

EXPLORING HOW CURRENT FEDERAL, PROVINCIAL, AND FIRST NATIONS
GOVERNMENT POLICIES SUPPORT AND PROMOTE HEALTHY AGING
AMONG OLDER MI'KMAQ IN ATLANTIC CANADA

by

Christie L. Stilwell

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For my grandfather, Professor Frank Silversides

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ABSTRACT

Older Indigenous peoples in Canada, including Mi'kmaq in the Atlantic region, face significant health disparities that occur earlier and more often than for non-Indigenous Canadians. These health disparities mask the unique and positive ways in which Elders and older Mi'kmaq can promote wellbeing within their communities in Atlantic Canada, introducing challenges to promoting health across the life course. As more Mi'kmaq reach older age, creating healthy aging policies that aim to promote health is essential. This study explored: 1) What are the current federal, provincial, and First Nations government policies that promote healthy aging among older Mi'kmaq living on-reserve in Atlantic Canada; and 2) a) how do policymakers integrate and reflect upon Mi'kmaq perspectives in the development, implementation, and evaluation process of healthy aging-related policies, and b) how can these policies support healthy aging of older Mi'kmaq living in their communities.

A two-phase qualitative descriptive approach was used to answer these questions. First, a systematic search was conducted to locate 11 federal, provincial, and First Nation policies, strategies, frameworks, and action plans related to healthy aging and older Mi'kmaq on organizational and governmental websites. Second, nine interviews were conducted with individuals working in federal, provincial, and First Nations government departments, First Nations Health Organizations, First Nations Health Centres, and members of provincial aging policy development committees across the Atlantic region. Inductive content analysis generated four descriptive themes from the policy documents: a) Transparent Inclusion of Older First Nations During Policy Development, b) Engaging Elders and Older Mi'kmaq, c) Determinants of Health Approach, and d) Programs and Services; and three descriptive themes from the interviews: a) Government Relations and Communication, b) Current Healthy Aging Policies for First Nations, and c) Integrating Older First Nations Healthy Aging-Related Priorities in Health Policies.

Findings indicated inconsistencies between First Nations and Canadian government policies related to service provision and programs intended to promote healthy aging among Elders and older Mi'kmaq on-reserve. In addition, priorities related to healthy aging identified in Mi'kmaq organization mandates have not been integrated into federal or provincial healthy aging policies. These findings highlight the urgent need for meaningful collaboration between First Nations and Canadian governments to co-create comprehensive, Indigenous-focused policies to promote healthy aging. It was also emphasized that Elders and older Mi'kmaq living on-reserve need to be meaningfully engaged to understand what each community wants to age well. Critically, a process for inclusive and comprehensive engagement with communities is needed to ensure healthy aging is supported and needs are being addressed.

LIST OF ABBREVIATIONS USED

AAEDIRP	Atlantic Aboriginal Economic Development Integrated Research Program
AANDC	Aboriginal Affairs and Northern Development Canada
CAG ASEM	Canadian Association on Gerontology Annual Scientific and Educational Meeting
CIRNAC	Crown Indigenous Relations and Northern Affairs Canada
ECWG	Elder Care Working Group
FNIGC	First Nations Information Governance Centre
FNIHB	First Nations Inuit Health Branch
FNIHCC	First Nations and Inuit Home and Continuing Care
ISC	Indigenous Services Canada
NIHB	Non-Insured Health Benefits
OCAP	Ownership Control Access Possession
REB	Research Ethics Board
TCPS	Tri-Council Policy Statement
TRC	Truth and Reconciliation Commission

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CHAPTER 1 INTRODUCTION

Within First Nations cultures, the medicine wheel is a symbol that is often used to visualize important teachings. In reference to health, the medicine wheel represents the balance and harmony between physical, mental, spiritual, and emotional wellbeing (Couture, 2011; Dapice, 2006). The medicine wheel can also symbolize the life course (Assembly of First Nations, 2007). Mi'kmaw Elder Murdena Marshall taught that the medicine wheel is aligned with the seven stages of life and the seven sacred teachings: love, honesty, humility, respect, truth, patience, and wisdom (Marshall, n.d.). The life course is often understood as a repeating cycle, where rather than mark the end of life, old age signals the accumulation of wisdom and a time for teaching this wisdom to others so that the spirit lives on in the next generation and as part of the spirit world (Assembly of First Nations, 2007; Castellano, 2011).

Canada's population is aging (Statistics Canada, 2018). Though much attention is given to the aging citizens of the general population, and specifically their increasing health care needs, the attention is not distributed equitably among all demographics or regions. Living in both urban and rural areas of Canada on mostly unceded and/or treated traditional territory are Indigenous peoples who, despite attempted multi-generational genocide (Truth and Reconciliation Commission of Canada, 2015), have survived and are aging. In comparison to the rest of the country, the proportion of Indigenous older adults is increasing more quickly than in the general population (Habjan, Prince, & Kelley, 2012). Inequitable political and social factors imposed by colonization have had, and continue to have an especially severe and negative impact on the health of Indigenous peoples in Canada (Adelson, 2005; Cooke, Guimond, &

McWhirter, 2008; Hayward, Paquette-Warren, & Harris, 2016). These colonial factors severely disrupted the rich and cultured histories and connections with the land that have sustained Indigenous peoples for thousands of years.

Indigenous older adults face significant health disparities that surface earlier and more frequently than in the general Canadian population (Beatty & Berdahl, 2011). For Mi'kmaq it was found that just over half of all adults age 44 and below have a least one chronic health condition, and 37% of adults age 45 and above have four or more chronic health conditions (Sinno, Hull, & Bombay, 2018). These health disparities are not due to certain physiological traits of Indigenous peoples, but rather the cumulative results of trauma-inducing colonization and centuries of oppressive social and political injustices that Indigenous peoples have had to endure to survive (Adelson, 2005). Many Indigenous older adults are dealing with inter- and cross-generational stress and trauma stemming from racist and colonial policies (Beatty & Berdahl, 2011; Reading, 2009). This includes the residential school system, which began in the 1800s and continued until the last school closed in 1996, where Indigenous children were forced to attend Christian boarding schools, exposing them to horrific abuses, neglect, and alienation from their families and culture (Truth and Reconciliation Commission of Canada, 2015). Of Indigenous older adults over age 60, 42.3% reported attending a residential school when they were younger (FNIGC, 2018). A large proportion of Indigenous peoples have also been deeply affected by child welfare policies that removed Indigenous children from their families and placed them in foster homes outside of their communities, or adoption by non-Indigenous families, called the sixties scoop (Spencer, 2017) and overrepresentation in child welfare services continues to this day. Indigenous children

(primarily First Nations) account for nearly half of all children in foster care in Canada, despite making up just seven percent of the population aged 14 and below (Turner, 2016). The trauma from these events still strains personal health and wellbeing as well as extended familial relations among many First Nations (FNIGC, 2018). The impact of colonization on the health of Indigenous peoples is discussed further in Chapter 2.

Conditions such as diabetes, arthritis, and heart disease are highly prevalent and dramatically impact quality of life and life expectancy (First Nations Information Governance Centre (FNIGC), 2018; Habjan et al., 2012; Hayward et al., 2016). Declining health is just one of the many challenges Indigenous people face as they age. Current health and healthcare policies exacerbate these complex health issues by limiting access to health care and failing to address aging and wellbeing in an equitable and culturally safe way that meets the needs of this demographic (Habjan et al., 2012). Yet this persistent attention to disease and pathology masks the positive experiences and value associated with aging, such as an increasing sense of resiliency and strength, having an active leadership role in one's community, and teaching traditions, language, and cultural knowledges to younger generations (Baskin & Davey, 2015; FNIGC, 2016). Teachings from the medicine wheel show that different stages of life are associated with the seven sacred gifts, and with older age can come wisdom that may be shared with others (Marshall, n.d.). Elders and older Indigenous peoples are integral to cultural revitalization, building intergenerational connections, and sharing knowledges about the land and environment. Their resilience and strength are attributes to recognize, honour, and learn from in terms of understanding and promoting Indigenous healthy aging.

According to Statistics Canada (2017), as of 2016 there are approximately 1.67

million Indigenous peoples residing in Canada, accounting for about 4.9% of the total population. Compared to the general Canadian population that has an average age of 41, the average age of the Indigenous population is 32 years – while the average age is younger, the expected growth over time is greater (Statistics Canada, 2017). The number of Indigenous people aged 65 and older increased to 122,186 in 2016, nearly doubling the number of older Indigenous adults from 2001 (Statistics Canada, 2017; Wilson, Rosenberg, & Abonyi, 2010). This trend is set to continue as the large cohort of young Indigenous people move through their increasing lifespan. It is projected that the proportion of the Indigenous population over age 65 will more than double by 2036 (Statistics Canada, 2017). Concurrently, the non-Indigenous proportion of the older adult population continues to steadily increase, though different data sets (e.g., census data from Statistics Canada versus data from the First Nations Regional Health Survey) make growth comparisons between non-Indigenous and Indigenous older adults difficult.

