply called by different names (i.e., community-based participatory approach is the term preferred by western researchers). An indigenous framework is considered decolonizing (Lavallée, 2007) as it recognizes the connection between research and colonial practices and seeks the integration of indigenous concerns, practices, and participation in the research process to uphold the ultimate goal of the indigenous research agenda: self-determination (Smith, 1999).

The approach taken by myself and Ms. Prue was similar to the Community Involvement to Renew Commitment, Leadership, and Effectiveness (CIRCLE) framework developed by three Aboriginal community-based public health and research professionals. The CIRCLE framework embraces the principles of Community Based Participatory Research (CBPR) (Chino & DeBruyn, 2006; Minkler & Wallerstein, 2003). As its name suggests, CIRCLE is a cyclical process involving four main steps: 1) building relationships, 2) building skills, 3) working together, and 4) promoting commitment. To reinforce the importance of building strong relationships in Aboriginal cultures, an important time commitment is usually dedicated to step one (Chino & DeBruyn, 2006).
4.3.1 Community Based Participatory Research

Community Based Participatory Research (CBPR) encourages collective learning among local people and outsiders and is an exercise in both communication and the transfer of knowledge (Wallerstein & Duran, 2003). After years of researchers coming into Aboriginal communities, taking the information they want, and then leaving (Deloria, 1992), CBPR is a refreshing approach that encourages researchers to partner and collaborate with communities for the benefit of communities and academics (Wallerstein & Duran, 2003) and is very consistent with values and practices of some Aboriginal groups (Cargo et al., 2008).

When conducting research of this nature, it is crucial that the community is incorporated into all aspects of the research process as CBPR requires a strong relationship between community members and outside researchers (Brown & Vega, 1996). When working within an unfamiliar cultural context, it is important that researchers be open and respectful of alternative ways of working (Sullivan et al., 2003). Mutual respect and trust among partners are considered to be core elements of CBPR (Cargo & Mercer, 2008). It was essential to the success of the project that Ms. Prue and I establish a strong working relationship.

One of Dr. Lévesque’s former students had volunteered with Ms. Prue and the AKWE:GO program. I contacted Ms. Prue hoping that I too could be of assistance to this program within the context of a community-academic partnership experience. Ms. Prue was open to a collaboration and suggested that I first familiarize myself with the AKWE:GO program by attending an AKWE:GO session so I accompanied the children on a March Break outing. During my visits to the Katarokwi Native Friendship Centre, I learned about the many programs offered there. I also
learned about some of the traditions and teachings that inform the Centre’s work. For example, when we decided to ask an Elder to help with several components of the project, I learned how to offer tobacco when extending the request.

The direction for this project came from Ms. Prue. She indicated that there seemed to be a disconnect between the health messages AKWE:GO participants received at program (e.g., being physically active, cooking healthy meals, building self-esteem, etc.) and those they received at home. It was the identification of this gap that led us to apply for funding through a Heart & Stroke Advocacy Planning Grant. Ms. Prue and I met on a weekly basis away from the university campus to discuss ideas for research and dissemination.

There is a continuum of participation in CBPR ranging from minimal community involvement in the decision making processes to a community-controlled model with minimal researcher input (Cargo et al., 2008). Given the close working relationship between Ms. Prue and I, and our consultation with Ms. Hooper, a respected community Elder, this project can be considered an example of shared decision making and is situated in the middle of the continuum indicating more consistent opportunities for equal decision making among partners (Cargo et al., 2008).

Ms. Prue is a specialist in Aboriginal social work. She has Mohawk heritage and, as a recognized member of the Aboriginal community, she was trusted to speak on behalf of our intended audience throughout the research process. Her connection to and familiarity with the parents and children involved with the AKWE:GO program at the Katarokwi Native Friendship Centre through her position as a social worker allowed her to direct research efforts in a way that was respectful and beneficial to all participants. Ms. Prue’s inclusion in the grant writing process was
also a first step towards building capacity within this community and developing partnerships
with outside agencies, such as the Heart & Stroke Foundation of Ontario and Queen’s University.
The Heart & Stroke Foundation’s commitment to improve the wellbeing of children facing
increased barriers to healthy living and the AKWE:GO program’s mandate to provide at-risk
children aged 7-12 years with the necessary skills and resources to make healthy life choices
made this an ideal partnership.

While the overall campaign had three main aims: 1) to increase community stakeholder
awareness of the AKWE:GO program, 2) to recruit volunteers, and 3) to engage families living
on low incomes to support wholistic health messages received by AKWE:GO regarding healthy
living in the home setting, this project focuses on the third aim. Therefore, once we had a clear
idea that our project aim was to develop strategies and resources that would best engage families
in supporting the wholistic health messages received through AKWE:GO and that our research
aim was to uncover how best to do this from the parents and children themselves, we established
a protocol for working together and agreed to meet weekly. My background in health promotion
and research was beneficial in the grant writing process, development of the literature review, and
establishment of the research methodology. Ms. Prue’s heritage, background in social work, and
experience working with AKWE:GO parents and children provided necessary insight to ensure
the cultural relevance of the research design and implementation plan. Cultural relevance was
addressed in the wording of documents and questions, appropriateness of recruitment methods,
use of the sharing circle, and involvement of a community Elder (i.e., Ms. Hooper). All major
decisions related to the project were approved by both Ms. Prue and I. From the very beginning,
this project was a true collaboration that required our combined knowledge and skill set and a
recognition that neither one of us could do it alone.
Funding (i.e., a budget) was provided by HSFO to develop and carry out activities related to implementation. Unfortunately, there was not enough funding to conduct an evaluation of the implementation and thus, this project was limited to the development and implementation phases only.

4.3.2 Conceptual Framework

In keeping with the indigenous framework and CBPR approach, we agreed that the input of those we intended to engage (i.e., the families) was needed. When seeking to understand the complicated issues related to people’s experiences and perceptions, qualitative methods are generally used (Patton, 2002). Given that the research aim was to explore what types of strategies and resources would best engage families in supporting the wholistic health messages received through AKWE:GO, I determined that social marketing would be the most practical and relevant framework to guide the data collection. For the purposes of this project, we considered the strategies and resources we identified and developed as products for dissemination. A product is a belief, idea, commodity, behaviour, or service (Kotler & Roberto, 1989; Smith, 2000) that can be offered to fulfill an existing need (Kotler & Keller, 2005).

Social marketing seeks to invoke voluntary behaviour change by using techniques common in commercial marketing to sell behaviours and their benefits to a specific audience (Andreasen, 1999). Social marketing procedures can be useful in painting a clearer picture of the intended audience by examining their needs and values, as well as their perceptions about specific behaviours. Since this project is based on promoting wholistic health, we predetermined this to be
our core product, while the participants, through our discussions, determined our products for dissemination (i.e., actual products).

4.4 Study Context & Recruitment

In its initial conception, this study was going to be limited to the Katarokwi Native Friendship Center. However, after discussions with one of the provincial AKWE:GO Programme funders and Ms. Prue, I was invited to attend the annual meeting of all the AKWE:GO coordinators in Ontario to provide them with information about this project. The funder and Ms. Prue thought there might be an interest in this project from other AKWE:GO coordinators, and in particular the coordinator at the M’Wikwedong Cultural Resource Centre in Owen Sound given that this Centre had previously applied for HSFO funding.

4.4.1 Centre Recruitment

I created project information packages to take to the annual meeting that included a one page summary of the project (Appendix A), information on how to get involved (Appendix B), and an appendix with all necessary supporting documentation (Appendix C). Ms. Prue discussed the project with other coordinators at the meeting and provided project information packages to coordinators who expressed interest. These coordinators were also asked to place their names and contact information on a list of interested centres. After my discussion with Ms. Prue and her funder, she contacted the AKWE:GO coordinator at the M’Wikwedong Cultural Resource Centre, Ms. Mara Bouwman, who then indicated that she would like to hear more about the project. As a result, I met separately with Ms. Bouwman to provide additional details and to
answer any questions that she might have. At that meeting she agreed to participate in the project and took a Centre Letter of Information and Center Consent Form (Appendixes D & E) to show to the proper authority at the M’Wikwedong Cultural Resource Centre. A follow-up email (Appendix F) was sent to the other 13 coordinators who expressed interest at the meeting. None of these centres responded to the email. Due to this lack of response and limited availability of funding for travel to other centres, participating centres were limited to Kingston and Owen Sound. Since Ms. Bouwman agreed to participate, she was asked to complete the AKWE:GO Program Coordinator Survey (Appendix G) via telephone. This survey allowed us to plan sharing circle visits and logistics according to the preferences of the community.

4.4.2 Participant Recruitment

In Kingston, participants were recruited by Ms. Prue and I. Using the names and contact information of the approximately 64-70 children who were involved with AKWE:GO during the school year, we contacted their parents by phone. When there was no answer, a message was left on the answering machine to contact Ms. Prue to hear more about the project and the potential to participate. Follow-up calls were also made during the following week. Parents who did answer the phone were read the Verbal Recruitment Script by Ms. Prue or I (Appendix H) so that they could determine whether or not they would like to participate. Once a parent had agreed to participate, he/she was asked to attend one of the two sharing circle dates. A follow-up call was made the day prior to his/her attendance as a reminder.

Children ages 7-13 years were recruited after parents. Parents attending sharing circles were informed of their children’s opportunity to participate through the Parents’ Letter of Information (Appendix I) and were asked to sign a Parental Consent form (Appendix J) to give permission for
their children to participate in a sharing circle. Since we felt that all children should be given a chance to participate, parents who decided not to participate in the sharing circles themselves were informed over the phone (using the Verbal Recruitment Script) about the opportunity for their children to participate in a sharing circle. If the parent expressed interest, he or she would be read the Children’s Letter of Information (Appendix K). If he or she agreed to let their children participate, verbal consent was obtained by the researcher.

Children whose parents had given consent (either by phone or after they had participated in the sharing circle) were approached by Ms. Prue and asked if they wanted to participate in a sharing circle. Ms. Prue explained the contents of the Children’s Letter of Information and obtained verbal assent from those children who were interested.

In Owen Sound, all participant recruitment was done by the program coordinator, Ms. Bouwman. The recruitment process was outlined for her and she was given a copy of the Kingston parent and child Letters of Information (Appendixes I & K), and the Verbal Recruitment Script (Appendix H). Parent and child Letters of Information were later adjusted to be specific to Owen Sound by substituting the proper names and places.

To ensure the success of the sharing circles, we wanted to provide snacks, refreshments, transportation, and child-minding (for parent circles). Given that the funding provided though the HSFO Advocacy Planning Grant was to be spent directly on activities outlined in the grant application, this money could not be used towards these amenities. Therefore, we contacted HSFO and outlined our plan to engage with AKWE:GO parents and children to inform our
advocacy campaign and HSFO then allocated an additional $1160 to be used towards the facilitation of sharing circles.

### 4.5 Participants

As per the recommendations of Krueger (1994), we attempted to recruit approximately eight participants for each sharing circle. However, the number of participants in each circle varied, depending on interest and availability. Six sharing circles were held in total- 3 parent circles and 3 child circles. In total, 15 parents (12 female, 3 male), 2 adults who were not parents (1 female, 1 male), 23 children (13 female, 10 male), and 3 female Elders participated. Table 4-1 summarizes this information.

**Table 4-1: Sharing Circle Locations and Participants**

<table>
<thead>
<tr>
<th>Location</th>
<th>Group type</th>
<th>Number of groups</th>
<th>Number of participants</th>
<th>Male/Female count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston</td>
<td>Parents</td>
<td>2</td>
<td>8 (7 parents, 1 Elder)</td>
<td>8 female</td>
</tr>
<tr>
<td></td>
<td>Children</td>
<td>2</td>
<td>19</td>
<td>10 female 9 male</td>
</tr>
<tr>
<td>Owen Sound</td>
<td>Parents</td>
<td>1</td>
<td>12 (8 parents, 2 non-parents, 2 Elders)</td>
<td>8 female 4 male</td>
</tr>
<tr>
<td></td>
<td>Children</td>
<td>1</td>
<td>4</td>
<td>3 female 1 male</td>
</tr>
</tbody>
</table>
4.5.1 Parents

Seven women (average age = 33.7 years, average length of child’s participation in program = 17.6 months) participated in two parent sharing circles conducted in Kingston. Most participants were single mothers and many were unemployed and/or collecting a disability allowance. Each mother had more than one child and was their primary guardian.

One sharing circle only had one participant due to several last minute cancellations. We still wanted to allow the one parent to share her thoughts and ideas, therefore Ms. Prue, Ms. Hooper, and I participated to maintain our sharing circle methodology. Ms. Hooper’s contributions were used during analysis, but contributions by Ms. Prue and I were not used as these were biased by our involvement in the creation of the sharing circle guide.

Eight women and four men (average age = 39.4 years, average length of child’s participation in program = 15 months) participated in one parent sharing circle held in Owen Sound. Two of these participants were Elders from the community and two were not parents. Parents in the circle had children in the AKWE:GO, Community Action Program for Children (CAPC), and Urban Multipurpose Aboriginal Youth Centres (UMAYC) programs. The CAPC program is for children ages 0-6, and the UMAYC program is for youth aged 12-24. In the welcoming Aboriginal tradition of the M’Wikwedong Cultural Resource Centre, it was not appropriate to exclude any willing participants for not being parents or not having children in the AKWE:GO program.
4.5.2 Children

Ten girls and nine boys participated in two child sharing circles held in Kingston and three girls and one boy participated in one child sharing circle held in Owen Sound. All children were participants in the AKWE:GO program and therefore between the ages of 7-12 years.

4.6 Data Collection

Research in social marketing oftentimes uses approaches common to market research, such as group discussions with members of the intended audience and product testing (Smith, 2000). Participants for sharing circles are often chosen based on common characteristics and relation to the discussion theme (Krueger, 1994). In Aboriginal cultures, sharing or talking circles provide a space where one can speak freely and without judgment. These types of circles are often used for healing purposes (University of Saskatchewan, 2003) and offer a space to build relationships and self-confidence, and to un-burden the mind (Joseph, 2005). Oftentimes, a feather or talking stick is used to determine who is speaking; the circle opens with a prayer, everyone is to respect the person who is speaking, and nothing said within the circle is repeated outside of the circle (Joseph, 2005; personal communication, B. Hooper, December 5, 2007). Although contradictory to traditional sharing circle practice, it was necessary to tape-record and transcribe sharing circle discussions for the purposes of the research process. The guiding principles of traditional sharing circles were still upheld to encourage free thought and speech. Furthermore, parents and children understood that this project strives to enable Aboriginal families to promote wholistic health in the home, thus, parents and children were willing to participate in this atypical sharing circle.
In Western research, sharing circles are often referred to as focus groups. Focus group discussions are designed to obtain the ideas and opinions of participants as they pertain to a specific topic (Krueger, 1994), which is particularly useful for social marketers hoping to get to know their intended audience. Ideally, 7 to 10 participants are present at each focus group and a minimum of three focus groups are conducted for any given topic (Krueger, 1994).