This critical context introduces challenges to support wellbeing as Indigenous peoples age. For example, Indigenous older adults are more likely to live in poverty and in crowded housing environments (Cooke et al., 2008). Chronic health conditions, caused in large part by socioeconomic factors, can lead to physical debilitation, diminished mental capacities, and social exclusion (National Collaborating Centre for Aboriginal Health, 2012). However, these health disparities continue to distract from the unique, positive, and important contributions that Elders and older Indigenous peoples can make to overall community wellbeing.

Aging itself is a physiological reality framed through socio-cultural constructs (Levy, 2009; Meisner & Levy, 2016), and many of the defining criteria of healthy aging

varies cross-culturally (Löckenhoff et al., 2009). As such, it is critical that policies intended to support healthy aging in specific populations are representative and inclusive of diverse cultural values. Current federal and provincial policies that support healthy aging are accessible for a majority of Canada's older adults (Canadian Institutes for Health Information, 2011). A recent environmental scan of healthy aging policies in rural and urban Canada yielded 39 examples of frameworks, strategies, and action plans that aim to promote various aspects (i.e., supportive environments, aging in place, caregiver support) related to aging well (Jeffery, Muhajarine, Johnson, McIntosh, Hamilton & Novik, 2018). By comparison, detailed policies from federal, provincial, and Indigenous governments for promoting the healthy aging of Indigenous peoples are under developed (Habjan et al., 2012). Indigenous peoples are by no means a homogenous group, rather they are distinct Nations with diverse histories and cultural practices. As increasing numbers of Indigenous peoples reach old age, attention to policies that support healthy aging and reflect each community's needs and values (as defined by Indigenous peoples) is imperative to promote their health and wellbeing in appropriate and meaningful ways. This study examined healthy aging policies relevant to Elders and older Mi'kmaq living in First Nation communities in Atlantic Canada.

1.1 Definitions

Operational definitions of the key terms used in this thesis are reviewed below to generate clarity and contextual understanding. The key terms to be discussed are: Indigenous peoples, Mi'kmaq First Nations in the Atlantic region, older Indigenous person, Elders and older Mi'kmaq, policy documents, and stakeholders. Rationale is given, where necessary, for the selection of certain terms.

1.1.1 Indigenous Peoples

The term Indigenous peoples refers to First Nations, Inuit, and Métis populations inclusive of non-status or self-identified peoples that live within Canadian borders, mirroring the definition given by the National Collaborating Centre for Aboriginal Health (2012). The Canadian Constitution uses the word ‘Aboriginal’ and ‘Indian’ to describe and recognize First Nations, Inuit, and Métis. The term *Indigenous* was selected over *Aboriginal* because this terminology is mostly preferred by Indigenous peoples as it better acknowledges the diversity of languages, cultures, and traditions. This term is also used in the United Nations Declaration of the Rights of Indigenous Peoples, which recognizes Indigenous peoples’ rights for survival, dignity, and wellbeing (Joseph, 2016; United Nations General Assembly, 2007). However, terminology referring collectively to Indigenous peoples or groups may vary throughout this study based on the preferences of the participants or the language used in, or specificity of, existing policies or literature.

Inuit refers to the original inhabitants of the vast polar region who share a distinct culture and language (International Journal of Indigenous Health, n.d.). In Canada, a majority of Inuit live in the Yukon, Northwest Territories, parts of Northern Quebec, and along the coast of Labrador. Métis refers to people of mixed Indigenous and European heritage (Daniels v. Canada 2016); however, prior to this recent supreme court decision, Métis were recognized by their mixed ancestry, customs, and group identities that were distinctly separate from other Indigenous or European groups (R. v. Powley, 2003). First Nations refers to all other original peoples including status, non-status, and treaty. The term ‘status’ refers to Indigenous peoples registered under the *Indian Act* in Canada, and

‘treaty’ refers to First Nations or Bands that have signed a treaty with the Crown (Statistics Canada, 2019). Currently there are 634 First Nation communities across Canada (Assembly of First Nations, 2016). Every effort was made to clearly specify which Indigenous group(s) was(were) the focus of a policy or previous study to avoid cultural erasure and generalizations.

1.1.2 Mi’kmaq First Nations in the Atlantic Region

This study focused on the older Mi’kmaq population living on-reserve in the Atlantic region, consisting of the provinces of New Brunswick, Nova Scotia, Prince Edward Island, and Newfoundland and Labrador, as it is primarily the traditional territory of the Mi’kmaq (along with Innu, Inuit, and Wolastoqiyik). There are 25 land-based Mi’kmaq communities (also referred to as reserves) located in the Atlantic provinces with a combined total population of approximately 29,000 people: Two in Prince Edward Island (Abegweit, Lennox Island), 13 in Nova Scotia (Acadia, Annapolis Valley, Bear River, Chapel Island, Eskasoni, Glooscap, Membertou, Millbrook, Paq’tnekek, Pictou Landing, Sipekne’katik, Wagmatcook, Waycobah), nine in New Brunswick (Big Cove, Buctouche, Burnt Church, Eel Ground, Eel River Bar, Fort Folly, Indian Island, Pabineau, Red Bank) and Miawpukek, which is located on the island of Newfoundland (Atlantic First Nations Health Partnership, n.d.; Mcgee Jr, 2018; Unama’ki College, 2019). In addition, the Qalipu Mi’kmaq in Newfoundland are landless, but boast a large membership of 24,000 people with at least 75% residing in the region (Atlantic First Nations Health Partnership, n.d.). Although they are currently a small segment of the total on-reserve population in the Atlantic (i.e., 6% or about 1,700 persons), on-reserve older First Nations populations have increased rapidly over the last decade – a 15%

increase in older adults (65 years and greater) was calculated between 2008 and 2013 (Health Canada, 2015a), and a 23% increase of older adults (65 years and greater) between 2011 and 2014 (Health Canada, 2017).

Outside of Atlantic Canada, there are four other Mi'kmaq communities, three in Quebec (Gesgapegiag, Gespeg, Listuguj) and one in Maine (Aroostook). Mi'kmaq have a distinct history, culture, and societal structure dating back over 11,000 years in this region (Confederacy of Mainland Mi'kmaq, 2007; Davis, 1991). Some estimate that it is closer to 14,000 years ago in Debert, Nova Scotia (Unama'ki Institute of Natural Resources, 2007).

1.1.3 Older Indigenous Person

Centuries of abuse and marginalization have resulted in reduced life expectancy of Indigenous peoples, which can range between five and 15 years shorter than the Canadian average (Statistics Canada, 2015), therefore the definition of aging or older Indigenous adult must be considered. A shorter lifespan and earlier onset of chronic disease often result in the biological traits associated with later age being discernable earlier. For these reasons, an older First Nations person is considered anyone 55 years of age or older (Assembly of First Nations, 2007; Wilson et al., 2010). It should be noted that in the general Canadian population, age 65 years is recognized by the Government of Canada as the beginning of senior citizenship, particularly when it comes to eligibility for government supports such as “Old Age Security” payments (Wilson et al., 2010, p. 357). Although Indigenous people are thought to show biological signs of aging earlier (Assembly of First Nations, 2007), they do not receive any age-based social welfare benefits earlier, and, in fact, during the establishment of Canadian *Old Age Pension* in

1927, Indigenous peoples were excluded entirely as this pension was only for British subjects over age 70 who had resided in Canada for at least 20 years (Library and Archives Canada, 2018). Indigenous peoples were not eligible for pensions until the *Old Age Security* and *Old Age Assistance Acts* replaced *Old Age Pension* in 1952 (Bryden, 1974).

1.1.4 Elders and Older Mi'kmaq

Elder is a title given to an older Indigenous person who holds cultural, spiritual, and healing knowledge and are approached by community members when guidance is needed (Baskin & Davey, 2015). Elders are respected members of their communities who teach and share accumulated wisdom and stories of earlier generations (Assembly of First Nations, 2007). In Mi'kmaq communities, Elders are “keepers of the culture” who share stories of ancestors, legends, spirituality, traditions, and history (Confederacy of Mainland Mi'kmaq, 2007, p. 27). They are often teachers of language, leaders of ceremony, and the links between and across generations. Through age and experience, Mi'kmaq Elders are recognized as “keepers of the sacred lessons of tribal and global harmony for all living things within the environment” (Confederacy of Mainland Mi'kmaq, 2007, p. 51). The role of Elder is not given to all older Mi'kmaq; nor are all Elders necessarily older people. In an effort to recognize the importance of Elders within the older Mi'kmaq demographic and overall community, *Elders and older Mi'kmaq* are used to describe the older Mi'kmaq population in the Atlantic region in this study.

1.1.5 Policy Documents

Public policy documents were a key source of data for this study. Public policy is

a broad term that can refer to published records of the decisions and responses made by governments to address or ignore a particular situation (O'Neill & Pederson, 1992). Importantly, policy documents provide guidance for provincial and federal funding allocation, research and innovation investments, and the development of targeted interventions. Public policies can also infer the “framework of ideas or values” used by governments to guide the decision-making process (O'Neill & Pederson, 1992, p. 26), such as how the needs of ‘seniors’ will be addressed and how their health will be promoted as they advance through later life.

Policies can influence the implementation of aging-focused programs and services that enable older adults to live well and remain active members of their communities. Yet, at the same time, policies can also reinforce negative stereotypes about older people by focusing on the burden of disease and other social issues that require a significant commitment of time and resources to address. This study examined current federal, provincial, and First Nations governments policies, frameworks, action plans, and strategies currently in use to better understand how healthy aging is promoted among Elders and older Mi'kmaq living on-reserve in Atlantic Canada. Policy documents that met the following inclusion criteria were examined for this study: (a) authored by or commissioned by the federal, provincial, or First Nations governments; (b) made reference to promoting the health of older First Nation/Mi'kmaq population living on-reserve in Atlantic Canada; (c) publicly available online; and (d) the most current version or edition.

1.1.6 Stakeholders

This study involved speaking directly with key stakeholders involved in the

creation, action, and evaluation phases of healthy aging-related public policy that impacts Elders and older Mi'kmaq living on-reserve in the Atlantic region. Based on the Healthy Public Policy Framework, key stakeholders may come from any one or more of the following four main domains: (a) policymakers, such as politicians or policy analysts; (b) policy influencers, such as lobbyists; (c) the public, such as voters; and (d) the media; both traditional and modern forms, which can influence how a situation is presented and understood (Milio, 1984, as cited in Nutbeam, Harris, & Wise, 2010). In this study, stakeholder and policymaker are used interchangeably, but refer to policymakers (i.e., policy analysts), policy influencers (i.e., political advocates, council members) and policy users (i.e., healthcare practitioner) working in federal, provincial, or First Nations governments. It is beyond the scope of the study to include and examine the perspectives of older Mi'kmaq, or the media, but this is not an indication that those perspectives are not valued or are less important.

1.2 Significance

As the population of Canada ages, more focus is being given to the study of gerontological issues, especially given the longer life expectancy of the 'baby boomers' entering their later years. However, not all segments of the Canadian population can expect the same aging experience. Many First Nations have a shorter life expectancy, display the biological features often associated with old age sooner (i.e., onset of chronic conditions, issues with mobility), and are likely to have one or more chronic health conditions (Assembly of First Nations, 2007; FNIGC, 2018; Habjan et al., 2012). Indigenous health research has linked these health disparities with inequitable distribution of social services and supports, compounded over centuries by oppressive policies

(Reading, 2009; Reading & Wien, 2013). Presently, a majority of the health research involving Indigenous populations focuses on the health of children and youth, while older adults and their unique health needs associated with aging are largely ignored (Cooke et al., 2008; National Collaborating Centre for Aboriginal Health, 2014). This trend is perhaps not surprising, given the young average age of First Nations and other important health-related issues and priorities that require immediate action (i.e., clean water, housing, mental health), but a balanced approach is needed to promote healthy aging among older adults now, and ensure future needs of this population are considered.

The current research on the topic of healthy aging among Indigenous adults in Canada, and by extension older Mi'kmaq in the Atlantic region, is sparse (Cooke et al., 2008; Wilson et al., 2010). There are Canadian studies addressing issues like caregiving in First Nations communities (Habjan et al., 2012) and healthcare in urban environments (Beatty & Berdahl, 2011), yet the purposeful promotion of healthy aging in a First Nations context is rarely mentioned explicitly. Further, there is no single definition of 'healthy aging' or 'aging well' that is comprehensive of the beliefs and values held by the many cultures and communities living within Atlantic Canada, including the settler population, immigrants, or diverse Indigenous groups and First Nations communities. With this in mind, it is necessary to examine the current policies that aim to promote the health of older Mi'kmaq by, first, examining how current policies are (or are not) supporting healthy aging among Mi'kmaq in the Atlantic region and, second, by exploring how older Mi'kmaq and their cultural beliefs and values on aging are (or are not) integrated, represented, and respected within these federal, provincial, and First Nations government policies. Further, it is important to gain an understanding of how

policymakers include (or do not include) older Mi'kmaq in the policy process.

This study used two qualitative research approaches to construct an understanding of the current policy implications for promoting healthy aging among Elders and older Mi'kmaq living on-reserve in Atlantic Canada. Current policy documents were analysed, followed by interviews with policymakers and stakeholders. This approach allowed for comparison between the written documents and the perspectives of the policymakers in an effort to gain a deeper, more comprehensive, and nuanced understanding of how the federal, provincial, and First Nation governments are promoting healthy aging among Elders and older Mi'kmaq in Atlantic Canada.

1.3 Purpose and Research Questions

The purpose of this qualitative study was to examine current healthy aging policies applicable to older Mi'kmaq, explore how the perspectives of Elders and older Mi'kmaq are considered and integrated into these policies, and gain an understanding of how these policies can support and promote healthy aging among older Mi'kmaq based on the experiences and perceptions of policymakers and stakeholders. This study explored the following questions:

- 1) *What are the current federal, provincial, and First Nations government policies in place intended to support healthy aging among older Mi'kmaq living on-reserve in Atlantic Canada?;*
- 2) *a) How do policymakers integrate and reflect upon Mi'kmaq perspectives in the development, implementation, and/or evaluation process of healthy aging-related federal, provincial, and First Nations governments policies, and in the perceptions of policymakers and stakeholders, b) how can these policies*

support healthy aging of older Mi'kmaq living on-reserve in their communities?

The objective of this study was to add to the understanding of how policies impact healthy aging among older Mi'kmaq within the four Atlantic provinces, and ultimately inform policy reform through a review of the current healthy aging policies and a meaningful inquiry with policymakers and stakeholders. Another objective was to encourage the development of healthy public policies and implementation practices with and for Mi'kmaq that are culturally relevant. As a broader outcome, this study aimed to contribute to the Calls to Action for Truth and Reconciliation between Indigenous peoples and Canada, specifically Number 18:

We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties (Truth and Reconciliation Commission of Canada, 2015, p. 322).

1.4 Study Design Overview

Qualitative description was used to guide this study. A qualitative description design was selected to produce clear answers to the research questions without “adorn[ment]” and is especially practical for policymakers (Sandelowski, 2000, p. 337). Qualitative description does not prescribe the use of one particular qualitative methodology, but instead encourages the inclusion of overtones from other existing philosophies, such as transformative philosophy (see below). This approach also supports

the use of multiple data collection types such as documents and interviews (Sandelowski, 2000). The following subsections briefly describe and offer rationale for the chosen methodology and methods to be used in this study.

1.4.1 Methodology

Given the historical trauma endured by Indigenous peoples in Canada, paired with the complex and intersectional issues still present to this day, a transformative philosophical approach (Mertens, 2009) was used to guide this study. This worldview opposes the marginalization of peoples and promotes the idea that research and political change are not mutually exclusive (Creswell, 2014). The key principle of transformative philosophy is the consideration of power, as too often research does not have consideration for those who are not in positions of power, which in turn prevents the advancement of human rights and social action through research (Mertens, 2007). Mertens (2007) also warns against using a single method to understand reality and determine the need for change, as this can also obscure issues related to power. Transformative research is multi-levelled and action-oriented, calling for the reform of oppressive institutions and policies.

1.4.2 Methods

This study used two different methods of data collection in two separate phases. First, by examining and analyzing the most current provincial, federal, and First Nations government healthy aging-related policy documents pertaining to Elders and older Mi'kmaq living on-reserve in Atlantic Canada; and second, by conducting semi-structured interviews with policymakers and stakeholders knowledgeable about the development and use of these policies.