4.6.1 Development of Sharing Circle Guides

Sharing circle guides (one parent, one child) were developed with the core product of wholistic health and the marketing mix in mind and most questions were coordinated with one of the following concepts: product, price, place, promotion, or competition\(^3\) as illustrated in Table 4-1.

<table>
<thead>
<tr>
<th>SOCIAL MARKETING CONCEPT</th>
<th>RELATED SHARING CIRCLE QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product</td>
<td>- Describe a healthy/balanced person.</td>
</tr>
</tbody>
</table>

\(^3\) Although not one of the 4P’s, competition was included as a social marketing concept due to its association in determining strategies related to price, place, and promotion (Kotler & Lee, 2008). Bryant, Forthofer, Landis, and McDermott (2000) recommend the inclusion of competition as part of marketing’s conceptual framework in order to gain a greater understanding of the risk behaviours in which the intended audience may currently be engaged.
| Price          | - What makes it hard to engage in these activities?  
|               | - What would make it easy to engage in these activities?  
|               | - Some activities have barriers that can’t be changed, so what would make those barriers acceptable to you? What would make these barriers not matter?  
| Place         | - Do you think in advance about engaging in healthy behaviours, or does it happen at the spur of the moment?  
|               | - When and where do you get the urge to listen to and act upon health messages?  
|               | - Do you know of any other places in the community that promote health?  
| Promotion     | - From what source/where would you most like to receive information about health? About healthy choices?  
|               | - What are the benefits of each of these activities?  
|               | - In what type of format would you prefer to get information about health and healthy activities?  
|               | - What information would help you to choose a healthy activity?  
|               | - We are going to be putting together materials for your families about promoting the healthy activities we discussed earlier, as we begin this process, what advice do you have for us?  
| Competition   | - What unhealthy activities or behaviours compete with healthy activities?  
|               | - How could the benefits of these unhealthy activities be made less attractive?  
|               | - What are some ideas on how to get you away from these unhealthy activities?  
|               | - Which of these unhealthy activities/behaviours do you think would be easiest to change?  
|               | - What would make healthy behaviours more attractive than these unhealthy behaviours?  

Ms. Prue and I pilot-tested the questions with a volunteer to ensure the responses they elicited were in fact the type of information we were looking for. Ms. Prue changed the wording of some questions (e.g., behaviour to activity) to increase their relevance and accessibility for our intended audience. Copies of the parent and children Sharing Circle Guides (Appendixes L & M) were then reviewed by Ms. Barbara Hooper before being finalized.


**4.6.2 Sharing Circle Facilitation**

In both Kingston and Owen Sound, the AKWE:GO coordinators facilitated the sharing circles while I attended as an observer. A one-page guide to facilitating sharing circles (Appendix N) was developed by me and my supervisor, Dr. Lucie Lévesque. This guide, based on the teachings of Krueger (1998), was used to complement the knowledge Ms. Prue and Ms. Bouwman had about how to facilitate the sharing circles. I met with each of the facilitators to review this guide and the process for conducting the sharing circles. The participation of Ms. Prue and Ms. Bouwman was fundamental to the workings of the sharing circles and the overall project. Ms. Prue was essential in the development of all research activities and materials and in ensuring their cultural relevance, and Ms. Bouwman was fundamental to the recruitment of participants in Owen Sound.

Sharing circles were held at each of the Native Friendship Centres so as to enhance participant comfort through a familiar environment. Healthy snacks and refreshments were provided at the beginning of each sharing circle. On-site childcare was offered during all parent sharing circles, as well as transportation to and from the centre. Since child circles were held during regular AKWE:GO hours, those children who routinely required transportation in order to attend the program were picked up and dropped off by the centre’s volunteer driver as they normally would be. Sharing circles lasted about 1.5 - 2 hours and were tape recorded and subsequently transcribed into NVivo 8 software.

All parent sessions began by having the Parent Letter of Information and Parent Consent Form (Appendixes I & O) read aloud. It was necessary to read these forms aloud as not all parents were
able to read. Participants were then asked to sign or mark their consent form if they agreed to participate. I was assured by the program coordinators that all parents were able to sign their name.

Program coordinators then asked questions according to the Parents’ Sharing Circle Guide (Appendix L). An opening ice-breaker question asking each participant to state that their name was included in the Sharing Circle Guide. The tape recorder was not turned on until after this question was answered by all participants. Participants were notified when the tape-recorder was about to be turned on. The researcher again told participants that, if they were uncomfortable with the tape recorder being on, they were free to leave at anytime. A rain stick was used as a talking stick during Kingston parent sharing circles. Participants held the rain stick while speaking and then turned it over when they had finished. It was then passed around the circle to the next participant who wished to speak. No talking stick was provided for use during the Owen Sound parent sharing circle. Ms. Hooper (Elder) was present at both Kingston parent sharing circles, and two Elders were present at the Owen Sound parent circle. An offering of tobacco was made to all Elders when asked to open and close the sharing circles. In Kingston, the Elder opened with a prayer, a smudging ceremony and an explanation of the traditional guidelines for the talking circle. In Owen Sound one Elder delivered an opening prayer, while the other Elder gave a closing prayer. In both Kingston and Owen Sound, the Elders incorporated culturally relevant, less westernized language.

The children’s sharing circles followed the same protocol as the parents’ sharing circles. Sharing circle times were set around the AKWE:GO program so that children did not have to make a special trip to the Native Friendship Center. Both boys and girls were invited to the same sharing
circle and a healthy snack was offered to participants. Participants in Kingston held a feather when speaking and passed it to the next participant when they were finished. The community Elder explained the significance of the feather while also outlining the traditional guidelines for the talking circle. No feather was used in Owen Sound. Ms. Prue and Ms. Bouwman asked questions according to the Children’s Sharing Circle Guide (Appendix M). An Elder was present at the Kingston children’s circles, while no Elder was present at the Owen Sound children’s circle. The community Elders did not live close to the centre and, given the winter weather and their attendance and participation in the parent circle earlier in the week, Ms. Bouwman decided not invite them to the child circle.

### 4.7 Data Analysis

Sharing circle transcripts were transcribed verbatim\(^4\) using Microsoft Word. Transcription resulted in 172 pages of single-spaced text. The unit of analysis was the sharing circle so all participant responses were anonymous. We were not interested in analyzing the data according to gender or age characteristics as we were interested in making materials that were appropriate for the entire family, and not interested in making materials according to specific characteristics (e.g., male/female). Therefore, inductive and deductive content analysis was conducted on all sharing circle transcripts to identify core consistencies and meanings (Patton, 2002) as managed with NVivo 8 software. Content analysis encompasses both pattern and thematic analysis. Typically, recurring patterns are used to identify themes; these patterns may or may not be quantified depending on the research aims. In the present project, data were grouped into free nodes during

\(^4\) To avoid reinforcing stereotypes and cultural constructions of marginality when reporting findings, linguistic tics were tidied (Standing, 1998). Nevertheless, every effort was made to accurately represent meaning and no words were changed
initial coding. These were then pared down and placed into tree nodes with corresponding parent and child nodes. Deductive content analysis was used to identify common patterns and eventually themes related to the social marketing framework components, while inductive content analysis was used to explore emerging themes. For the deductive analysis, data from the parents and children were examined together in order to discern similarities and differences in parent and child perspectives so as to develop a promotional plan to suit the entire family. For the inductive analysis, only the parent data were retained.

There is always an inherent bias when conducting research because in addition to having chosen which questions to ask, the investigator will always have an influence on how data are interpreted (Rich & Ginsburg, 1999). Although data were interpreted in collaboration with Ms. Prue, the interpretation was partially influenced by me: a white, female researcher from outside the Aboriginal community with a personal worldview. One strategy to attenuate some of this inherent bias was to collect different perspectives on the issue of wholistic health. Conducting sharing circles with both parents and children allowed us to view the problem from different points of view. Ms. Prue’s perspectives also influenced the data. In addition to contributing to the research design and sharing circle facilitation, she brought a more intimate knowledge of the community as a whole, both as the AKWE:GO coordinator and as a social worker. Her perspectives simultaneously constitute a bias and strength of the research. “Comparing the perspectives of people from different points of view” (p.559) is a form of triangulation, which is a method used to add credibility to qualitative research findings by examining the data using assorted methods, sources, analysts, and/or theories (Patton, 2002).
A review of research findings by inquiry participants is another form of triangulation that provides great insight into the accuracy, completeness, fairness, and perceived validity of the research analysis (Patton, 2002). A community level review of this thesis occurred simultaneously with the academic review. Copies of this document were provided to Ms. Willow Prue (AKWE:GO coordinator Kingston), Ms. Barbara Hooper (Elder from the Kingston Aboriginal community), and Ms. Mara Bouwman (AKWE:GO coordinator Owen Sound) for examination. Findings were also presented to participants at the Katarokwi Native Friendship Centre (KNFC) and they were encouraged to provide feedback. No parents disagreed with our findings; however no additional feedback was given. Representatives from the Heart & Stroke Foundation, the KNFC Board of Directors, and Queen’s attended. The presentation was also open to members of the community.

4.7.1 Deductive Content Analysis

In deductive analysis, “data are analyzed according to an existing framework” (Patton, 2002, p.453), which in this study, was social marketing. This framework was based largely on the concepts of competition and the marketing mix (4P’s). Sensitizing concepts (i.e., concepts introduced by the researcher) were used to name themes and orient the data within a social marketing framework (Patton, 2002). Data were initially coded according to sharing circle questions using twelve predetermined themes (Table 4-2).

Table 4-3: Pre-determined Themes for Initial Coding

<table>
<thead>
<tr>
<th>Themes</th>
<th>Related data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceptions of health</td>
<td>Any comments indicating what health means to them</td>
</tr>
</tbody>
</table>
Wholistic | Any comments indicating how they define wholistic
---|---
Physical health | Any activities that they associated with physical health
Mental health | Any activities that they associated with mental health
Emotional health | Any activities that they associated with emotional health
Spiritual health | Any activities that they associated with spiritual health
Barriers | Anything that makes engaging in healthy behaviours difficult
Facilitators | Anything that does/ or would make engaging in healthy behaviours easier
Benefits | Any good things that would result from engaging in healthy behaviours
Competition | Any activities that currently compete with healthy activities
 | Any ideas on how to disengage from competing activities
Community Health Promotion | Any other places in the community known to promote health
Family Activities* | Any activities the children listed as activities they could/ would like to do with their whole family

*A question about family activities was added to the children’s sharing circle guide after discussions from the initial parent sharing circle revealed a “lack of family activities” as a concern for parents

### 4.7.2 Inductive Content Analysis

Following deductive analysis, all transcripts were re-examined and inductive content analysis was also conducted by allowing for the emergence of new themes dictated by the data itself (Patton, 2002). It used the more indigenous practice of drawing on the key terms and phrases cited by participants to define and name new themes (Patton, 2002). When I noticed a phrase or topic was recurring, a new node (i.e., theme category) was created in NVivo 8 to house all data relating to the emerging theme. The name of the node generally reflected the most common recurring word or phrase. Once a new theme was discovered, any transcriptions that had already been re-examined were again re-visited to search for data relating to the new theme. After inductive
analysis was complete, nodes were opened to examine the new themes. This revealed that inductive themes were largely derived from parent sharing circle discussions.
Chapter 5

Results & Discussion

This chapter integrates the study results and discussion. Findings from the deductive and inductive analyses will be presented separately. All data, from parent and child circles in both Kingston and Owen Sound, were taken together to conduct the deductive content analysis. After initial coding during the inductive analysis, only the parent data were retained for full inductive analysis. Findings from the deductive content analysis of responses pertaining to the 4 P’s of the marketing mix (i.e., product, price, place, and promotion) and competing behaviours will be presented first. Inductive content analysis will then be used to highlight themes that emerged from the data during initial coding, mainly differences in emergent themes between Kingston and Owen Sound. These findings will then be used to inform the main goal of AKWE:GO Advocacy Grant Funding (i.e., to inform the development and dissemination of resources and strategies to engage families in supporting wholistic health messages received through AKWE:GO). For the sake of simplicity, this will be referred to as “the campaign” in this chapter. Limitations, recommendations, and implications are discussed.

Given that this project aimed to develop strategies and resources that would best engage families in supporting wholistic health messages, we wanted to know about the challenges families face so that we could address them with our campaign. Therefore, the design of the research and the nature of questioning drew out the challenges and barriers associated with achieving optimal health, as opposed to the positive aspects already in place, which support positive health (e.g., we
asked, “What makes it hard to engage in healthy activities” instead of “What are some good things about your home life?”).

It is also important to recognize that we are focusing on Aboriginal communities that are living in an urban setting. There are barriers and issues that are unique to urban settings and the conveniences of modern society. Responses from participants are reflective of these factors.

5.1 Findings from the Deductive Analysis

Knowing your audience is important for marketing success. Understanding what makes it difficult for them to engage in the desired behaviour, what advantages they identify with engaging in the desired behaviour, what they are currently doing rather than engaging in the desired behaviour is central to any promotional (i.e., marketing) campaign (Kotler & Lee, 2008). Barriers, benefits, and competing behaviours are often specific to a given audience and desired behaviour, which is why it is important that the intended audience and objectives be determined early on so that the campaign is developed in a manner that is effective for them within their specific situation (Kotler & Lee, 2008). This information also helps to inform marketing mix strategies.

5.1.1 Product

This campaign is centered on wholistic health and what the intended audience feels they need to and could do to achieve wholistic health. Therefore, the research process started from the premise that “achieving wholistic health” would be the core product. The core product of a social
marketing campaign is the benefit the intended audience expects to receive by engaging in the desired behaviour(s) (Kotler & Lee, 2008).