Data from Phase 1 were retrieved in the form of publicly-available documents from each governmental jurisdiction's official website. This included the: First Nations and Inuit Health Branch of Health Canada, Nova Scotia Department of Seniors, and Atlantic Policy Congress of First Nations Chiefs Secretariat. Findings from Phase 1 (policy content analysis) informed the interview guide for Phase 2 (semi-structured interviews) in the sense that questions exploring areas where policies differed (i.e., in terms of engaging older Indigenous people) were asked. Data for Phase 2 came from the transcribed audio-recorded interviews with policymakers and stakeholders representing three jurisdictions of government (federal, provincial, and First Nations). Qualitative content thematic analysis was the primary method used to analyze these data from Phases 1 and 2 as it is commonly used in health research, especially for studies pertaining to aging and population health (Elo & Kyngäs, 2008). When applied inductively, content analysis allows the researcher to take specific data, and create a general interpretation of the issue (Elo & Kyngäs, 2008). In this study, the analysis of the perspectives and experiences of the policymakers and stakeholders, along with the analysis of the policies, were used to interpret how these policies support and promote healthy aging among Elders and older Mi'kmaq.

1.5 Relevance to Health Promotion

Health Promotion was established on the principles of empowering people to take control and improve their health, with the understanding that health is more than just overall wellbeing, but also the ability to set and achieve goals, to have needs met, and to adapt to environmental changes (World Health Organization, 1986). In the field of Health Promotion, it is understood that certain foundational factors must be established for

health to be realized; beyond food, shelter, and income are less concrete factors such as social justice and equity. This overarching framework is especially relevant when working to understand and address the health disparities caused by the absence of these basic necessities for health. It is understood that marginalized and oppressed populations, such as Indigenous peoples, often have poor health outcomes due to factors well beyond personal control (de Leeuw, Lindsay, & Greenwood, 2015; Reading, 2009).

This equitable approach directly contradicts the biomedical belief that the onus of good health is the responsibility of the individual, and instead acknowledges the top down implications of high-level policy decisions that influence and shape individual behaviours. The equitable provision of and access to the necessities for health and wellbeing for Indigenous peoples has been a contentious issue since colonization. Government policies and agreements stemming from colonization still dictate how health is promoted and healthcare is provided to Indigenous peoples, including Mi'kmaq.

For example, the First Nation and Inuit Health Branch of the federal government funds general health promotion, mental health, and chronic condition management programs, and also provides health transfers to First Nation communities. Agreements with provincial governments allows for the delivery of other public health services including hospital visits (e.g., for medical imaging, surgeries, specialists), rehabilitation (e.g., occupational or physical therapy). The provinces do not deliver health services directly on reserves, which often results in gaps in care because of jurisdictional disputes over responsibility for the provision of services (see Chapter 2.5.2). All First Nations with Indian status (excluding non-status Mi'kmaq) are eligible to have certain medical expenses covered through a federal program called Non-Insured Health Benefits (NIHB),

such as some dental services, prescription medications, or medical equipment. However, there are gaps and limitations in NIHB coverage. For example, treatments at private clinics are generally excluded, and there is a limit on the number of appointments for services like counselling, vision, dental, and chiropractic services. These policies dictate eligibility for healthcare benefits, cost coverage, and even transportation allowances and have had a profound impact on First Nations' wellbeing as they age and require additional supports (Assembly of First Nations, 2007).

Further, Westernized notions of healthcare, like education, have historically been culturally insensitive or presented with dark intentions (Truth and Reconciliation Commission of Canada, 2015). The development, implementation, and evaluation of Indigenous healthy aging policies is positioned well within the field of Health Promotion. A push for relevant and equitable healthy public policy with a health promotion lens creates an opportunity to engage and mobilize policymakers and stakeholders to consider addressing aging-related Indigenous health issues with preventive measures, rather than crisis-oriented responses, and may help move healthy aging to a more prominent position on political and research agendas.

1.6 Summary

This chapter provided a brief overview of some of the complex reasons for health disparities faced by aging Indigenous peoples in Canada and revealed the gap in knowledge pertaining to healthy aging policies that support older Indigenous peoples. This gap highlights the need for exploration and examination of the current policies that are created and used as guides for promoting healthy aging among older Indigenous peoples, and specifically for older Mi'kmaq in Atlantic Canada. An overview of the

qualitative methods used for this study was also presented, as well as the operationalization of key terms. Finally, the relevance of this study to the field of Health Promotion was discussed. The next chapter contextualized the research questions with a review of the published and grey literature on the health and wellbeing of older First Nations and Mi'kmaq in Atlantic Canada; the determinants of health, including colonization; and historical development of health policies.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

The purpose of this literature review is to lay the foundation of what is currently known about the health of older First Nations in Canada and when possible with attention to Elders and older Mi'kmaq in Atlantic Canada. The role of government health policies pertaining to health status is also examined. The review begins by examining the current status of older Indigenous peoples' health, and older First Nations health and wellbeing, is reviewed along with some of the health-related challenges faced by members of these communities. Beliefs on aging and the role of Elders and older adults in First Nations communities are described. This is followed by a description of the historical background of First Nations health policies, Indigenous health models, and a discussion of how colonization created the conditions for the health disparities presently experienced by many Indigenous peoples. This chapter concludes with the rationale for why further research is needed on the health policies that affect aging First Nations, including Elders and older Mi'kmaq living on-reserve in Atlantic Canada.

2.2 Profile of the Health and Wellbeing of Older Indigenous Peoples in Canada

Indigenous peoples, including First Nations, Inuit, and Métis, are seeing a drastic shift in age demographics within their populations. The number of older Indigenous adults aged 65 years and greater has nearly doubled in the last 15 years (Wilson et al., 2010), and is predicted to double again from 7.3% to over 15% of the population by 2036 (Statistics Canada, 2017). Compared to the general population, Indigenous peoples experience a shorter life expectancy (i.e., how long one can expect to live) of 5-15 years (Statistics Canada, 2015); however, this gap is closing. Indigenous peoples are more

likely to have their lifespan (i.e., the duration of one's life over time) reduced due to high rates of preventable diseases and chronic conditions (Beatty & Berdahl, 2011; Park et al., 2015). For this reason, older age is often considered to start at age 55 rather than age 65 (Assembly of First Nations, 2007; Wilson et al., 2010).

Of those living in Indigenous communities, residing in inadequate and overcrowded housing is prevalent (FNIGC, 2018). Primary healthcare accessibility is dependent on place of residence, with older Inuit in the far north having the most difficulty receiving care, followed by older First Nations living in rural and remote communities (Turcotte & Schellenberg, 2007). For example, in Nova Scotia, home care services do not meet the needs or expectations of the patients living on-reserve. Users of this service report difficulty accessing acute home nursing, continuing care, complex care, and transportation (Nova Scotia Aboriginal Home Care Steering Committee, 2010b). Inadequate home health support services shift the responsibility for caregiving from the healthcare system to family and partners, who are unpaid for their work and are often older adults themselves. Among the requirements for homecare coverage is the exhaustion of 'informal' or unpaid caregivers (Nova Scotia Aboriginal Home Care Steering Committee, 2010b), which puts unnecessary strain on personal relationships and may disrupt relationships with other community members as well, as resources are limited and Band Councils cannot always afford to pay for additional healthcare costs.

Access to culturally appropriate care is a pressing concern for older First Nations as non-Indigenous healthcare professionals often are not trained to nor practice cultural safety or make efforts to acknowledge the importance of cultural, spiritual, and traditional practices in their care approaches (Habjan et al., 2012). Further, language barriers can

make care delivery difficult or ineffective. Federal policies make the construction and operation of on-reserve long-term care facilities difficult for First Nations communities, placing the onus of funding such residences on the community (Beatty & Berdahl, 2011; Nova Scotia Aboriginal Home Care Steering Committee, 2010a). Low income and poverty are a common reality among older First Nations, and many rely on government transfers for income (Beatty & Berdahl, 2011).

Regardless of chronic diseases, disrupted social connections, and diminished mental and physical health due to generations of marginalization (National Collaborating Centre for Aboriginal Health, 2011), there are opportunities for older Indigenous peoples to promote positive wellbeing within their communities. Positive aging for older Indigenous peoples is often concerned with maintaining community connections and passing on traditional knowledge to younger generations (Austin & Sylliboy, 2017; Baskin & Davey, 2015; FNIGC, 2016). Indeed, strong cultural and community connections are significant contributing factors to overall feelings of wellbeing compared to physical health limitations (Baskin & Davey, 2015; Reading, 2009), but this does not excuse the lack of attention or resources directed at supporting the other necessities for aging well for these groups.

2.2.1 Profile of the Health and Wellbeing of Older First Nations Living On-Reserve in Atlantic Canada

There are approximately 64,000 registered First Nations living in the Atlantic region, with 24,000 living on-reserve in 33 First Nation (Innu, Mi'kmaq, and Wolastoqiyik) communities (Health Canada, 2017). Approximately six percent of First Nations living on-reserve are over the age of 65 years; however, it is important to note

that this population increased by 23% between 2011 and 2015 (Health Canada, 2017), and this number increases if age 55 is used as an indicator for older adult status. Home and Community Care services were accessed primarily by First Nations over the age of 56 years to assist with conditions like diabetes, cardiovascular disease, muscle and bone issues, and wound care (Health Canada, 2017).