The actual product refers to the behaviour or action required to obtain the core product (Kotler & Lee, 2008). There were many behaviours listed by participants as conducive to wholistic health, and therefore in this campaign, actual products were determined by drawing from the predetermined themes to identify common groupings of activities (e.g., any specific activities relating to exercise, fitness, sports, etc. would be grouped under “physical activity”). Responses to the questions: “How do you achieve good physical health?”, “…mental health?”, “…emotional health?”, and “…spiritual health?” were used to develop lists of activities participants deemed as related to each of these realms of wholistic health. These lists were then examined and any activities that were mentioned in at least three of the four wholistic health categories were selected as actual products – with the exception of budgeting (Figure 5.1). Given the large number of activities mentioned, retaining only those mentioned in three of the four wholistic health categories narrowed the list to a size that was more manageable and realistic for dissemination. I felt that any activities that prominently recurred in only one or two of the wholistic health categories would be picked up through the inductive analysis and therefore, was confident that no information was lost. Also, identifying activities repeated across three of the four categories to include in the campaign would likely have greater potential to impact on each of the areas of wholistic health. Although budgeting did not meet this criterion (i.e., not mentioned in 3 of the 4 categories), it was nonetheless retained as an actual product because budgeting difficulty was mentioned by parents as something that made it difficult to engage in behaviours conducive to wholistic health. When taken together with the additional barriers mentioned, it was thought that promoting budgeting may have the potential to address some of
the most persistent barriers. Figure 5-1 also provides examples of some specific activities mentioned by participants pertaining to the five actual products.

Figure 5-1: Actual Products to be Disseminated through Strategies and Resources Promoting Wholistic Health

Ideally, actual products should be as specific as possible so that the intended audience is very clear about what they are being asked to do. However, the actual products in this campaign are quite broad and more market research is necessary to determine what specific behaviours within these categories members of the intended audience: a) would benefit from the most, and b) are ready to take on. For example, promoting increased fruit and vegetable intake (i.e., 10 a day) may be a specific behaviour to promote under the umbrella of healthy eating.

5.1.2 Price

Price refers to what the intended audience must forfeit in order to obtain the potential benefits associated with a given behaviour (Grier & Bryant, 2005). It is related to the barriers that must be
overcome to engage in the desired behaviour (Kotler & Lee, 2008; Smith, 2000). The costs associated with participation might be monetary or non-monetary (Kotler & Lee, 2008).

5.1.2.1 Barriers

It is important to learn which barriers the intended audience will face when attempting to engage in the desired behaviour in order to be able to counter them through a social marketing campaign (Kotler & Lee, 2008). Barriers were identified during initial coding primarily by examining the responses to the question, “What makes it hard to engage in these activities?” As outlined in Table 5-1, nine barrier categories were identified based on recurrent themes that appeared throughout the text.

**Table 5-1: Barrier Categories Derived from Reported Barriers to Engaging in Wholistic Health Behaviours**

<table>
<thead>
<tr>
<th>Barrier Categories</th>
<th>Verbatim comments to support category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Money</td>
<td>“I can’t afford to do yoga and I can’t afford to go out and take an arts &amp; crafts class and I can’t afford to go and do karate and I need time for me, and I can’t justify taking the money out of the budget and going and paying for a, crafting class or whatever it is that gets me out of the house and gives me an hour without the kids, and with other adults, that gives me sanity for myself.”</td>
</tr>
<tr>
<td>Lack of Transportation</td>
<td>“My big thing too is transportation. My boys love coming. I’d love to get down here [Native Friendship Centre], I’d love to do some of these things too but I don’t have the transportation.”</td>
</tr>
</tbody>
</table>
| Lack of Support | “I quit smoking for three months and then went back to it, and you just need the support and that is a big thing… the support, or you sit and think about things for three weeks, six weeks, six months….”

“Sometimes you just need a little bit of support to get you going and get you moving on things.” |
| Lack of Time | “…for me, I can’t do the prep time. So I have to have food that is cooked easily.”

“I don’t even have time to say downtime.” |
| Lack of Knowledge | “…not having the knowledge. For example with healthy eating, if you’re raised a certain way, preparing certain meals, growing up... we have all heard about healthy eating and healthy living but not all of us have lived that way. So not really having a good understanding of that and not really knowing where it starts.” |
| Pain, Disability, & Disease | “Follow my medication, evaluate my pain levels on a daily basis, and do activities that I can tolerate. Evaluating level of pain - that for me is everything. If I’m in too much pain then nothing is going to work.”

“My son’s mental problems are a huge blocker, my mental problems are huge.” |
| Lack of Venue/Environment | “I live in a neighborhood where… you never see kids outside, so they don’t play with each other, they don’t… I remember living in the same kind of neighborhood when I grew up and we all played together, all day – everyday. Now it’s, nobody can be bothered to go outside, they’re all too busy with the computer.” |
“Believe in what you want to believe and don’t let other people tell you that they’re not real, or they’re fake or something.”

“If you know your friends are in a rough spot, you don’t want - and especially when you have gone through as much pain as I have - you are so scared to make that phone call because you hear that hesitation in their voice when they know it’s you. And there’s just not enough time, good times, to call just to say hi.”

These verbatim comments provide evidence of many intrapersonal barriers (i.e., lack of time; lack of knowledge; pain, disability & disease; fears) as well as barriers in the social (i.e., lack of support; bullying/peer pressure) and physical (i.e., lack of money; lack of venue/environment; lack of transportation) environment. These findings are consistent with previous research conducted with Aboriginal parents and children regarding barriers to physical activity (Berkowitz et al., 2008; Duplantie et al., 2003). Formative evaluation for the VERB™ campaign revealed that lack of time, family responsibilities, lack of access to facilities, and fear of embarrassment and failure are all considered to be barriers to physical activity for tweens (Berkowitz et al., 2008). Similarly, interviews and focus groups conducted specifically with American Indian parents and tweens revealed similar barriers to physical activity, such as lack of money, parents’ conflicting work schedules, lack of safe places to be active in reservation communities, and tween home responsibilities (Huhman et al., 2008). The identification of “lack of money” as a barrier category is consistent with findings from Statistics Canada (2004) indicating that 41.6% of Aboriginal people in Census Metropolitan Areas (CMAs) are living in low income situations. Similarly, information from Statistics Canada (2008c) provides support for “lack of knowledge” as a barrier category reporting that as of 2006, 34% of Aboriginal Peoples aged 25-64 years had
not completed high school which may compromise their ability to access and understand health information.

5.1.2.2 Potential Costs

In order to determine the potential cost of each barrier and eventually counter these through the campaign, barrier categories were then sorted into two types of costs: monetary and/or nonmonetary (i.e., time, effort and energy, psychological barriers, and pain and discomfort; Kotler & Lee, 2008). By breaking down barrier categories into their potential costs we came up with a list of expenses and sacrifices associated with engaging in a given behaviour (i.e., product; Table 5-2). This kind of list is useful in determining which issues can and cannot be addressed within a given campaign.

**Table 5-2: Potential Costs to Engaging in Wholistic Health Behaviours Associated with the Identified Barrier Categories**

<table>
<thead>
<tr>
<th>MONETARY</th>
<th>Barrier Category</th>
<th>Potential Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of money</td>
<td>- registration fees for classes</td>
</tr>
<tr>
<td></td>
<td>Lack of transportation</td>
<td>- gas money</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- cab fare</td>
</tr>
<tr>
<td></td>
<td>Lack of Knowledge</td>
<td>- college tuition</td>
</tr>
<tr>
<td></td>
<td>Lack of support</td>
<td>- hiring a sitter</td>
</tr>
<tr>
<td>NONMONETARY</td>
<td>Lack of time</td>
<td>Lack of venue/Environment</td>
</tr>
<tr>
<td>------------</td>
<td>--------------</td>
<td>---------------------------</td>
</tr>
</tbody>
</table>
| **Time, Effort, Energy** | - taking time to plan things out  
- food preparation and cooking healthy meals  
- having to baby-sit siblings  
- finding out what activities are going on in the community  
- volunteering to coach a child’s sport team | - rallying government/school boards to provide more physical activity opportunities during and after school | - not knowing how to cook healthy meals | - being afraid to open up to people  
- fear of being unprepared  
- fear of burdening others | - getting picked on | - asking others for help | - engaging in exercise or physical activity |

Table 5-2 details the potential costs derived from answers provided by participants. Evidence from the literature suggests that other monetary costs related to lack of venue/environment may be associated with the reduced access to resources (e.g., health services, recreational facilities) experienced by those living with low incomes (Fitzgivvon et al., 1997; Wickrama et al., 1999). Holding additional sharing circles would allow for further investigation into potential costs associated with these nine barrier categories specific to AKWE:GO families.
5.1.3 Place

“Place is where and when the target market will perform the desired behaviour, acquire any related tangible objects, and receive any associated services” (Kotler & Lee, 2008, p. 247). For the most part, place was predetermined for this campaign. Since the Native Friendship Centre is a common hub that connects our intended audience, it was chosen as the main venue for the dissemination of strategies and resources to engage families in supporting wholistic health messages received through AKWE:GO. The home was encouraged as a place to perform the desired behaviours. Responses to questions listed under “Place” (Table 4.1) were used to verify that the Native Friendship Centre was the correct place for the dissemination of wholistic health information. This decision was supported by participants’ overwhelming responses in favour of having the Native Friendship Centre as the place where they could perform the desired behaviours, acquire tangible objects associated with the behaviour, and receive services related to healthy living: “I know that my kids are in a safe environment when they’re here, I know that I’m around other parents...” (Female adult). Children indicated that they were already engaging in health behaviours while attending AKWE:GO, as evidenced by the following excerpts from female children: “We cook...”, “We play games”, “We go dog-sledding, snow-shoeing...”, “We talk about things!”, “We drum in the circles”.

Other venues where participants wished to perform relevant behaviours (e.g., physical activities) were their homes and various community settings, such as the YMCA. Community settings were also mentioned as desirable venues to receive information: “I think one of the best examples of giving out information in the not-for-profit sector is the YMCA, they’re doing a great job!” (Male adult).
Place is also used to identify where messages regarding the desired behaviour should be displayed (Bryant et al., 2000). Responses to the question, “When and where do you get the urge to listen to and act upon health messages?” indicate that participants are interested in receiving messages while at the grocery store, YMCA, or while attending a family or community event (e.g., at the Native Friendship Centre).

In an attempt to determine participants’ knowledge of health-promotion settings within the community, they were asked “Do you know of any other places in the community that promote health?” Responses were useful in determining what community resources participants are familiar with and allows the campaign to direct them towards useful community resources that they may not be accessing.

5.1.4 Promotion

Promotion is associated with getting the appropriate message to the intended audience at a time when they are likely to be receptive (Kotler & Lee, 2008; Smith, 2000). Health promoting messages are usually more positively received by the intended audience when they include the promotion of benefits related to the intended behaviour (Rothman & Salovey, 1997). Determining a promotion strategy requires social marketers to make decisions regarding the messages, the messengers, and the communication channels (Kotler & Lee, 2008; Rothman & Salovey, 1997).

5.1.4.1 Benefits & Messages

Benefits refer to something of value the intended audience believes they can obtain by participating in the desired behaviour (Kotler & Lee, 2008). Benefits were identified by the
researcher during initial coding of responses to the question “What are the benefits of engaging in these activities [for physical, mental, emotional, and spiritual health]?” Nine benefit categories were derived based on recurrent themes that appeared throughout the text (Table 5-3).

Table 5-3: Benefit Categories Derived from Reported Benefits of Engaging in Wholistic Health Behaviours

<table>
<thead>
<tr>
<th>Benefit Categories</th>
<th>Verbatim comments to support category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Being a Good Role Model</strong></td>
<td>“Showing good examples to your children.”</td>
</tr>
<tr>
<td></td>
<td>“Positive role modeling.”</td>
</tr>
<tr>
<td></td>
<td>“Healthy morals!”</td>
</tr>
<tr>
<td><strong>Energy</strong></td>
<td>“Definitely, I think more energy… just more energy I guess.”</td>
</tr>
<tr>
<td><strong>Improving Knowledge &amp; Chances of Success</strong></td>
<td>“If you stay in school to get an education then you’ll get a job that pays more and you can buy a house and actually have a life … rather than living on the street or something.”</td>
</tr>
<tr>
<td></td>
<td>“I think the benefit of learning is you’ll be smarter and you’ll get better grades and then you can go to a better college.”</td>
</tr>
<tr>
<td><strong>Happiness</strong></td>
<td>“You feel alive!”</td>
</tr>
<tr>
<td></td>
<td>“Good thoughts, good sleep…”</td>
</tr>
<tr>
<td></td>
<td>“You’ll feel good.”</td>
</tr>
</tbody>
</table>
| Helping Others | “Another benefit of learning is that you’ll be able to help somebody else learn.”
| | “We’d see an overall decrease in suffering.” |
| Improved Relationships | “If you’re emotionally healthy, you’re leading a healthier life, you’re able to be contented in your own space, so you’re equally happy to interact with other people, and it, it’s confidence.”
| | “A sense of belonging.” |
| Self-Improvement & Balance | “I think that they’re all small steps but when put together they lead to the betterment of the mind, body, and spirit.”
| | “I think that when you’re spiritually healthy, you’re more content with yourself and you’re more well-rounded.” |
| Stress Relief | “…you might be thinking more clearly, with more reason. So you don’t approach things from a state of panic. You are more thoughtful in making decisions.” |
| Strong Healthy Body | “Exercising, it helps… your bones to get strong.”
| | “When you stay physically active, you stay in shape.” |

Consistent with our finding that being a good role model is important to parents, focus groups and interviews conducted with American Indian parents and tweens for the VERB™ campaign indicated that parents being poor role models of physical activity was one of the barriers that tweens faced in becoming physically active (Huhman et al., 2008). Based on findings from formative research in the VERB™ campaign, Berkowitz and colleagues (2008) concluded that messages to promote physical activity need to be different for tweens and parents. They indicate
that messages for tweens should promote the idea that everyone is good at something and aim to build self-esteem while messages for parents should be a reminder of the importance of their involvement in encouraging their children to discover their passion. Since our campaign is aimed at increasing healthy behaviours, including physical activity among the entire family (i.e., children and parents), messages for parents should promote benefits - not only for themselves - but for their children as well.

**5.1.4.2 Messengers & Communication Channels**

While benefits are useful when determining messages, it is also important to use appropriate messengers and communication channels to disseminate these messages. Messengers are those people/organizations who will deliver and support the message, and communication channels reflect decisions about where and when the intended audience will be exposed to the message (Kotler & Lee, 2008). Responses to the question, “From what source/where would you most like to receive information about health and about healthy choices?” were used make decisions about ideal messengers and communication channels. Communication formats (e.g., written, oral, etc.) were also determined by the researcher using responses from the question, “In what type of format would you prefer to get information about health and healthy activities?” Messengers mentioned by sharing circle participants included the AKWE:GO program coordinator, Elders, and persons that the respondents trust. Children also indicated that they would like to hear the information from their mother, or another family member. Interestingly, some female children suggested that they prefer to receive information only from other females: “...not from my teacher because he’s a boy, but from Willow, or from her [points to Ms. Hooper], or from her [points to Karen], or from her [points to female friend]. Just those four, because I don’t trust anyone” (Female Child). Huhman and colleagues (2008) found similar results, noting that
authority figures within families were regarded as important influencers of behaviour for American Indian tweens.

Communication channels can be divided into three categories: mass media, selective media, and personal media channels (Kotler & Lee, 2008). According to Kotler & Lee (2008), mass media channels are used when attempting to inform a large group of people about an issue in a short period of time. Selective media channels are used to provide an accessible audience with a more detailed description of the desired behaviour via flyers, posters, telemarketing, internet, etc., while personal media channels provide person-to-person delivery of the message. Given our budget and the size of our audience, only selective and personal media channels would be realistic channels for our campaign.

Preferred formats of communication through selective media channels in this campaign include posters and printed materials. Some participants also indicated that calendars and websites were desirable communication channels. Teufel and colleagues (1999) who studied Native American families participating in a school-based health behaviour intervention to prevent childhood obesity found families to be very receptive to take-home materials (i.e., Family Action Packs, & Family Snack Packs) used to reinforce health behaviours introduced by the school curriculum. In regards to personal media channels, sharing circle participants were interested in having information given to them as an interactive presentation or workshop. This was desirable because many parents felt that they would be able to develop healthier habits, (e.g., cooking healthier meals) if they had the opportunity to try it out in addition to being given information on how to do it:
So many of these would be easier for me if it was a class, not necessarily in school, but a group similar to what we’re in right now... we could do a Monday night healthy cooking thing where we learn new recipes ... I learn best when I can see, hands on, and do those things.” (Female Adult)

Lending support for the use of personal media channels with an Aboriginal audience, Teufel and colleagues (1999) received positive feedback after hosting a Family Fun Night to kick-off their campaign. This event included interactive learning booths (e.g., taste-testing to compare high and low fat food items), physical activities, and the distribution of printed materials to Native American Families.

Sharing Circle findings were thus translated by Ms. Prue and I into relevant campaign materials including take home packages that contain information booklets, pedometers, a “how-to” budgeting booklet, calculators, family chore lists, daily checklists, etc., to be distributed to AKWE:GO families. An interactive workshop on developing and managing a family budget will be held at the Native Friendship Centre this coming fall. Due to financial and time constraints, no calendars were developed, but a list of web resources containing interactive tools such as a nutrient calculator, a physical activity log and calendar, and Aboriginal specific networks and resources was included in the take home packages.

5.1.5 Competition

While not considered part of the marketing mix, competition is useful when developing strategies related to price, place, and promotion (Bryant et al., 2000). Competition is defined as any behaviour the intended audience currently prefers over the desired behaviour, any negative
behaviour that has become a “habit”, and/or any organizations that promote messages that conflict with that of the desired behaviour (Kotler & Lee, 2008). Knowing the competition enables social marketers to develop a campaign that positions the desired behaviour more favourably than competing behaviours. Adjusting the ratio of benefits to barriers in favour of the intended behaviour may be achieved by increasing the benefits and/or decreasing the barriers of the intended behaviour, or increasing the barriers and/or decreasing the benefits of the competition (McKenzie-Mohr & Smith, 1999). This might include making the desired behaviour more accessible or less costly than the competition (e.g., selling bottled water in the same vending machine as soft drinks but for half the price).

Sharing circle participants were asked about competing behaviours and about incentives that might get them away from these behaviours. Table 5-4 presents an exhaustive list of responses to the questions “What unhealthy activities or behaviours compete with the healthy activities?”, “What are some ideas on how to get you away from these unhealthy activities?”, and/or “What would make healthy behaviours more attractive than these unhealthy behaviours?” All of the competing behaviours and incentives mentioned by parents and children during the sharing circle discussions are included. Responses are listed in no particular order and competing behaviours are not linked with any specific healthy behaviour nor are incentives presented in a way that corresponds to specific competing behaviours. These questions were intended to provide a general idea of what unhealthy behaviours are currently competing with their healthier alternatives.
Table 5-4: Behaviours that Compete with Wholistic Health Behaviours & Incentives to Reduce Participation

| COMPETITION | BEHAVIOURS: eating unhealthy/fast foods, spending time at the computer (games, MSN, email, YouTube, Facebook), watching TV, over-sleeping, doing housework, smoking, playing video games, being lazy, drinking, thinking negatively, working | INCENTIVES (to get them away from competing behaviours): having access to healthy activities, being around healthy foods, having time and opportunity to socialize with friends and family, having friends and family available, being reminded of the benefits of the healthy activities, having good weather, knowing what other activities are available (in & outside of the home), being around people engaging in healthy activities, having positive role-models (through teachers, Elders, etc) |

Certain incentives (i.e., having friends and family available, being around people engaging in healthy behaviours), are consistent with findings outlining the importance of support from significant others (Epstein et al., 1994), and the influence of parents in maintaining positive health outcomes in children (Sallis et al., 2000).

Interestingly, responses from child participants to the questions: “What is something good about being involved in the AKWE:GO program?”, and “What part of the program do you really like?” indicate that being able to attend an AKWE:GO session provides motivation to disengage from unhealthy activities: “…you get to do more stuff than just sit down or [play] video games; you get to go outside and walk around and play in the snow” (Male Child), “…it helps you have things to do instead of sitting in the house all day and watch TV and [play] on the computer”
(Male Child). This indicates that the AKWE:GO program itself may act as an incentive to get children away from competing behaviours.

Findings from the deductive analysis of sharing circle responses highlight the multi-layered nature of wholistic health. Reported barriers and incentives related to health behaviours identified as conducive to wholistic health (i.e., physical activities, healthy eating, budgeting, talking with significant others, and traditional activities) were found to be intrapersonal, social, and physical. Findings related to competing behaviours also provide insight about the challenges encountered in an environment that is full of cues to engage in unhealthy lifestyles. The adoption of an ecological perspective to develop tailored strategies and resources to engage families in supporting wholistic health messages received through AKWE:GO thus appears relevant for our intended audience.

5.2 Findings from the Inductive Analysis

The decision to conduct an inductive analysis of the overall verbatim came from a certain discomfort I felt after completing the deductive analysis, which was mainly guided by the social marketing framework. There appeared to be richness in the data that could not be captured without a greater openness to emerging themes. I thus proceeded to conduct an inductive analysis after noticing that certain topics appeared to be recurring. Closer examination revealed that these recurring topics were found mainly in the parent circle and not the child data. Thus the focus of the inductive analysis is limited to parent data. Interestingly, there was a discernible difference in the themes that emerged from the Kingston data and those that emerged from the Owen Sound data. While some discussion topics were comparable in both locations, the tone and theme of the
overall discussion varied between places. Findings from these analyses will be presented separately for Kingston and Owen Sound.

5.2.1 Kingston

From the Kingston sharing circle data, three sub themes emerged: “Pain, Disability & Disease”, “Need for Adult Time”, and “Need for Support”. Although similar themes of “Pain, Disability & Disease”, and “Lack of Support” were categorized as barriers, these sub-themes were prominent in discussions with Kingston parents and are important in explaining the overarching theme of “Sense of Hopelessness” present in this group. Comments and observations from these sharing circles reflected a pervasive conviction from most participants that wholistic health is out of reach. Parents cited being too overwhelmed by daily life to even consider undertaking a health behaviour change attempt: “I’m in pain every step I take everyday, so I’ve got that to overcome, but it’s been that way for 14 years so I just deal with it, but aside from my pain – finances, transportation, babysitting…” (Female Adult), “…there’s always something with the money and the time, your energy levels [sigh]…” (Female Adult).

In their responses to most questions, parents discussed the happenings and realities of their immediate environment. The barriers that they are experiencing at the individual level appear to be acting as a screen that sometimes prevents them from thinking beyond their direct situation: “It’s impossible for housework. I don’t think there are very many things that make it easy...” (Female Adult), “The biggest thing is already up there [written on the flip chart paper] which is time...they’re all up there - no one around, hard to budget...” (Female Adult), “I can’t afford to do yoga and I can’t afford to go out and take an arts and crafts class and I can’t afford to go and
do karate and I need time for me ... I can’t justify taking the money out of the budget” (Female Adult).

Various aspects of “Pain, Disability & Disease” were present in both sharing circle discussions with Kingston parents. Chronic pain for some of these women is a fact of life and it is something that they must plan for everyday. Living with chronic pain also makes it difficult to plan other things in advance because plans may need to be altered depending on the level of pain. “Follow my medication... evaluate my pain levels on a daily basis, and do activities that I can tolerate. Evaluate level of pain - that for me is everything. If I’m in too much pain then nothing is going to work” (Female Adult). The physical pain often outweighs the desire to engage in healthy activities and can contribute to feelings of isolation. “For me it’s pain. I’d love to go for a walk. Just spend a day in the park” (Female Adult), “...so living with all those stairs doesn’t help ... being in my house and trapped will actually depress me even more” (Female Adult). Depression can also overpower desires to get up and move: “...it’s getting out of the depression and just getting motivated to get up and move” (Female Adult).

Given the increased incidence of chronic disease in the Aboriginal population (Statistics Canada, 1999b) it is not surprising that “Pain, Disability, & Disease” emerged as a prominent theme. Therefore it is especially important to take limitations due to pain, disability, and/or disease into consideration when developing strategies and resources to engage Aboriginal populations in supporting wholistic health messages.

The pain, disability or disease of a child is considered just as much of a barrier as personal problems. “My son’s medical problems are a huge blocker in my life” (Female Adult), “My son’s
mental problems are a huge blocker, my mental problems are huge” (Female Adult), “ADHD, ODD and severe learning disability” (Female Adult).

Participants all recognized the “Need for Adult Time”; time to be spent out of the house with people other than their children. The majority of these women were single mothers who had primary, if not exclusive responsibility for their children. There was a palpable sense of isolation. The preoccupation of attending to the needs of their children has left them with a sense of disconnect: “When day to day is a trial, extras just don’t come out, and unfortunately, times or, us as people, not as moms tend to get pushed to the way-side” (Female Adult). It is evident that there is a craving for socialization and time to connect with others.

I’m trying to think back to when I was not mentally healthy but I thought I was. I know I had a lot more time for me. I had a lot more time to get out and do things and connect with people and I wasn’t as isolated as I am now. So that was definitely, yeah... get out, meet people, talk, move...(Female Adult)

Those who do take time for themselves feel that having this time enables them to be better mothers:

I don’t feel guilty anymore for taking time for me, because I know if I don’t take time for me or myself then what kind of shape am I going to be in for my kids? And when you’re a single parent you have to think that way.... (Female Adult)
This sub-theme provides increased support for the use of personal media channels such as workshops, seminars, and presentations in promotion efforts with this group, as this would get parents out of the house and interacting with others.

“Need for Support” was another sub-theme that emerged from the Kingston parent sharing circles. Lack of support was often mentioned as a barrier to engaging in healthy activities, while having support was brought up as a facilitator. Support was often referred to as having family around, or having someone to call on in an emergency. However, support systems were sometimes non-existent or ineffective, suggesting that when family and friends were around, the relationships were not strong enough to be perceived as supportive. The parents said that oftentimes, their friends are in similar situations and dealing with similar problems and therefore friendships can become stressful.

...not allowing other people’s lives and issues crowd your life and issues. Nothing wrong with caring about other people and helping, but ... I used to take everybody else’s problems on my shoulders and carry them. I still kind of do, but.... (Female Adult)

...learn to tell your good friends no when they are constantly asking you to watch their children, and not being there then you need them. (Female Adult)

Although not discussed outright, it was also evident that these parents wanted more support from their children. These families are comprised of one parent and often two or more children, so the parents are constantly on the go addressing the various needs of their families:
I’ve got 2 different schools, with my kids. They’re on totally different times, well class times work on, but one is on a bus, so she’s got to be out the door before the other ones are even up, so my day starts that much earlier because I have to be up to make sure she’s up! (Female Adult)

When there is only one parent, and especially a parent with chronic pain or disability, it restricts what the children are able to do:

There’s not a whole lot that I can do, and it’s so frustrating because my kids would love to be able to do all kinds of activities, and most of them you need a parent there, so if I can’t do it they can’t go. (Female Adult)

In particular, Kingston parents expressed an interest in having the support of their children in cleaning and helping with other household duties, however, they also admit that they have difficulties in relinquishing control and allowing their children to help out:

My kids don’t lift a finger unless I’ve totally lost my fuse and then they’ll do what they have to do. But… everything is mummy’s way, I have a certain way I do my dishes, my laundry is all folded a specific way so it fits in the closet, and so I’ve just always done it all…. (Female Adult)

Anytime I’ve allowed them to do things like that, 100% of the time I have to redo it because it’s not even close to…[the way I like it done]. (Female Adult)
They also request support from their children in the form of cooperation, such as eating the dinner that is prepared for them, not fighting with their siblings, and participating in activities as a family since opportunities to spend one-on-one time with each child are so rare:

*I kind of gave up a lot of the planning. Plan dinner? Well pointless because well, this kid’s not going to eat it, or it turns out I don’t have enough time to cook that now so I’m going to have to cook Kraft Dinner, that’s just how… I can’t plan anymore, it never works.* (Female Adult)

*... so constant just ... fighting and fighting and bickering and bickering I mean, I know sibling rivalry and kids fight, but if I could find something that they all like that I could do with them....* (Female Adult)

Being the head of a lone parent family likely contributes to the lack of support expressed by Kingston parents. However it is not just the absence of a relationship that contributes to this sub-theme, it may also be linked to existing relationships. Most often the people in the parents’ social networks are in similar situations with similar stressors which reinforce the sense of hopelessness:

*What would be really helpful would be ... to have someone to call on 24/7, you know ‘I’m going to have a nervous breakdown, you need to take my kids now’... that’s not possible, because by the time I’m having a nervous breakdown, both of my friends over here are usually having a nervous breakdown and we jump back and forth when we’re having one.* (Female Adult)

The sub-themes that emerged (i.e., pain, disability, and disease, lack of adult time, and lack of support) are all related to the overarching sense of hopelessness within this group. They are all factors within the immediate environment that appear to be roadblocks to achieving wholistic
health. Therefore, prior to initiating a campaign to promote wholistic health in this group it is necessary to address existing roadblocks.