In 2015-16, Mi'kmaq adults in Nova Scotia, and Prince Edward Island over the age of 45 years were more likely than younger adults to describe their health as 'fair' or 'poor' and report physical and mental health conditions that limited their activities (Sinno, Hull, & Bombay, 2018). These are similar to earlier findings noted by Loppie and Wien (2007). Mi'kmaq in Nova Scotia, and Prince Edward Island, also have high instances of multimorbidity, as approximately 37% of adults above age 45 are diagnosed with four or more chronic conditions (Sinno, Hull, & Bombay, 2018). The most common chronic diagnoses are high blood pressure, high cholesterol, allergies, and diabetes. Notably, the incidence of high blood pressure is increasing, while that for diabetes is decreasing (Sinno, Hull, & Bombay, 2018). Mi'kmaq adults reported 'good' or 'excellent' mental health, yet concurrently report emotional and physical symptoms associated with depression and anxiety. Housing issues ranging from major repairs to maintenance were common, and access to healthcare was made difficult by long waitlists, transportation issues, NIHB-related issues, health practitioner unavailability, and culturally inadequate services (Sinno, Hull, & Bombay, 2018; Loppie & Wien, 2007).

2.3 Considerations for Aging and Older Indigenous Peoples in Canada

The physical, mental, spiritual, and social changes associated with older age are complex and can occur at different times during the life course. Although most people

want to stay healthy well into later life, there is a variety of circumstances that can alter, interfere with, or promote a healthy aging trajectory. This includes the social determinants of health such as access to healthcare, adequate housing, and social supports, but also education, social status, and available income (Mikkonen & Raphael, 2010).

Perceptions of healthy aging vary based on socio-cultural expectations (Levy, 2009; Meisner & Levy, 2016), and so-called ‘acceptable’ and ‘unacceptable’ aging processes are often dependent on culture (Löckenhoff et al., 2009). In a study on Elders and older First Nation women in Toronto, the activities the participants described did not quite fit with typical notions of older adults and healthy aging. For example, the Elders and older First Nation women described dealing with adversity and stereotypes, learning to use humour to cope with past traumas (including residential schools), caring for grandchildren for extended periods of time, and performing cultural ceremonies (Baskin & Davy, 2015). As these narratives are frequently missing from government healthy aging policies, it is important to consider why more attention must be given to the unique health needs of culturally and socially marginalized older Indigenous peoples.

When the health of Indigenous peoples in Canada is discussed in relation to the health of the non-Indigenous Canadian population, often the focus on diseases and diagnoses distracts from the positive experiences and values associated with aging, such as an increasing sense of resiliency and strength, being active in community affairs, and imparting knowledge and teachings across generations (Baskin & Davey, 2015). These positive achievements are often overshadowed by health disparities between Indigenous and non-Indigenous populations. Indigenous peoples experience far worse overall health

than other residents of Canada (Adelson, 2005; Reading, 2009). In Western medicine, health is regularly measured by the presence or absence of disease or condition rather than by more holistic indicators of wellness, which is incongruent with Indigenous perspectives on health and wellbeing (Reading, 2009). Reducing health to a diagnosis can lead to stigmatization and impact negative self-perceptions of health status (Reading, 2009). By using deficit models to measure the health of Indigenous peoples (i.e., looking at prevalence of type 2 diabetes, heart disease, disabilities, or mental health and addictions), the underlying factors that promote illness or wellness are ignored (Reading & Wien, 2013) while stereotypes are perpetuated. Further, a focus on diagnosing the disease instead of the root causes of the disease distracts from finding relevant and appropriate solutions to complex Indigenous health issues.

As it relates to improving Indigenous health and wellbeing, The Truth and Reconciliation Commission (TRC) clearly explains that the cause of “...*the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools...*” (Truth and Reconciliation Commission of Canada, 2015, p. 322). The TRC has released 94 calls to action, seven being health-specific, to begin to heal the deep wounds of the Canadian governments’ long-established attempts to disenfranchise Indigenous peoples. Recent reports on the status of the calls to action indicate that the health-related calls are in the proposal stage, or are currently underway (Canadian Broadcasting Corporation, 2018).

2.3.1 The Role of Elders

Older First Nations adults, and especially those with the role of Elder, have important roles in their communities including teaching traditional ways of knowing and

imparting values to younger generations, along with leading ceremonies, opening or closing certain events, and offering counseling (see Atlantic Policy Congress Circle of Elders, 2014; FNIGC, 2016; Baskin & Davey, 2015). Elders are also storytellers and historians (for example Knockwood, 2018; Paul, 2006), the knowledge brokers of “*legends, prophecies, ceremonies, songs, dance, language, and customs*” of their people and lands (Couture, 2011, p. 20).

Mi’kmaq Elders are often the most appreciated and respected members of their communities (Confederacy of Mainland Mi’kmaq, 2007). Their guidance and advice have been sought in community decision making in Mi’kmaq territory for over 11,000 years (Confederacy of Mainland Mi’kmaq, 2007; Paul, 2006). Historically, Elders’ advice could determine the outcomes for conflicts, the course of action on engaging in war or peace agreements, and the division of hunting and fishing locations. Mi’kmaq Elders are the teachers to younger generations on culture, spirituality, and knowledge of the land (Austin & Sylliboy, 2017). Mi’kmaq culture and language emphasizes connectivity among families and communities, and that all people are created equal (Paul, 2006). Connections to family and relations are promoted through the matrilineal clan system and each clan is led by a grandmother (Marshall, Marshall, & Bartlett, 2015).

Traditional knowledge and teachings come from the relationship Mi’kmaq have with Mother Earth, who is understood as wise, life-giving, and healing (Marshall et al., 2015). Mi’kmaq Elders may teach, nurture, and offer guidance through stories that engage learners spiritually, emotionally, intellectually, and physically, which allow for deeper understandings with each repetition, emphasizing that there is never just a single meaning or lesson in a story (Austin & Sylliboy, 2017; Marshall et al., 2015). The roles

of Elders have changed too, where Westernization of education, medical care, and manufactured goods have created a disconnect between generations (Holmes & Holmes, 1995), resulting in fewer opportunities for intergenerational teachings and learnings. Efforts are being made to involve Elders in these domains (for example, integrating Elders into education programs (Austin & Sylliboy, 2017). Elders recognize that, to live well, First Nations must be able to exist in two worlds, within their community and within the larger society (Marshall et al., 2015).

2.4 Historical Background on First Nations Health Policies

Since European settlement began in Atlantic Canada in the late 15th century, the lives of First Nations have been dictated by racist policies written by colonizers. These policies determined every aspect of their lives, from where they could live, to how they would be educated, to how their health would be managed (Lavoie, 2013; National Collaborating Centre for Aboriginal Health, 2011; Richmond & Cook, 2016; Royal Commission on Aboriginal Peoples, 1996). To provide the historical context for how policies impact Indigenous health, the purposes and intents of the *Indian Act*, *Indian Health Policy*, and *Indian Transfer Policy* were examined.

Initially, traditional Mi'kmaq territory was settled by the French, whom the Mi'kmaq taught how to hunt, fish, and forage. Conversion to Christianity started in the early 17th century, and traditional ways of living were replaced with hunting for trade (Clark et al., 1987; Paul, 2006). English settlers had a contentious and violent relationship with Mi'kmaq and the French, as these European nations fought for control of Mi'kmaq territory. In the mid 18th century, Peace and Friendship treaties were signed with the English, promising Mi'kmaq that their unceded territory would remain undisturbed

(Clark et al., 1987; Paul, 2006). These treaties were not honoured, fully implemented, or sustained by the Crown from the late 1700s (but were later reaffirmed in the Constitution Act 1982 and in a number of Supreme Court of Canada decisions). Like many other First Nations, their land and rights were subjugated by the colonial government, and they were forced to assimilate or be persecuted (Paul, 2006). The introduction of the *Indian Act 1876* placed further restrictions on Mi'kmaq and other First Nations.