5.2.2 Owen Sound

In Owen Sound, focus appeared to be less about the individual and more about the community and culture. “Society & Government” was the main theme that emerged, however it is also interesting to note that traditional activities were brought up far more frequently in Owen Sound than in Kingston.

Parents in Owen Sound appear to be in a place where they can think beyond their immediate environment and consider how external factors play a role in overall health. Society and government are seen as large scale forces that influence behaviours – in a negative way: “A lack of will on the part of government, societies, leaders... a lack of leadership perhaps” (Male Adult). People feel that difficulties experienced at the family level are related to problems with the expectations and conveniences of modern society:

Just working, for parents, competes because in their time off with their kids there has to be an immediate activity, like, park the little kid in front of the TV, or order some low impact, you know, no nutritious activity for the kids because the parents are too busy chasing the dollar just to get by. So it’s the financial competition, it’s not direct activity. And we’ve got to make a TV dinner or give them a can of Alphaghetti because we just don’t have the time and energy after we’ve worked to put into these things. I mean where’s society? I think it’s a society problem. (Male Adult)

Parents in Owen Sound appeared to be aware that there are numerous community organizations that make various services and programs available to adults and children for little to no cost, but
parents were unaware on how to find out when and where these programs were running. Many resources within the community remain untapped: “There’s a big volunteer system here in Owen Sound ... and a lot of people don’t know that. There are a lot of volunteers that work in the community and they’re not accessed by all the groups” (Female Adult). They feel that community organizations should partner to meet mutual needs and to effectively advertise health information and programs. However, they also feel that larger corporations, like grocery stores, guard their own interests over those of the general public:

_A lot of stores you’ll find are pretty picky on what you can put on there [bulletin boards]. I think one of the areas we run into is everything you’ve got out there is sprinkled randomly with commercial interests. Like if I’m interested in yoga well, I might luck out and get somebody who’s going to offer yoga for free and in a good location at the time that I want, but more than likely I’m going to have to go to a yoga studio and have to pay whatever it is per session._ (Male Adult)

Although the topic of support from significant others was also raised in discussions with Owen Sound parents, it was not as striking as in Kingston and was focused more on support from outside the family - from counselors’ and organizations like BigBrothers/BigSisters.

When considering findings from these two communities relative to wholistic health, it appears that they are at a different place when it comes to thinking about and taking action for wholistic health. These differences may reflect a difference in community readiness.

### 5.2.3 Community Readiness

Community readiness is described as the “predisposing factors within the community, particularly its means of assessment or degree of community mobilization” (Salsberg et al., 2008, p. 127),
however it may also be related to aspects internal or external to the community itself (Salsberg et al., 2008). Internal community aspects include predisposing, reinforcing, and enabling factors, as outlined by the PRECEDE-PROCEED Model (Green & Kreuter, 2005). Knowledge, attitude, beliefs, cultural values, and perceptions of the community are considered predisposing factors, while attitudes, health behaviours, and other people are considered reinforcing factors (Salsberg et al., 2008). “Enabling factors are the availability of resources, accessibility, and skills internal and external to the community” (Green & Kreuter, 2005 as cited in Salsberg et al., 2008, pp.127-128). When these are positively aligned with behaviours related to wholistic health, there is a greater likelihood that people, families, and communities will engage in wholistic health (Salsberg et al., 2008). External community aspects relate only to enabling factors. When external factors are present in addition to internal predisposing, reinforcing, and enabling factors, the likelihood that people, families, and communities will engage in wholistic health is increased.

The discussion in the Owen Sound parent sharing circle reflected this higher level of readiness as evidenced by consideration for the ways in which external factors could be leveraged to enhance the wholistic health of community members. This also may indicate an increase in collective efficacy among Owen Sound residents. Brown & Cagney (2003) reported that increased collective efficacy among neighborhood residents increases their awareness of the needs of fellow community members. They also suggested that communities with higher rates of collective efficacy were more likely to have improved rates of self-rated health.

Owen Sound’s increased desire for action on the part of the community, society, and the government is related to differences in predisposing factors. Predisposing factors provide an indication of a group’s willingness to act based on knowledge, feelings, beliefs, values, and self-
confidence or self-efficacy (Green & Kreuter, 2005). Sharing circle findings suggest that, as a
group, participants in Owen Sound are seeking external enabling factors to support a readiness to
act. Reasons for this level of community readiness are ultimately unknown, but I think that it may
be due to Owen Sound’s proximity to a reserve community and/or Owen Sound’s smaller size
(i.e., increased likelihood that participants live closer together). Ms. Bouwman also indicated that
participants may have been especially apt to convey this type of empowerment and readiness
following a week of ceremonies and teachings that preceded the sharing circle.

While as a group, Kingston parents expressed a desire to improve the health of their children,
their families, and themselves, the discussion at the Kingston sharing circles was contained to
predisposing factors. I thought this could be related to Kingston’s larger size and possible
dispersion of participants and/or the time of year in which sharing circles were conducted (i.e.,
the stress of the holidays). Some of the predisposing factors may need to be addressed before
external factors can be considered. Programs to improve collective efficacy among Kingston
parents may help to enhance their community readiness.

Further study is necessary to gather more information regarding community readiness in Kingston
and Owen Sound. If indeed this discourse reflects varying degrees of readiness for health
behaviour change, it will be important to take this into consideration when developing our
wholistic health campaign.

5.3 AKWE:GO Advocacy Grant Campaign

This project was an initial step in determining how best to develop and disseminate strategies and
resources to engage families in supporting wholistic health messages received by children through AKWE:GO. Since the advocacy campaign funding was intended for the Kingston AKWE:GO families, Ms. Prue (AKWE:GO program coordinator) and I felt that the underlying sense of hopelessness among Kingston parents needed to be addressed before any real attempts at health behaviour change could be made. Ms. Prue’s experience working with these families further confirmed that parents were too overwhelmed with parenting duties and making ends meet to focus attention on daily physical activity and healthy eating. Therefore, while this campaign does address the five actual products that were identified by the sharing circle respondents, we felt that the first order of business should be placed on gaining a sense of organization and manageability within the households.

Given that this project is focused on the family as a unit, and because support emerged as an important theme in both the inductive and deductive analyses, recruiting additional support from children was a main focus of our campaign efforts. Family chore lists were developed to assist parents in engaging children in the daily/weekly chores. Common household tasks were represented using illustrations and printed onto magnetic pages to make them more appealing to children. Morning and evening checklists were made for parents and children to help keep track of things that need to be done. The children’s checklists were also intended to help them gain increased independence and to decrease dependence on their parents in completing daily tasks. Blank spaces on the checklists allow families to create lists that are specific to their lives and routines. Also on the checklists are spaces for parents and children to indicate daily goals, how they feel upon awakening, and to consider how their day went. We hope that this will help participants to reflect on their feelings, and to open the lines of communication between family members.
To address the parents’ concerns about the lack of common family activities, we asked the children specifically about activities that they could participate in as a family, and then compiled a list of family activities. While this will not solve the problem, we hope it will provide parents with more ideas of what activities to do as a family and perhaps inspire creative thinking on their part. We also encouraged parents to allow their children to cook with them and involve them in the process which would make them more likely to cooperate in eating it. Children cook while at AKWE:GO and therefore already have some of the necessary skills to help out in the kitchen.

Participation in each of the actual products (i.e., physical activity, healthy eating, budgeting, talking with significant others, and traditional activities) was promoted in some way by the family take-home packages (Table 5.5), however, given the broadness of the categories and our limited budget, it was difficult to provide adequate resources and information regarding each activity category. Also, it was felt that participation in traditional activities is currently promoted by the KNFC and that the inclusion of handouts on how to participate in traditional activities might be insulting to this audience. Therefore, participation in traditional activities was encouraged on an introductory page outlining the five actual products being promoted to improve wholistic health, but no specific handouts regarding traditional activities were included in the booklets. Table 5-5 summarizes the contents of the take-home packages that were informed by this study.

Table 5-5: Actual Products & Related Package Materials

<table>
<thead>
<tr>
<th>Actual Product</th>
<th>Related package materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Activity</td>
<td>Pedometers; Kingston Gets Active info sheet, “Physical Activity” info sheet HSFO “Healthy Waists” tape measure; the PARC Walk</td>
</tr>
</tbody>
</table>
Many of the barriers mentioned by sharing circle participants were difficult to address using the Advocacy Grant Funding. We made an effort to address lack of support (which would in turn hopefully have a positive influence on lack of time) by encouraging an increase in support within the family, and lack of knowledge by providing information on physical activity, healthy eating, budgeting, communication, and reducing stress but many of the most pervasive barriers (e.g., lack of money), could not be addressed directly through this campaign.

For the simplicity of this campaign, participants received information regarding the actual products (i.e., the take-home packages) from the Katarokwi Native Friendship Centre. While this campaign encourages parents and children to perform health related behaviours in their home settings, the overall message is related to engaging in healthy activities as a family, regardless of place. By also providing information about Kingston Gets Active, a community resource that was not mentioned by participants, we hope this will become a new site where our intended audience may receive health related messages.
In keeping with the advocacy piece of the Heart & Stroke Foundation Advocacy Grant, we wanted to increase community awareness of the AKWE:GO program. Therefore we developed community posters to advertise the program to the public. Volunteer posters were also developed to recruit additional volunteers to the program. Additional volunteers would allow the program coordinator to welcome more children, and would therefore increase the number of families that we could engage through our campaign.

In order to bring the project full circle, a presentation will be held at the Katarokwi Native Friendship Centre (KNFC) to discuss the findings of this project. Parents, children, the KNFC Board of Directors, the local Heart & Stoke Community Mission Specialist (Beth Collins), HSFO staff member overseeing the Community Advocacy Funding projects, HSFO Provincial Diversity Lead, the Kingston Gets Active Coordinator (Linda Whitfield), and Ms. Barbara Hooper have all been invited to attend. Parents in attendance will be given the completed packages. Ms. Collins and Ms. Whitfield will speak on behalf of their respective organizations. Their attendance at this presentation is significant as it will be a visual reminder of the community partnerships this project has initiated for the KNFC.

5.4 Limitations & Recommendations

Our limited sample size and broad range of discussion topics restricts generalization of these results beyond Kingston and Owen Sound. I was unable to recruit a sample large enough to represent the urban Aboriginal population across the province. Even within Kingston and Owen Sound I do not feel that a saturation of views was reached. While every effort was made to recruit
as many parents and children as possible (sharing circle dates placed on the monthly AKWE:GO calendar, multiple phone calls, messages, reminder calls, provision of food, child-minding, & transportation etc.), participant recruitment remained our biggest challenge. In Kingston, holding sharing circles in the month of December may have deterred parents who were already overwhelmed with holiday preparation, while in Owen Sound, February snow storms may have limited participation. In both locations, illness due to winter weather may have played a role in the limited attendance.

A more representative sample of male and female parents would have been ideal; however the limited participation of adult males was in some ways unavoidable. In Kingston, the vast majority of AKWE:GO children live in lone parent homes headed by single mothers.

Given the limited number of sharing circles conducted in each location, it is possible that certain participants may have led sharing circle discussions in a direction they may not have taken had that participant not been present. In Owen Sound especially, having had only one parent circle and one child circle, no comparison can be made to confirm the emergent themes.

In Kingston, the use of the talking stick gave order to the circle, ensured that only one participant spoke at a time, and may have increased the contributions of more reserved participants since all participants had to touch the stick when passing it around the circle. Therefore, we recommend that all sharing circles make use of the talking stick if deemed culturally appropriate by participants.
Due to the difficulty in recruitment of participants, it was not feasible to conduct pilot testing within this population. Sharing circle guides included numerous questions relating to each of the 4 P’s, however it was found that there was not enough time during the actual sharing circles to address all of the questions. Therefore, future investigations on this subject that utilize sharing circles should include fewer questions.

The current study provided information regarding the types of activities AKWE:GO families deem necessary to achieve wholistic health. Subsequent studies should investigate what specific factors relating to physical activity, healthy eating, talking with significant others, budgeting, and traditional activities should be promoted. These studies should include a larger sample size from a more representative population across the province. Unfortunately, this was not achieved in this study due to limited time, funding, and interest from other centres.

5.5 Implications

Consideration for community readiness indicates that differences in predisposing factors might be contributing to an increased community readiness among Owen Sound’s urban Aboriginal community. Addressing issues, such as the sense of hopelessness among Kingston participants, may help to move this community along the continuum of readiness to a place where they feel ready to take on health behaviour changes. The results of this study may be useful to the Kingston and Owen Sound Native Friendship Centres and various community organizations, such as the HSFO, in determining how best to address the needs of these communities.
Findings from this study also indicate that information is best presented to this population using personal media channels. Therefore future efforts to promote wellness among AKWE:GO families should consider doing so in the form of an interactive presentation, workshop, or class.
Chapter 6

Conclusion

6.1 Lessons Learned

Working cooperatively with Ms. Prue through the grant application and research processes was essential to the success of this project. This collaboration also served as a form of capacity building for both of us. Ms. Prue has now had exposure to the grant application process, working with the HSFO, and learning about the research process. This experience has increased my capacity for working with community partners and Aboriginal communities. I gained valuable knowledge of Aboriginal cultures and traditions (e.g., offering tobacco before asking someone a favour) and beneficial experience working within a CBPR framework.

6.2 Next Steps

Most importantly, for the community, the initial efforts begun with this project will be continued over the next year because HSFO has provided the AKWE:GO program with additional funding through a new (and larger) Advocacy Development Grant. The Katarokwi Native Friendship Centre, the local HSFO Mission Committee, and other community organizations will be using the information gained through this investigation to guide the design and implementation of health-related interventions to improve physical, mental, emotional, and spiritual health among urban
Aboriginal families. Ms. Prue and another Queen’s student working with Dr. Lévesque will collaborate to implement these next steps.