The year 1867 marked the confederation of the Dominion of Canada and the enactment of the new Canadian constitution, known as the *Constitution Act 1867* or the British *North America Act 1867*. Within this act, a single line in section 91(24) passed the authority to govern over “*Indians, and lands reserved for the Indians*” from the British Crown to the newly established Canadian parliament, placing Indigenous affairs in the federal jurisdiction (Bird, 2010, p. 1). Notably absent from the confederation discussions were Indigenous peoples, an indication that the federal government no longer viewed Indigenous peoples as independent ally nations, but rather subjects that needed to embrace European values (Gettler, 2017). The *Indian Act 1876* came into effect shortly after confederation, giving the federal government full rule over and responsibility for First Nations, and later Inuit as well. It is important to note that the Mi'kmaq did not sell or give their land to the English. Rather, it was taken from them and they were forced onto reserves (Paul, 2006). The underlying intention of the *Indian Act* was to assimilate the original inhabitants of the land through the infliction of multiple social systems that were incongruent with traditional beliefs such as Christianity, land ownership, institutional education, imposition of a cash economy, devaluation of the status of women, and a different governing structure (Richmond & Cook, 2016; Royal

Commission on Aboriginal Peoples, 1996). Further, First Nations were forbidden from starting their own governments or practicing ceremonies, traditions, or language (Paul, 2006). This colonialist approach to dealing with Indigenous peoples living on the land they wished to occupy worked to diminish their traditional ways of life and incorporate them into colonial society (Richmond & Cook, 2016).

Although provinces are responsible for providing services like education and healthcare, Indigenous services are still managed federally, which has resulted in conflict and confusion over where services can be accessed (Lavoie, 2013; Richmond & Cook, 2016). As it pertains to health, section 73 of the *Indian Act* gives the federal government authority to make regulations for: controlling the spread of disease on reserves, providing medical treatment and health services, providing hospitalization and treatment for infectious disease, preventing overcrowding of dwellings on reserves, and providing sanitary conditions in private and public places on reserves (Indian Act, 1985). Health of First Nations was not truly of concern to the federal government. Rather, resources and territory were desired and the *Indian Act* was another tool to regulate, control, and subdue First Nations. The systems and services created from that *Act* were formed under pretenses of racism, marginalization, and disrespect and most of these systems and services are still used to this day.

The *Indian Health Policy 1979* and the *Indian Transfer Policy 1989* are two additional federal policies Lavoie (2013) draws attention to in an Indigenous health policy scan. Short, vague, and without clear directives, the *Indian Health Policy 1979* proposes an “*increasing level of health for Indian communities, generated and maintained by the Indian communities, themselves*” (p. 1) built on three pillars:

community development, the traditional relationship between Indigenous peoples and the federal government, and the Canadian Healthcare system (Government of Canada, 2014b). Problematically, the *Indian Health Policy* does not recognize the federal government's role as the root cause in Indigenous peoples' health status, stating:

The over-riding concern from which the policy stems is the intolerably low level of health of many Indian people, who exist under conditions rooted in poverty and community decline. The Federal Government realizes that only Indian communities themselves can change these root causes and that to do so will require the wholehearted support of the larger Canadian community
(Government of Canada, 2014b, p. 1).

Building on the goal set out by the *Indian Health Policy 1979*, the purpose of the *Indian Transfer Policy 1989* was to tangibly support Indigenous communities that wanted to take control of their health programming and services through financial and administrative assistance (Government of Canada, 2005).

2.4.1 First Nations Healthy Aging Policies

Policies supporting the needs of older people have been developed and implemented by the provincial, territorial, and federal governments in an effort to promote the health of older people in Canada. For example, the federal government's 'Action for Seniors' report (Government of Canada, 2014a) boasts nearly 50 programs or initiatives that focus on seniors' wellbeing in Canada. A scan of healthy aging strategies from the federal, provincial, and territorial governments found 39 age-related policies (Jeffery et al., 2018). Importantly, these documents send a message about expectations of healthy aging, including proper diet and exercise, aging in place, employment and

volunteering, falls prevention, and literacy and/or lifelong learning. What is noticeably missing from these policies are ways to promote healthy aging among Indigenous peoples, who hold distinct rights and necessitate distinct considerations. Using the aforementioned report (Government of Canada, 2014a) as an example, of the nearly 50 initiatives linked to the report, only two directly mentioned Indigenous people: Home and Community Care provided through the First Nations and Inuit Health Branch, and the On-Reserve Non-Profit Housing Program. First Nations older adults are mentioned only twice in the descriptions of the Canadian aging strategies scan (Jeffery et al., 2018).

Healthy aging policies aimed at the general Canadian population are not directly addressing the unique health needs or the distinct histories, traditions, and cultures within First Nations, Inuit, and Métis communities across Canada. The Assembly of First Nations (2007) identified the following requirements for aging well: physical, mental, emotional, social, and spiritual wellbeing; empowerment; access to medical, social and other programs and support services; the ability to age in place with respect and dignity for as long as possible; access to a supportive social environment; community involvement; and financial security including affordable housing and transportation. Recent healthy aging policy reviews show that considerations for the needs of aging Indigenous peoples are only briefly mentioned in these documents, if at all. This may be due, in part, to the departmentalized nature of federal and provincial government structures, where there could be a Department of Seniors and a Department of Indigenous Affairs, but they are not working together.

A review of Indigenous health policies revealed a “patchwork” of “thin and loosely woven” and often ambiguous legislation where the key concern was jurisdictional

responsibilities in providing health care, rather than addressing Indigenous health needs (Lavoie, 2013, p. 1). The lack of clear Indigenous health policies adds to the complex and problematic healthcare delivery system between the Canadian government and Indigenous peoples. Briefly, the federal government pays for certain health programs, transfers funds to Indigenous communities to provide others, and supplies special insurance to pay for additional services provided by the provinces (see Chapter 4, Phase 2 for a detailed description of this system as it relates to older Mi'kmaq living on-reserve). Indigenous healthy aging policies, like Indigenous health policies, are not numerous. However, there are examples of their existence (e.g., Well Elder Policy in a Mi'kmaq First Nation Community Health Centre; Atlantic First Nations Elder Care Strategic Action Plan) that warrant further investigation.

Historical injustices have led to a contentious relationship between many Indigenous peoples and the government (Truth and Reconciliation Commission of Canada, 2015). Yet the government, in many instances, still determines how social supports and healthcare are (or are not) made accessible among Indigenous communities and to Indigenous peoples with and without status, living on- and off reserve (i.e., through First Nations Inuit Health Branch (FNIHB) and (NIHB). Indigenous peoples in Canada have faced significant adversity since colonization which has resulted in a detrimental impact on their lifespan, health status, and aging process (Czyzewski, 2011; Statistics Canada, 2015). Yet, in spite of this, more and more Indigenous peoples are living longer (Statistics Canada, 2015). The next section describes a framework to demonstrate the interconnectedness of the Indigenous determinants of health and explains how colonization directly impacts the health of First Nations.

2.5 Indigenous Health Frameworks

Frameworks and models are helpful tools for visualizing complex and interconnected relationships and systems. The Integrated Life Course and Social Determinants Model of Aboriginal Health (Reading & Wien, 2013) places various factors that influence Indigenous health outcomes at proximal, intermediate, and distal levels of impact. This is a helpful model for tracing the complex relations between and among different determining structure, conditions, and processes that affect health and wellbeing throughout the life course. For example, proximal inter- and intrapersonal factors, such as housing and education, are determined by community infrastructure and the education system at the intermediate level that is impacted at the distal level by colonialism and self-determination. There are also determinants of Indigenous peoples' health that cannot be categorized as 'social' that need to be considered when seeking to understand the current state of Indigenous health. These additional determinants include, "*spirituality, relationship to the land, geography, history, culture, language, and knowledge systems*" (de Leeuw, Lindsay, & Greenwood, 2015, p. xii). To expand on the determinants of health model, Richmond and Ross (2009) spoke directly with First Nations and Inuit about factors that impact their communities' health, which offered a more nuanced list of determinants of health that includes environmental and cultural connections, social and material resources, education, life control, and balance of a person's physical, mental, spiritual, and emotional attributes. Although this model did not directly inform the data collection or analysis of this thesis, given the inclusion of the life course (including older age) within this model, it supports the need to consider how the connections among the determinants of health can promote or hinder healthy aging.

2.5.1 Colonization as a Determinant of Health

The impact of colonization is present in nearly every facet of Indigenous life. For example, many Indigenous peoples in Canada are survivors of the residential school system or have close relations who are survivors (FNIGC, 2016). Some Indigenous peoples were victims of the sixties scoop (Spencer, 2017), and others have been impacted by the violence perpetrated against Indigenous women (National Inquiry into Missing and Murdered Indigenous Women and Girls, 2019). Others are experiencing environmental dispossession due to forced removals and relocation, unsanctioned economic development, or effects of climate change (King, Smith, & Gracey, 2009). These experiences have impacted Indigenous peoples' cultural identities, traditions, and the relationship among individuals, families, community members, and between communities.