6.3 Community Feedback

The academic and community level reviews of this project occurred simultaneously. I felt this was an appropriate way to obtain feedback from both communities. It was important to have this document reviewed by Ms. Prue, Ms. Hooper, and Ms. Bouwman as they are representatives from the Kingston and Owen Sound communities who this document is ultimately about. Findings were presented to community members, but they were not asked to review this document. It is fitting that they should now have the final word.

6.3.1 Feedback from Ms. Barbara Hooper (Kingston Community Elder)

Ms. Hooper provided her feedback as well as some comments regarding the need for traditional teachings:

I've read your in-depth work and found it highly interesting, easy to read - for this "lay" person - and also most informative for the reader who did not participate. Because I was involved in some of the process, I know your reporting of the feedback from sharing circles is very accurate. I also very much concur with your observations (e.g. dealing first with some core issues before introducing some activity; the positive effect of the "talking stick.")

The latter, as you might know, is an ancient sacred helper. Proper instruction on its use, and respecting the Nations who introduced it, is key to understanding its "power." Not to be taken lightly ... Thank you for commenting on this effectiveness for your sharing circles.

The former (problematic core issues), I think, are a direct result of the absence of clear values, and therefore a way (or permission) to seek out or create some solutions: I'm talking about the absence of "tradition."
If we're talking about First Nations, Métis, Inuit or Aboriginal "traditions", then contained in those "traditions" are (the Talking Stick) and all the other values and practices to help us arrive (eventually) at physical, emotional, mental and spiritual balance – with ourselves, and with all creation, found in Medicine Wheel teachings (Plains nations; Ojibwe) or the Thanksgiving Address (Haudenausonee), to name just a few.

So, although I find that while "traditional activities" are seemingly, at least on paper, last in line (p. 69) or N/A (p. 96), the participants without knowing it (for the most part) were/are actually crying out for what those traditions teach - albeit in a different form. When/if they learn WHY the Wheel, WHY the Address, they'll begin to understand more, to help young and old through scary, hungry, difficult, fearful, fun, happy times. It's a lifetime process, isn't it, for all of us?

Karen, thank you so much for the privilege of reading your detailed, well deliberated Thesis. Thank you for the honour of being asked to share with you all for this important project. Finally, Chi Miigwetch for what you have given back to the AK:WEGO program and therefore, to our community.

6.3.2 Feedback from Ms. Mara Bouwman (Owen Sound AKWE:GO Coordinator)

Ms. Bouwman’s feedback is centered around one of the possible explanations for the high level of community readiness found in Owen Sound:

I did read over the whole thing......so much work involved.....it looks great! I think you captured the overall themes of the sharing circle that was held here, as well as the limitations involved (e.g., only one sharing circle, and therefore no point of comparison). Reading the differences between O.S and Kingston was interesting, and something I pondered. I didn't think of this at the time in terms of research, but just as an FYI, and if you do further research in Aboriginal communities: as you may recall, we had a week of Ceremonies & Teachings at the Centre the week before the Sharing Circle, and that had an "uplifting", healing and empowering affect on individuals and the community as a whole, as these things always do, and although not all parents at the circle were part of the Ceremonies, some of them were. I think this had an impact on the "spirit" of the Sharing Circle......this sense of readiness to move forward. I don't think that "readiness" was false because I believe that exists in this community (as well as the daily and difficult challenges) and was further strengthened by Ceremonies - yet the overall sense of empowerment was still at a high point. In terms of doing research in First Nations communities, that is something to consider for the future.

I think your thesis is very relevant and I genuinely commend you for the work you are doing.
References


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Appendix A

AKWE:GO Program Coordinator Packages: Project Summary
Bringing the Message Home:
Enabling urban Aboriginal families for wholistic health

PROJECT SUMMARY

The home and family environment is the primary situation in which children are nurtured and socialized and is therefore an important factor in influencing the behaviours and lifestyle choices of children. Social support groups, such as the AKWE:GO program provide another space where children can develop social networks, provide and receive support, and improve wellbeing.

Aboriginal children are at an increased risk for health problems such as diabetes and obesity compared to non-Aboriginal children. Interventions to reduce children’s risks should emphasize a wholistic approach, consistent with indigenous understandings of the interconnectedness of physical, spiritual, mental, and emotional wellbeing. Targeting younger children with such interventions will equip them with the tools necessary to establish healthy habits that could continue into adulthood.

One objective of this project is to increase parental involvement in the AKWE:GO program, and to assist parents and children with promoting wholistic health in their home setting. This will hopefully improve the chances that the messages children receive at home are consistent with the messages they receive at AKWE:GO. We also hope to increase community awareness of the AKWE:GO program. Funding has been provided through a Heart & Stroke Foundation of Ontario Advocacy Planning Grant.

Parents and children from the AKWE:GO program will be asked to participate in sharing circles to discuss wholistic health and the AKWE:GO program. The information obtained from these sharing circles will be analyzed by the researchers and used to inform the development of take-home materials for AKWE:GO families, and promotional materials for the program.

The take-home materials will be culturally relevant and tailored to the needs expressed by participants. They will be used to help bring the wholistic health messages the children receive while attending AKWE:GO into the home setting. The promotional materials will help create greater community awareness of the AKWE:GO program.

This project will be beneficial to many different groups and stakeholders. The benefits for the participants will be ultimately receiving the culturally relevant take-home materials to assist them with promoting wholistic health in their homes. The benefit for the research community is to gain a greater understanding of the barriers and facilitators for this population, and the benefit to society is becoming aware of the AKWE:GO program as a community resource. Finally, the benefit for AKWE:GO Program Coordinators and Friendship Centers will be to receive all materials and use them to promote their program and assist their participants. Findings from sharing circle analyses will also provide information about the needs of this population.

**This project has received approval from the Queen’s University General Ethics Board**
Appendix B
AKWE:GO Program Coordinator Packages: How to Get Involved
HOW TO GET INVOLVED

If you are interested in having your center participate, please have the appropriate authority at your center read the attached Friendship Center Letter of Information, and then sign the Friendship Center Consent Form (this form will then need to be returned to Karen).

Please feel free to contact Karen or Lucie with any questions or concerns you may have.

We hope you will consider joining us in this new and exciting endeavour!

Contact Information:

**Karen McNeil**
Email: 5kpm@queensu.ca
Phone: 613-888-5762

**Lucie Lévesque**
Email: lucie.levesque@queensu.ca
Phone: 613-533-6000 ext: 78164
Appendix C
AKWE:GO Program Coordinator Package: Appendixes
APPENDIXES

Heart & Stroke Foundation of Ontario (HSFO): Community Advocacy Fund
- Discusses what advocacy is and what and who the HSFO community advocacy grants are for.
- **Please note:** We have received an Advocacy Planning Grant

Queen’s University General Ethics Review Board (GREB): Letter of Approval
- Letter that states the Queen’s GREB approval of this project

Methods
- Overview of the complete protocol and methodology for the project

Verbal Recruitment Script
- Will be used by AKWE:GO coordinators and Karen McNeil when recruiting participants (parents) by phone

Parent Letter of Information (LOI)
- Will be read aloud at the beginning of all parent sharing circles. Parents will also be given a copy to keep.

Children Letter of Information (LOI)
- Will be read aloud to parents who are considering giving their children permission to participate in a sharing circle. It will either be read to them at the parent sharing circle (if they have chosen to attend), or over the phone (if they have chosen not to attend a sharing circle). It will also be read to the children who have been given parental consent (and who may or may not decide to participate).

Parent Consent Form
- Will be read aloud at the beginning of all parent sharing circles. Participants will then be asked to sign the form. Participants who choose not to sign this form will not be participating in the sharing circle and may leave.

Parental Consent Form
- Will be read aloud to parents at parent sharing circles who are considering giving their child permission to participate in a sharing circle. Parents will then be asked to sign the form.
- **Please note:** Verbal assent will be obtained from parents who do not attend a sharing circle, but agree to let their child participate.

Sharing Circle Guide: PARENTS
- These are the questions that will be asked during parent sharing circles
- **Please note:** This guide may be slightly altered once reviewed by the thesis proposal committee

Sharing Circle Guide: CHILDREN
- These are the questions that will be asked during children sharing circles
- **Please note:** This guide may be slightly altered once reviewed by the thesis proposal committee
Appendix D
Letter of Information: Friendship Centre
FRIENDSHIP CENTER LETTER OF INFORMATION

Bringing the Message Home: Enabling urban Aboriginal families for wholistic health.

This study is being conducted by Karen McNeil, a Master’s student in the School of Kinesiology and Health Studies, at Queen’s University. Her supervisor is Dr. Lucie Lévesque. Before agreeing to have your center participate, please make sure you have read this Letter of Information and have had any questions answered. Please keep a copy of this letter for your records.

We are asking your center and AKWE:GO coordinator participate in the above mentioned research project. Children and parents involved in your AKWE:GO program will be recruited to participate in a sharing circle. Participants will be recruited via telephone by the AKWE:GO program coordinator and Karen McNeil using the contact information they have provided to the center. Sharing circles will be led by the AKWE:GO program coordinator and will be held at your Friendship Center. Each sharing circle and will last approximately 60 minutes. Some sharing circles will consist of a small group of moms/dads who have children involved in the AKWE:GO program. Other sharing circles will include children aged 7-13 that are involved in the AKWE:GO program. We will talk about wholistic health and the AKWE:GO program. The main goal of this project is to develop strategies to help families promote wholistic health at home in conjunction with the AKWE:GO program.

We will work in collaboration with the AKWE:GO program coordinator to design the most relevant and appropriate strategy for participant recruitment. Parents will be asked to give permission for their child to participate. Only children whose parents have given permission and signed a Parental Consent Form will be asked if they would like to participate. No child will be forced to participate. All of these forms have received the approval of Queen’s General Research Ethics Board after having undergone full board review. Ideally, sharing circles will be held at your centre at a time that is convenient for you and your program participants. We will ask participants to consent to the audio-recording of the sharing circles.

Participation in this project is the choice of you and your coordinator. There are no known physical, psychological, economic, or social risks associated with this study. We promise the strict confidentiality of the centre and all the study participants. We will not write down or record names, so all participants will be anonymous. Only age, gender, and how long a child has been involved in the program will be recorded. The researcher will listen to the cassette tape and type up the sharing circle discussion. This will make it easier to study the information. Any cassette tapes and the written copies of the discussion will be kept in a locked filing cabinet at Queen’s University. All electronic data will be saved on the computer in password-protected files. Although the researchers involved with this study will know which centres participate, the centre will not be named in any publications or presentation unless you prefer that the centre be identified.

The information from all sharing circles will be used to make take-home materials for families involved with the AKWE:GO program. These materials will contain information and tools to help promote health in the home setting. The information will also be used to help promote the AKWE:GO program in the community. For example, we might create a poster with images suggested by participants to make the AKWE:GO program better known in the community. The
information may also be used for future publications in academic journals. This could help others looking to do similar research and/or develop community-based programs. Responses will not be connected with individual participants in any publication that results from this study.

If you would like more information about the study, or have any other questions or concerns, please feel free to contact Karen McNeil at 613-533-6000 Ext: 74699, or 5kpm@queensu.ca, Dr. Lucie Lévesque at 613-533-6000 Ext: 78164, or lucie.levesque@queensu.ca. You may also contact the Chair of the Queen's University General Research Ethics Board (GREB), Dr. Steve Leighton at (613) 533-6081 or chair.GREB@queensu.ca.

Sincerely,

Karen McNeil
Master of Science Candidate
School of Kinesiology & Health Studies
Queen's University
Kingston ON  K7L 3N6
Appendix E
Consent Form: Friendship Centre
FRIENDSHIP CENTRE CONSENT FORM

I, _________________________________, in my role as ______________________ at the Native Friendship Centre, give permission for the study titled “Bringing the Message Home: Enabling urban Aboriginal families for wholistic health” to be conducted through our center, ______________________________________. The aim of this project is to learn more about perspectives on wholistic health and the AKWE:GO program. This information will help us develop strategies to help families promote wholistic health at home in conjunction with the AKWE:GO program. I have read the Letter of Information and have had all questions answered to my satisfaction.

I understand that the participation of our center will involve the recruitment of participants and the conducting of sharing circles in our facility. Contact information for participants will be provided by the AKWE:GO program coordinator. I understand that the information provided by the participants will be used in the development of take-home materials to promote wholistic health. I understand that this information will also be used to develop promotional materials about AKWE:GO program.

I understand that, if I ask, I may have a full description of the study results. I understand that the researchers plan to publish the findings of the study.

Should I have further questions I am aware that I can contact any of the following individuals:

- **Karen McNeil:** Queen’s Student # 613-533-6000  Ext: 74699, email 5kpm@queensu.ca
- **Lucie Lévesque:** Supervisor # 613-533-6000  Ext: 78164, email lucie.levesque@queensu.ca
- **Dr. Steve Leighton:** Chair of the Queen’s University General Research Ethics Board (GREB) # 613-533-6081, email chair.GREB@queensu.ca

Name: ___________________________________

Title: ___________________________________

Signature:_________________________________  Date:___________________
Appendix F
Follow-up Email: AKWE:GO Program Coordinator
Hi ______,

My name is Karen McNeil. I am a graduate student at Queen’s University in the School of Kinesiology & Health Studies. You received a proposal package for the project titled: “Bringing the Message Home: Enabling urban Aboriginal families for wholistic health” from Willow Prue at your annual meeting in Toronto. I am contacting you because you expressed interest in having your center participate in the project… thank-you!

I understand that you will require additional information and may have additional questions prior to consenting to participate. For this reason, I would like to contact you by phone to further discuss the project. Please let me know if there is a good day and time to contact you within the next week or so.

In the meantime, attached you will find:

1) A letter of information explaining the project and your center’s participation
2) A consent form for your center that will need to be signed by the appropriate authority (someone who would need to give clearance for us to recruit AKWE:GO parents and to conduct sharing circles at your center)

Please review these documents at your earliest convenience and we can discuss these over the phone. If you decide to participate, I will also need to ask you a few questions about your centre and program during our telephone conversation.

Fax  # 613-533-2009   (Attn: Karen McNeil)

Mailing address:        Karen McNeil
                    School of Kinesiology & Health Studies
                    Physical Education Center, Room 223
                    69 Union St., Queen’s University
                    Kingston, ON
                    K7L 3N6

The participation of you and your center will enable us to develop culturally tailored take-home materials for AKWE:GO families, as well as promotional materials to promote the AKWE:GO program within your community. Your center will be provided with a copy of the take-home and promotional materials.

I look forward to talking with you to further discuss the program and your potential involvement.