In a review of data from the 2001 Aboriginal Peoples Survey, Wilson and colleagues (2010) found that many older Indigenous peoples were more likely to see a doctor rather than a traditional healer. While this may not be true of all older Indigenous peoples, the authors suggested that even when older Indigenous peoples do see a healer, they may be less likely to report it to Western medical providers because of the punishment that was inflicted for practicing their traditional ways in other institutional settings (Wilson et al., 2010). Alternatively, there could also be a lack of access to traditional healers. At face value, health disparities are often assumed to be caused by issues such as poverty and substandard housing; however, a more critical understanding of the multi-generational trauma endured by Indigenous peoples reveals that colonization, oppression, and racism (Bombay, Matheson, & Anisman, 2014; Reading, 2009;

Richmond & Cook, 2016) are the driving forces for the differences in health witnessed today.

2.5.2 The Impact of Colonialism on Health and Wellbeing

Although the Federal government is responsible for some of the cost of healthcare for First Nations peoples, there are some grey areas in terms of services and payments, which has had significant consequences. For example, when a young Cree child named Jordan River Anderson required homecare in the early 2000s, the dispute between the federal and provincial governments over cost responsibility kept him from ever leaving the hospital, where he ended up dying two years later (First Nations Child & Family Caring Society, 2014; National Collaborating Centre for Aboriginal Health, 2011). The subsequent legal battle led to the creation of *Jordan's Principle*, which states that care will be provided, and medical bills must be paid by whichever jurisdiction was in contact with the patient first, with reimbursements to be arranged if necessary (First Nations Child & Family Caring Society, 2014; National Collaborating Centre for Aboriginal Health, 2011). Most importantly, those requiring immediate medical treatment should never be delayed or denied because of jurisdictional disputes.

More recently, the Human Rights Tribunal ruled that the Federal Government has intentionally underfunded child and family services for First Nations children living on-reserve despite the knowledge that these children often have more needs (Fontaine, 2016). This persistent underfunding creates environments where abuse and violence can flourish, and has resulted in higher numbers of Indigenous children being taken from their families and put in the child welfare system and subsequently in non-Indigenous care situations, where the government controls the future of these children and alienates

them from their Indigenous communities (Fontaine, 2016). The high rate of children in the child welfare system is a result of the negative effects of the residential school system where actions were taken with the intent of assimilating Indigenous children into Canadian society by separating them from their families, communities, and cultures. Although unrelated to older Indigenous peoples' health experiences, these are two of many examples of the mishandling of Indigenous health and wellbeing due to colonial practices embedded in government policy.

The Integrated Life Course and Social Determinants Model of Aboriginal Health (Reading & Wien, 2013) can be used as a lens through which one can understand the impacts of the *Indian Act* and other policies directed at Indigenous peoples, where the top-down effects of colonialism become immediately clear. In an attempt to eliminate the self-determination of Indigenous peoples through assimilation, colonialist policies focused on cultural erasure for the purposes of cost savings ultimately promoted racism and social exclusion (Royal Commission on Aboriginal Peoples, 1996). These policies then influenced the healthcare and education systems, access to resources, and how cultural and environmental practices can (or cannot) be performed. In turn, these systems dictate food status, educational attainment, job or income, housing, and shape health-related behaviours. The health and wellbeing of Indigenous peoples are still controlled by many of these antiquated policies. As the demographics and health needs of Indigenous people become better understood, attention can be focused on amending or developing inclusive, community need-driven policy documents that support health throughout life and into the later years.

2.6 A Call for First Nations Healthy Aging Policies

Canada is preparing to meet the increased health demands of an aging population with age-friendly health-promoting policies that were developed to support healthy aging. However, similar healthy aging policies have not been developed to the same extent for older Indigenous peoples, including Elders and older Mi'kmaq in Atlantic Canada, who face distinctly different health challenges stemming from centuries of marginalization. A complex interplay of social, environmental, cultural, economic, environmental, historical, and political factors has complicated their aging experiences. It is argued that there is a lack of support for aging First Nations (Cooke et al., 2008), and this is reflected in the under-representation of the needs of First Nations in national and provincial aging policies meant to guide the provision and allocation of funds and support (Habjan et al., 2012; Richmond & Cook, 2016).

In addition to policy scans presented earlier (Jeffery et al., 2018; Government of Canada, 2014a, Lavoie, 2013), Wilson and colleagues (2012) conducted a review of current federal, provincial, and territorial age-related health policies which assessed the general aim of each region's aging policy. Of the 14 policies that met the inclusion criteria of this study, only one explicitly mentioned First Nations older adults, and three other policies broadly referred to *diversity*, but were unclear if that definition included Indigenous people (which would also be problematic as that fails to recognize Indigenous-specific needs).

To continue to advance knowledge in the fields of healthy aging policy and Indigenous health policy it is necessary to conduct a policy scan specifically looking at Indigenous healthy aging policies to gain an understanding of how healthy aging is being

promoted among older Indigenous peoples. This thesis begins to address this gap in knowledge by conducting a scan of federal, provincial, and First Nations government policies that promote healthy aging for Elders and older First Nations living on-reserve, with a focus on Mi'kmaq in Atlantic Canada.

2.7 Summary

Aging Indigenous peoples' health profiles stands in stark contrast to those of the general population of Canada. Indigenous health research has linked these disparities in health with inequitable distribution of social services and supports, compounded over centuries by oppressive policies (Cooke et al., 2008; Reading, 2009). This is reflected in the under-representation of the needs of First Nations in national and provincial aging policies meant to guide the provision and allocation of funds and support (Habjan et al., 2012; Richmond & Cook, 2016). The Integrated Life Course and Social Determinants Model of Aboriginal Health (Reading & Wien, 2013) is useful as a representative model to understand and investigate the cause of these disparities, as the focus is changed from Indigenous ancestry as a determinant of health (as in the Canadian Facts (Mikkonen & Raphael, 2010)) to colonization as the source for producing inequitable social, political, and economic conditions that infiltrate all other determinants of health. Colonialism is much more representative of the underlying cause of the health disparities. Being Indigenous does not equate to poor health, but being colonized certainly does (Adelson, 2005).

This chapter gave an overview of the contrast in health status between the general and Indigenous populations in Canada. The Integrated Life Course and Social Determinants Model of Aboriginal Health was presented as an approach to use when

considering the explanatory reasons why certain health and disease outcomes are present within Indigenous populations. Colonialism was explored as a key determinant of health, and a synopsis of Mi'kmaq history and the *Indian Act* were presented. It is clear from the current literature that more research is needed to understand if/how healthy aging policies for older First Nations peoples are developed, implemented, and evaluated. The following section describes the methodological approach and methods that were used to guide this study.

CHAPTER 3 METHODS

The purpose of this qualitative study was to examine current healthy aging policies applicable to older Mi'kmaq, explore how the perspectives of Elders and older Mi'kmaq are considered and integrated into these policies, and gain an understanding of how these policies support and promote healthy aging among older Mi'kmaq. To gain a deeper understanding of the relationship between healthy aging and policy among Elders and older Mi'kmaq in Atlantic Canada, this study answered the following questions: 1) *What are the current federal, provincial, and First Nations government policies in place intended to support healthy aging among older Mi'kmaq living on-reserve in Atlantic Canada?;* and 2) a) *How do policymakers integrate and reflect upon Mi'kmaq perspectives in the development, implementation, and/or evaluation process of healthy aging-related federal, provincial, and First Nations governments policies and b) how can these policies support healthy aging of older Mi'kmaq living on-reserve in their communities?*

3.1 Methodology, Methods, and Design

Given the complex, intersectional, traumatic, and oppressive issues endured by Indigenous peoples in Canada, a transformative philosophical approach (Mertens, 2009) was used to guide this study. A transformative worldview opposes the marginalization of peoples, and calls for research to not only create knowledge, but to be a tool for social and political change (Creswell, 2014; Mertens 2007). Transformative research is action-oriented and calls for reform to oppressive institutions, aligning well with the calls to action of the TRC, which brought attention to an unjust system and provided remedies to address the injustices. Descriptive and exploratory qualitative methodology was used to

frame this study to gain a deeper understanding of the relationship between healthy aging and policy for Elders and older Mi'kmaq in Atlantic Canada.

Qualitative description (Sandelowski, 2000) was used as the overarching research method to guide data collection and analysis approaches in this study. A qualitative description approach was chosen as the intent of the study is to produce clear answers to the research questions without “*adorn[ment]*” and to present the facts using “*low-interference description*” (Sandelowski, 2000, p. 335). In addition, qualitative description does not adhere to one particular qualitative methodology, but instead borrows from other existing philosophies and supports the inclusion of multiple sources of data including documents and interviews (Sandelowski, 2000). Qualitative description is well suited to achieving the intention of transformative worldview research as it remains close to the data collected directly from participants, without over-interpretation or an attempt to fit the results within a pre-existing theory that may not be culturally relevant or appropriate to use.