Sincerely,
Karen

Karen McNeil   BKin & Nutr, PFLC
School of Kinesiology & Health Studies
Queen's University
Kingston ON   K7L 3N6
Tel: 613-533-6000  ext. 74699
Appendix G
Survey: AKWE:GO Program Coordinator
AKWE:GO Program Coordinator Survey

Name: 
Center: 

1) Would you be able to run sharing circles with parents & children during program time? 
   Y     or      N

If no, what day(s) and time(s) would be best?
________________________________________________________________________

2) What days and times will the AKWE:GO program be running in Jan 2008?

- Sunday       Y     N     Time:
- Monday       Y     N     Time:
- Tuesday      Y     N     Time:
- Wednesday    Y     N     Time:
- Thursday     Y     N     Time:
- Friday       Y     N     Time:
- Saturday     Y     N     Time:

3) Is there a space at your center that would accommodate a sharing circle (approx. 8-12 people)?
   Y     or      N

If no, is there a space in the community that would be available to use?
________________________________________________________________________

4) Would you be comfortable facilitating the sharing circles (guiding the group and asking the questions)?
   Y     or      N

If no, do you feel that participants would be comfortable having an outsider (myself) facilitate the sharing circles?
   Y     or      N
5) Is there an elder from your community that you feel might be willing to be present (and if they wish, speak) at the sharing circles?

                        Y     or     N

************************************************************************

To get a better idea of potential numbers for sharing circles…

6) How many children are currently enrolled in your AKWE:GO program?

________________________________________________________________________

7) How many parents currently have children enrolled in your AKWE:GO program?

________________________________________________________________________

8) How many parents do you think would be willing to participate in sharing circles?

________________________________________________________________________
Appendix H
Verbal Recruitment Scripts
VERBAL RECRUITMENT SCRIPT (Karen)

Project Title: Bringing the Message Home: Enabling urban Aboriginal families for wholistic health

Hi, my name is Karen McNeil and I am a student from Queen’s. Do you have five minutes to talk about your possible participation in a project related to the AKWE:GO program?

If NO, ask Can I call you at another time? YES: set time 
NO: Thank you. END CALL

If YES proceed:

I am running a project about how to promote the AKWE:GO program in the community. We are also interested in how to promote wholistic health at home. Willow and I are calling all parents with children in the AKWE:GO program to invite them to a sharing circle. Willow will be running sharing circles where parents can meet to talk about health, family, and the AKWE:GO program. We would like to find out more about what makes wholistic health easy or difficult for you and your family. Food, beverages and childminding will be provided. Would you be interested in participating? Please note that whether you choose to participate or not, your child’s involvement in the program will not be affected.

- if yes, proceed
- if unsure, ask if they would like to hear more information about it
- if no (and they have children aged 7-13), say we will also be conducting sharing circles with children aged 7-13. Would you be interested in letting your child participate?
  - if yes, read the Children’s Letter of Information and gain verbal assent
  - if no, say thank you and hang up
- if no (and they do not have children aged 7-13), say thank you and hang up

Thank you. I’ll explain a few more details. The sharing circles are confidential, so we won’t record your name. The only information we will write down is your age, gender, and how long your child has been involved with the AKWE:GO program. Nobody outside the group will know what you’ve said, so all information you give is anonymous. You will not need to answer any question that makes you feel uncomfortable and if you decide during the sharing circle that you don’t want to continue, you are free to leave. The session will be tape-recorded but no one will know who is talking on the tape. The session needs to be tape recorded for study purposes. I will listen to the cassette tape and type up the sharing circle discussion so that it can be printed to paper. This will make it easier to study the information. Any cassette tapes and the written copies of the discussion will be kept in a locked filing cabinet at Queen’s University. All electronic data will be saved on the computer in password protected files.

Do you have any questions?

(Find out availability and decide when they will be attending)

Thank you very much. I will call the day before as a reminder. I look forward to meeting with you.
VERBAL RECRUITMENT SCRIPT (Willow)

Project Title: Bringing the Message Home: Enabling urban Aboriginal families for wholistic health

Hi, it’s Willow from the Katarokwi Native Friendship Center. Do you have five minutes to talk about your possible participation in a project related to the AKWE:GO program?

If NO, ask Can I call you at another time? YES: set time
NO: Thank you. END CALL

If YES proceed:

I am helping Karen McNeil, a student from Queen’s with a project about how to promote the AKWE:GO program in the community. We are also interested in how to promote wholistic health at home. Karen and I are calling all parents with children in the AKWE:GO program to invite them to a sharing circle. I will be running sharing circles where parents can meet to talk about health, family, and the AKWE:GO program. We would like to find out more about what makes wholistic health easy or difficult for you and your family. Food, beverages and childminding will be provided. Would you be interested in participating? Please note that whether you choose to participate or not, your child’s involvement in the program will not be affected.

- if yes, proceed
- if unsure, ask if they would like to hear more information about it
- if no (and they have children aged 7-13), say we will also be conducting sharing circles with children aged 7-13. Would you be interested in letting your child participate?
  - if yes, read the Childrens’ Letter of Information and gain verbal assent
  - if no, say thank you and hang up
- if no (and they do not have children aged 7-13), say thank you and hang up

Thank you. I’ll explain a few more details. The sharing circles are confidential, so we won’t record your name. The only information we will write down is your age, gender, and how long your child has been involved with the AKWE:GO program. Nobody outside the group will know what you’ve said, so all information you give is anonymous. You will not need to answer any question that makes you feel uncomfortable and if you decide during the sharing circle that you don’t want to continue, you are free to leave. The session will be tape-recorded but no one will know who is talking on the tape. The session needs to be tape recorded for study purposes. The researcher will listen to the cassette tape and type up the sharing circle discussion so that it can be printed to paper. This will make it easier to study the information. Any cassette tapes and the written copies of the discussion will be kept in a locked filing cabinet at Queen’s University. All electronic data will be saved on the computer in password protected files.

Do you have any questions?

(Find out availability and decide when they will be attending)

Thank you very much. I will call the day before as a reminder. I look forward to meeting with you.
PARENT LETTER OF INFORMATION (Kingston)

Bringing the Message Home: Enabling urban Aboriginal families for wholistic health.

We are asking you to participate in a sharing circle. Willow Prue, the coordinator of the AKWE:GO program, will lead the sharing circle. It will be held at the Katarokwi Native Friendship Center and will take about an hour. A small group of moms/dads with children in the AKWE:GO program will be in the sharing circle. We will talk about wholistic health. We will also talk about AKWE:GO and how it can help families promote wholistic health at home.

Participation in the sharing circle is your choice. You do not have to answer any questions that make you feel uncomfortable. You are free to leave at anytime for any reason. The sharing circle will be tape recorded (NOT video taped). This is so that the researcher can listen back on what was talked about. Data recorded before you leave cannot be erased. This is because you will not be asked to identify yourself on the tape. We won’t know who is talking on the tape.

We will not write down or record your name. You will be anonymous. Only your age, gender, and how long your child has been in the program will be recorded. The researcher will listen to the cassette tape and type up what was said during the sharing circle. This will make it easier to study the information. Any cassette tapes and the written copies of the discussion will be kept in a locked filing cabinet at Queen’s University. All information on the computer will be protected by a password.

The information from sharing circles will be used to make take-home packages for AKWE:GO families. These packages will have information and tools to help promote wholistic health at home. The information will also be used to help promote the AKWE:GO program in the community. For example, we might make a poster with pictures that you suggest. The information may also be published in academic journals. This would help others doing this same kind of research. It could also help others develop programs for the community. Your responses will not be connected with your name in any papers or articles written about this study.

If we talk to parents and children we will be able to make better packages. We hope to have sharing circles with children who are 7-13 years old and are involved in the AKWE:GO program. If you have a child in this age group, you will be asked to give them permission to participate. No matter what you choose, their involvement in the AKWE:GO program will not change. Your child and your family will not be treated differently by program or project staff. If you are interested, you will be read the Childrens’ Letter of Information. You will then be asked to sign a Parental Consent form. Only children whose parents have given permission will be asked to participate. The child does not have to participate if they don’t want to.

This study is being run by Karen McNeil, a Master’s student in the School of Kinesiology and Health Studies, at Queen’s University. Her supervisor is Dr. Lucie Lévesque. Before you decide to participate, make sure you have read (or been read) this Letter of Information and that you understand what it says. If you have any questions, please ask. Please keep a copy of this letter.

If you would like to know more about the study, or have any other questions, you can contact Karen McNeil at 613-533-6000 Ext: 74699, or 5kpm@queensu.ca, Dr. Lucie Lévesque at 613-533-6000 Ext: 78164, or lucie.levesque@queensu.ca. You may also contact the Chair of the
Queen's University General Research Ethics Board (GREB), Dr. Steve Leighton at (613) 533-6081 or chair.GREB@queensu.ca.

Sincerely,

Karen McNeil  
Master of Science Candidate  
School of Kinesiology & Health Studies  
Queen's University  
Kingston ON K7L 3N6
PARENT LETTER OF INFORMATION (Owen Sound)

Bringing the Message Home: Enabling urban Aboriginal families for wholistic health.

We are asking you to participate in a sharing circle. Mara Bouwman, the coordinator of the AKWE:GO program, and Karen McNeil, a student from Queen’s University will lead the sharing circle. It will be held at the M’Wikwedong Native Cultural Resource Centre and will take about an hour. A small group of moms/dads with children in the AKWE:GO program will be in the sharing circle. We will talk about wholistic health. We will also talk about AKWE:GO and how it can help families promote wholistic health at home.

Participation in the sharing circle is your choice. You do not have to answer any questions that make you feel uncomfortable. You are free to leave at anytime for any reason. The sharing circle will be tape recorded (NOT video taped). This is so that the researcher can listen back on what was talked about. Data recorded before you leave cannot be erased. This is because you will not be asked to identify yourself on the tape. We won’t know who is talking on the tape.

We will not write down or record your name. You will be anonymous. Only your age, gender, and how long your child has been in the program will be recorded. The researcher will listen to the cassette tape and type up what was said during the sharing circle. This will make it easier to study the information. Any cassette tapes and the written copies of the discussion will be kept in a locked filing cabinet at Queen’s University. All information on the computer will be protected by a password.

The information from sharing circles will be used to make take-home packages for AKWE:GO families. These packages will have information and tools to help promote wholistic health at home. The information will also be used to help promote the AKWE:GO program in the community. For example, we might make a poster with pictures that you suggest. The information may also be published in academic journals. This would help others doing this same kind of research. It could also help others develop programs for the community. Your responses will not be connected with your name in any papers or articles written about this study.

If we talk to parents and children we will be able to make better packages. We hope to have sharing circles with children who are 7-13 years old and are involved in the AKWE:GO program. If you have a child in this age group, you will be asked to give them permission to participate. No matter what you choose, their involvement in the AKWE:GO program will not change. Your child and your family will not be treated differently by program or project staff. If you are interested, you will be read the Childrens’ Letter of Information. You will then be asked to sign a Parental Consent form. Only children whose parents have given permission will be asked to participate. The child does not have to participate if they don’t want to.

This study is being run by Karen McNeil, a Master’s student in the School of Kinesiology and Health Studies, at Queen’s University. Her supervisor is Dr. Lucie Lévesque. Before you decide to participate, make sure you have read (or been read) this Letter of Information and that you understand what it says. If you have any questions, please ask. Please keep a copy of this letter.

If you would like to know more about the study, or have any other questions, you can contact Karen McNeil at 613-533-6000 Ext: 74699, or 5kpm@queensu.ca, Dr. Lucie Lévesque at 613-
533-6000 Ext: 78164, or lucie.levesque@queensu.ca. You may also contact the Chair of the Queen's University General Research Ethics Board (GREB), Dr. Steve Leighton at (613) 533-6081 or chair.GREB@queensu.ca.

Sincerely,

Karen McNeil  
Master of Science Candidate  
School of Kinesiology & Health Studies  
Queen's University  
Kingston ON K7L 3N6
Appendix J
Consent Form: Parental (for child’s participation)
PARENTAL CONSENT FORM (for Child’s Participation)

I, ______________________________, hereby give my permission for my child, ______________________________, to participate in the study titled “Bringing the Message Home: Enabling urban Aboriginal families for wholistic health”. The aim of this project is to learn more about perspectives on wholistic health and the AKWE:GO program. I have been read the Childrens’ Letter of Information and have had all questions answered to my satisfaction.

I understand that my child’s participation will involve attending a sharing circle (lasting about 60 minutes). My child will be asked questions about wholistic health. He/she will also be asked about the AKWE:GO program. I understand that the information my child provides will be used in the development of take-home materials to promote wholistic health. I understand that this information will also be used to develop promotional materials about AKWE:GO program.

I understand that, if I ask, I may have a full description of the study results. I understand that the researchers plan to publish the findings of the study.

I understand that my consent does not guarantee my child’s participation; my child will be asked if he/she would like to participate in the sharing circle. He/she will be read the Childrens’ Letter of Information which contains all of this same information. He/she can then choose to participate or not. No matter what they decide, his/her participation in the AKWE:GO program will not be affected. My child and my family will be treated as we always have by program and centre staff.

I understand that my child’s participation in this study is voluntary. He/she does not have to answer any questions that he/she chooses not to. Finally, I understand that his/her name will not be collected. Only his/her age and gender will be written down. The session will be tape-recorded but no one will know who is talking on the tape.

Signature: __________________________________________ Date: ____________________
Appendix K
Letter of Information: Children
CHILDREN’S LETTER OF INFORMATION (Kingston)

**Bringing the Message Home: Enabling urban Aboriginal families for wholistic health.**

You are invited to be part of a sharing circle. The sharing circle will be a small group of AKWE:GO participants. We will talk about wholistic health and what makes it easy or hard to achieve. We will also talk about your experience at AKWE:GO and how it relates to health.

Karen McNeil, a Queen’s University student, will use this information to make some packages for you and your family. These packages will have information about healthy living.

The sharing circle will be lead by Willow at the Katarokwi Native Friendship Center. It will take about an hour. Healthy snacks will be provided. Our discussion will be tape-recorded but nobody will listen to the tape except for Karen and her supervisor.

We aren’t writing down your name. We just want to hear about your experiences with wholistic health at AKWE:GO and at home. You do not have to answer any questions that you don’t feel like answering. You are free to leave at anytime.

You do not have to participate if you don’t feel like it. It is totally up to you. Nothing will change about your visits to the centre or to AKWE:GO.

Would you like to participate?

YES – set time
NO – thanks
CHILDREN’S LETTER OF INFORMATION (Owen Sound)

Bringing the Message Home: Enabling urban Aboriginal families for wholistic health.

You are invited to be part of a sharing circle. The sharing circle will be a small group of AKWE:GO participants. We will talk about wholistic health and what makes it easy or hard to achieve. We will also talk about your experience at AKWE:GO and how it relates to health.

Karen McNeil, a Queen’s University student, will use this information to make some packages for you and your family. These packages will have information about healthy living.

The sharing circle will be lead by Mara and Karen at the M’Wikwedong Native Cultural Resource Centre. It will take about an hour. Healthy snacks will be provided. Our discussion will be tape-recorded but nobody will listen to the tape except for Karen and her supervisor.

We aren’t writing down your name. We just want to hear about your experiences with wholistic health at AKWE:GO and at home. You do not have to answer any questions that you don’t feel like answering. You are free to leave at anytime.

You do not have to participate if you don’t feel like it. It is totally up to you. Nothing will change about your visits to the centre or to AKWE:GO.

Would you like to participate?

YES – set time
NO – thanks
Sharing Circle Guide: PARENTS

TAPE-RECORDER OFF

Welcome: Explain that the purpose of the research is to talk about ideas for promoting healthy behaviours in the home and for developing ideas to be used for materials to promote the AKWE:GO program. Assure them that there are no right or wrong answers. We would like to hear opinions from everybody, but they don’t have to talk if they don’t want to.

Opening Question:
- Can you please say your name and one thing you’d like us to know about your child – one thing your child does that makes you smile.

[ASK PERMISSION TO START TAPING]
[TAPE-RECORDER ON]

Introductory Questions:
- When you hear the word “wholistic”, what comes to mind?
- When you hear the word “health”, what comes to mind?
  o We are looking to get an idea of what wholistic health is to you

Key Questions:
- Describe a healthy/balanced person.
- Probe: Health can have different dimensions: Physical, Mental, Spiritual, Emotional

HEALTH ACTIVITIES:
- How do you achieve good…
  o Physical health?
  o Mental health?
  o Emotional health?
  o Spiritual health?

Probe: What activities would make you physically, mentally, emotionally, or spiritually healthy?

[ACTIVITIES/BEHAVIOURS WRITTEN ON FLIP CHART]

- What are the benefits of each of these activities?
  Probe: For example, having more energy is a benefit of physical activity
  - address each activity individually

[LIST ACTIVITY-SPECIFIC BENEFITS NEXT TO EACH ACTIVITY/BEHAVIOUR RECORDED ON FLIP CHART]
- What makes it hard to engage in these activities?
  ○ Probe: Barriers can be anything... such as money, embarrassment, social status (it's not a “cool” thing to do), or not having access to the behaviour

  [LIST ACTIVITY-SPECIFIC BARRIERS NEXT TO EACH ACTIVITY/BEHAVIOUR RECORDED ON FLIP CHART]

- What would make it easy to engage in these activities?
  Probe: does not have to be the opposite of what makes it hard
  - IF money becomes the main topic of conversation, ask what other things would make it easy, GIVEN THEIR CURRENT SITUATION

  [LIST ACTIVITY-SPECIFIC FACILITATORS NEXT TO EACH ACTIVITY/BEHAVIOUR RECORDED ON FLIP CHART]

- Some activities have barriers that can’t be changed, so what would make those barriers acceptable to you? What would make these barriers not matter?
  Probe: For example, exercising takes time, so if time is a barrier to exercise, what would make it worth spending the necessary time exercising?
  *Can address barriers listed individually

COMPETING ACTIVITIES

- What unhealthy activities or behaviours compete with the healthy activities?
  Probe: For example, I watch TV in my spare time when I could be walking.

  [BEHAVIOURS WRITTEN ON FLIP CHART]

- How could the benefits of these unhealthy activities be made less attractive?
  Probe: For example, what could make watching TV less enjoyable?

- What are some ideas on how to get you away from these unhealthy activities?
  Probe: For example, there is less temptation to watch TV when you don’t have cable.

- Which of these unhealthy activities/behaviours do you think would be easiest to change?

- What would make healthy behaviours more attractive than these unhealthy behaviours?
  Probe: What would it take to make you want to go for a walk instead of watch TV?

Now we’re going to switch gears a little and I am going to ask you some questions about the AKWE:GO program and how it might be related to some of the health behaviours we’ve been talking about.

HEALTH INFORMATION:
- Do you think in advance about engaging in healthy behaviours, or does it happen at the spur of the moment?
  Probe: *For example, when do you think about what you are going to cook for dinner... in the morning, or driving home from work?*

- What information would help you to choose a **healthy activity**?
  o *What specifically would you like to know... in community settings, home setting, about parenting...etc.*
  o *Can address each activity individually*
  Probe: *For example, information about free community swims and skates would help my family be more active*

- From what source/where would you most like to receive information about health? About healthy choices?
  Probe: *Friendship Centre, other parents, your child’s school, community organization, City Hall, other...*

- In what type of format would you prefer to get information about health and healthy activities?
  Probe: *print materials, phone calls, emails, presentations/workshops, home visits*

- When and where do you get the urge to listen to and act upon health messages?
  Probe: *For example you may be most likely to purchase healthy foods if you have information about healthy foods when grocery shopping*

**AKWE:GO:**

- What role does the AKWE:GO program play in your family’s health?
- What role would you like it to play?
- If you were to tell someone about this program, what would you tell them?
- Do your children tell you about the program? What do they tell you?

- Are you aware of any other community resources or organizations that promote health?
  Probe: *For example, Pathways, Better Beginnings, Boys & Girls Club...*

**Ending Question:**

- We are going to be putting together materials for your families about promoting the healthy behaviours discussed earlier, as we begin this process what advice do you have for us?

**SUMMARIZE SESSION**

**Summary Question:**

- How well does that capture what was said here?

**Final Question:**

- Have we missed anything?
END TAPE RECORDING

THANK PARTICIPANTS
Welcome: Explain that the purpose of the research is to talk about ideas for promoting healthy behaviours in the home and for developing ideas to be used for materials to promote the AKWE:GO program. Assure them that there are no right or wrong answers. We would like to hear opinions from everybody, but they don’t have to talk if they don’t want to.

**Opening Question:**
- Can you please say your first name and one of your favourite physical activities.

[ASK PERMISSION TO START TAPING]
[TAPE-RECORDER ON]

**Introductory Questions:**
- When you hear the word “wholistic”, what comes to mind?
- When you hear the word “health”, what comes to mind?
  - We are looking to get an idea of what wholistic health is to you
  - Provide a description of what wholistic health is if children are unsure
    - Physical, Spiritual, Emotional, Mental

**Key Questions:**
- Describe a healthy/balanced person.
- Probe: Health can have different dimensions: Physical, Mental, Spiritual, Emotional

**HEALTH ACTIVITIES:**
- How do you achieve good…
  - Physical health?
  - Mental health?
  - Emotional health?
  - Spiritual health?

Probe: What activities would make you physically, mentally, emotionally, or spiritually healthy?

[ACTIVITIES/BEHAVIOURS WRITTEN ON FLIP CHART]

- What are the benefits of each of these activities?
  - Probe: For example, being able to concentrate at school is a benefit of physical activity
  - address each activity individually
- What makes it hard to engage in these activities?
  o Probe: Barriers can be anything... such as money, embarrassment, social status (not being “cool”), or not having access to the behaviour

- What would make it easy to engage in these activities?
  Probe: does not have to be the opposite of what makes it hard
  - IF money becomes the main topic of conversation, ask what other things would make it easy, GIVEN THEIR CURRENT SITUATION

- Some activities have barriers that can’t be changed, so what would make these barriers not matter?
  Probe: For example, exercising takes time, so if time is a barrier to exercise, what would make it worth spending the necessary time exercising?
  *Can address barriers listed individually

- What are some activities that your whole family can do together? (something that everybody likes to do)

- Do you think in advance about engaging in healthy behaviours, or does it happen at the spur of the moment?
  Probe: For example, when do you think about what you are going to do after school... do you plan at school to meet up with friends to play outside?

- What information would help you to choose a healthy activity?
  o What specifically would you like to know... in community settings, home setting, school setting...etc.
  o * Can address each activity individually
  Probe: For example, information about free community swims and skates would help my family be more active

- From what source/where would you most like to receive information about health? About healthy choices?
  Probe: Friendship Centre, your parents, your teacher, other...

- In what type of format would you prefer to get information about health and healthy activities?
  Probe: print materials, presentations, somebody talking to you one-on-one

- When and where do you get the urge to listen to and act upon health messages?
**COMPETING ACTIVITIES**

- What unhealthy activities or behaviours compete with the healthy activities?  
  Probe: *For example, I watch TV in my spare time when I could be active*

  **[BEHAVIOURS WRITTEN ON FLIP CHART]**

- How could the benefits of these unhealthy activities be made less attractive?  
  Probe: *For example, what could make watching TV less enjoyable?*

- What are some ideas on how to get you away from these unhealthy activities?  
  Probe: *For example, there is less temptation to watch TV when you don’t have cable.*

- Which of these unhealthy activities/behaviours do you think would be easiest to change?

- What would make healthy behaviours more attractive than these unhealthy behaviours?  
  Probe: *What would it take to make you want to be active instead of watch TV?*

**Now we’re going to switch gears a little and I am going to ask you some questions about the AKWE:GO program and how it might be related to some of the health behaviours we’ve been talking about.**

**AKWE:GO:**

- What role does the AKWE:GO program play in your family’s health?  
- What role would you like it to play?  
- What’s good about being involved with this program? What parts of the program do you really like?  
- If you were to tell a friend about this program, what would be the first thing you would tell them?  
- Do your parents ask you about the program? What do they ask you? What do you tell them?  
- Has anything changed since you started coming?  
- Do you know of any other places in the community that promote health?  
  Probe: *For example, Boys & Girls Club…*

**Ending Question:**

- We are going to be putting together materials for your families about promoting the healthy activities we discussed earlier, as we begin this process what advice do you have for us?

**SUMMARIZE SESSION**
Summary Question:
   - How well does that capture what was said here?

Final Question:
   - Have we missed anything?

END TAPE RECORDING

THANK PARTICIPANTS
Moderating Sharing Circles

Guiding Principles for Moderators:
- Must respect participants and truly believe they have wisdom
- Listen attentively and with sensitivity; have empathy and positive regard for participants
- Must guide discussion but NOT participate: comments on personal opinions or values could jeopardize discussion
- Must be ready to hear unpleasant views
- Use your unique talents and develop moderating strategies that are comfortable for you and effective for your sharing circle (ie: eye contact, smiles, attentive listening, reweaving comments)

Dealing with participant behaviour
- Experts, dominant talkers, disruptive participants, & ramblers → look away, don't take notes, & interrupt when necessary
- Quiet/shy participants → make eye contact, &/or call on them by name
- Inattentive participants → call on them by name, repeat question, ask if they would like to say something

Dealing with participant comments/questions
- Disrespectful or personal attacks → moderator should anticipate emotionally charged topics and address this in the ground rules
- Incorrect or harmful advice → if information is harmful, moderator can provide facts on the topic at the end of the discussion (may offer source of info)
- Personal disclosures → encourage “general” information on topic, but depending on the severity of the personal actions described, moderator may have to report actions to appropriate parties
- Questions after intro or during sharing circle → do not invite questions at these times, and if questions are asked, use discretion on whether or not to answer immediately, later, or deflect all together

BEFORE the Sharing Circle
- Mentally prepare (become familiar with questions and their rationale)
- Set up equipment, food & refreshments, and arrange the room

DURING the Sharing Circle
- Greet participants, make small talk, registration/small survey
- Introduce sharing circle (create atmosphere, set tone & ground rules)
- Ask simple ice-breaker question
- Ask key questions
- Anticipate the flow of the discussion (interrupt and refocus only when necessary)
- Control your reactions (neutral gestures and comments that don’t indicate agreement)
- Allow short pauses (after questions, after comments) and probe as needed
- Listen; ensure conversation stays on topic & that questions are understood
- Ask final question
- Summarize main points, ask participants if this is accurate & invite comments
- Debrief with assistant moderator
<table>
<thead>
<tr>
<th>Personal Qualities: Moderators</th>
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</thead>
<tbody>
<tr>
<td>- Understands group process</td>
</tr>
<tr>
<td>- Curious</td>
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<tr>
<td>- Communication Skills</td>
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<tr>
<td>- Friendly/ Sense of humour</td>
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<td>- Interest in people</td>
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<td>- Open to new ideas</td>
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<tr>
<td>- Listening skills</td>
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</table>

**Role of the assistant moderator (Karen McNeil):**

- Sits across from moderator, slightly back from the table
- Take comprehensive notes
- Operates tape recorder
- Handles food/refreshments, seating
- Responds to unexpected interruptions

**THANK-YOU FOR AGREEING TO MODERATE!**
Appendix O

Consent Form: Parent
PARENT CONSENT FORM

I, ______________________________, have volunteered for the study “Bringing the Message Home: Enabling urban Aboriginal families for wholistic health”. The goal of this project is to learn more about what parents and children think about wholistic health and the AKWE:GO program. I have been read the Letter of Information and have had all of my questions answered.

I know that I will be part of a sharing circle (lasting about an hour). I will be asked questions about wholistic health and the AKWE:GO program. I know that my answers will be used to make take-home packages about wholistic health. I know my answers will also be used to make posters to promote the AKWE:GO program.

I know that I can have a copy of the results if I ask. I know the researchers plan to publish the findings of the study. There are no known risks related to participating in this study.

I know that I may leave whenever I want. I may leave for any reason. I do not have to answer any questions that I don’t want to. I know that my name will not be written down. Only my age and gender will be written down. The sharing circle will be tape-recorded but no one will know who is talking on the tape.

Whether I choose to participate or not, my child and my family will be treated as we always have by program and centre staff.

If I have any questions I can contact any of the people listed below:

- **Karen McNeil**: Queen’s Student # 613-533-6000  Ext: 74699, email 5kpm@queensu.ca
- **Lucie Lévesque**: Supervisor # 613-533-6000  Ext: 78164, email lucie.levesque@queensu.ca
- **Dr. Steve Leighton**: Chair of the Queen's University General Research Ethics Board (GREB) # 613-533-6081, email chair.GREB@queensu.ca

Signature: ___________________________________________  Date: _____________________________________