This study was completed in two phases. Phase 1 conducted a scan and content analysis of the most current editions of federal, provincial, and First Nations government policies pertaining to healthy aging and applicable to Elders and older Mi'kmaq living on-reserve in Atlantic Canada. Phase 1 answered the first research question: *What are the current federal, provincial, and First Nations government policies in place intended to support healthy aging among older Mi'kmaq living on-reserve in Atlantic Canada?* Based on the findings from Phase 1, and through one-on-one interviews with policymakers and stakeholders involved in the policy process as it relates to healthy aging for Elders and older Mi'kmaq, Phase 2 answered the second, two-part research

question: 2) a) *How do policymakers integrate and reflect upon Mi'kmaq perspectives in the development, implementation, and/or evaluation process of healthy aging-related federal, provincial, and First Nations governments policies and b) how can these policies support healthy aging of older Mi'kmaq living on-reserve in their communities?*

3.1.1 Data Collection

Data collection occurred in two phases. The first phase included a comprehensive search for current versions of provincial, federal, and First Nations aging policies relevant to Mi'kmaq in the Atlantic provinces. The second phase collected data from interviews with policymakers and stakeholders (as defined in Chapter 1 and below). Data from both phases were analyzed using inductive content analysis methods.

3.1.1.1 Phase 1

The data for Phase 1 were collected from publicly-available government policy documents published online. These types of data are often referred to as grey literature or grey information, meaning it is not controlled or distributed by commercial publishing companies or it may be informally published (Adams et al., 2016). A search strategy was created by adapting the methods outlined by Wilson and colleagues' (2012) review of Canadian aging policies, and in consultation with Information Services Librarian Shelley McKibbin at the W. K. Kellogg Health Sciences Library at Dalhousie University. A list of the government departments for each region was compiled and an online search of these pre-identified government department websites was conducted using the "site search" function of an internet search engine (i.e., Google). Examples of websites explored were: Atlantic Policy Congress of First Nations Chief Secretariat, Indigenous Services Canada, Atlantic provincial governments (New Brunswick, Newfoundland and

Labrador, Nova Scotia, Prince Edward Island), Confederacy of Mainland Mi'kmaq, First Nations and Inuit Health Branch, Health Canada, Mi'kmaq Confederacy of PEI, Mi'kmaq First Nations, Public Health Agency of Canada, Assembly of First Nations, and Tripartite Forum.

Search terms included “aging” or “senior*” or “elder*” AND “policy” or “framework” or “action plan” or “strategy” AND “Mi'kma*” or “First Nations” combined with “site:” and each government website URL. Documents were retrieved and examined for this study that met the following inclusion criteria: (a) authored by or commissioned by the federal, provincial, or First Nations governments; (b) made reference to the health of older First Nation/Mi'kmaq population living on-reserve in Atlantic Canada; (c) publicly available online; and (d) the most current version or edition of its type. To verify that a document is the most current policy in use, and that additional aging-related policies were not missed during the initial search, a second separate manual search was performed by visiting each region's government website home page, navigating to the 'seniors' and/or Indigenous health sections of the site (when available), reviewing the publications, and confirming that the policy is currently in use.

3.1.1.2 Phase 2

Data for Phase 2 were collected using one-on-one, semi-structured interviews for qualitative description research as explained by Sandelowski (2000). A semi-structured interview guide informed by the findings in Phase 1 was used to facilitate the interviews. The questions in the interview guide were designed to gather information on how policymakers and stakeholders integrated and reflected upon Elders and older Mi'kmaq perspectives in the development, implementation, and/or evaluation process of aging-

related policies. Interviews primarily occurred over the telephone due the geographic distribution of the participants; however, three were conducted face-to-face. Interviews lasted between 25 and 60 minutes in length and were audio-recorded, with the exception of one that had written memos taken over the course of the dialogue. The recordings were transcribed by the lead researcher to generate transcript data. There did not appear to be any distinct differences between interviews conducted face-to-face compared to those conducted over the phone.

3.1.1.3 Participants and Recruitment

This study recruited key stakeholders involved in the creation, action, and evaluation processes of healthy aging-related public policy that impacts Elders and older Mi'kmaq living on-reserve in the Atlantic region. Potential participants met the inclusion criteria for this study if they were employed in some capacity as policymakers or stakeholders (i.e., policy analysts), policy influencers (i.e., political advocates, council members) and policy users (i.e., healthcare practitioners) working in federal, provincial, or First Nations governments. Recruitment occurred between February and October of 2018. For this phase of the study, nine participants were recruited, providing sufficient data to produce a description of the identified themes (Guest, Bunce, & Johnson, 2006).

To gain broad and diverse views on how aging Mi'kmaq perspectives were included in the aging policies, participants were recruited using purposive and snowball sampling methods through key informants (i.e., the supervisory committee members, colleagues, professional networks) who were connected to relevant healthy aging policy and public health-related sectors within the three jurisdictions of government. A recruitment instrument was circulated through these key informants (see Appendix B)

through email. Interested respondents contacted the researcher by phone or email. Participants were all from either Nova Scotia or New Brunswick. Recruitment efforts were extended to Indigenous- and aging-related government departments and First Nation health organizations in Prince Edward Island and Newfoundland and Labrador, and responses were received from potential participants in both provinces. However, no interviews were arranged after multiple attempts to find convenient times over a period of several months.

To assure respondents' eligibility for the study, they were asked to confirm their involvement in aging-related health policy work and agree to an interview. Following eligibility confirmation, participants were emailed the study consent form (Appendix C) for review and arrangements were made to conduct the interview at a time convenient for each participant. Participants were selected to take part in the study based on the order they contacted the researcher. Participation was completely voluntary, and no incentives were offered to take part in this study. The researcher did not have any relationship with the participants, nor did the participants have any prior knowledge of the researcher beyond the recruitment instrument. There were no known conflicts of interest.

3.1.1.4 Setting

Participants were situated across New Brunswick and Nova Scotia, but no interviews were completed with participants from NL or PEI. Six were interviewed over the telephone and three were interviewed in-person. In-person data collection locations were in Halifax, Nova Scotia; Dartmouth, Nova Scotia; and Fredericton, New Brunswick. Locations of phone interviews were not reported to protect participant confidentiality. The researcher conducted the interviews from a secure, quiet location to ensure privacy

and to obtain a clear recording and recommended that the participants did the same. The data collection that occurred during the interviews was an exchange exclusively between the researcher and the participant to promote trust and assure privacy and confidentiality.

Involvement in this study took approximately 40 to 75 minutes for each participant from start until finish. As mentioned before, this included 25 to 60 minutes for the actual interview and the remaining time for reviewing the consent information and addressing any questions the participant may have had. Participants were asked to provide oral consent (Appendix D) prior to beginning the interview and then answer the questions from the interview guide (Appendix E) to the best of their ability.

3.1.2 Data Analysis

The data for both Phase 1 and Phase 2 were analyzed using qualitative inductive content analysis (Elo & Kyngäs, 2008; Sandelowski, 2000). Qualitative inductive content analysis has been used in health research for studies pertaining to aging and population health (Elo & Kyngäs, 2008). When applied inductively, content analysis can be used to extrapolate general concepts from specific data (Elo & Kyngäs, 2008). Beneficially, inductive content analysis allowed for a focus on First Nations aging-related content in the policies and interviews without having to appraise the findings based on a particular pre-determined framework or model. Though this method is useful for exploratory research, it is best suited for descriptive reporting of the findings rather than generating new theories. Elo and Kyngäs' (2008) model was used for inductively analyzing the qualitative data from this study by: (a) selecting units of analysis (i.e., specific words); (b) making sense of the data (i.e., becoming immersed in the data by reading and re-reading); (c) open coding (i.e., categorizing and abstracting a general description of the

findings); and (d) reporting the results.

The data from both phases were coded primarily by the researcher, along with input and direction from the research supervisors to ensure agreement within the analyses. Several strategies were used to enhance the trustworthiness of the findings, as recommended by Korstjens and Moser (2018) and Shenton (2004). Meetings were held with the supervisors to discuss data (i.e., key quotes and emerging ideas), known as investigator triangulation (Korstjens & Moser, 2018). In addition, “*thick descriptions*” of the participants and their context are provided in the results section (Korstjens & Moser, 2018, p. 121; Shenton, 2004, p. 69). As this study had a manageable number of documents and participants, data management, such as transcription and coding, was done using word processing software (i.e., Microsoft Word) rather than a qualitative software management program. Analysis of Phase 1 data informed the interview guide questions in Phase 2. Probing questions regarding the participants’ experience with a particular policy they helped to develop (e.g., ‘can you tell me more about the consultation process?’) or that pertained to their community (e.g., ‘can you tell me about [document title] policy?’) were added. The results from Phase 1 and Phase 2 are presented separately in Chapter 4 to specifically answer the research questions, but are discussed in relation to each other in Chapter 5.

3.2 Ethical Considerations Overview

Phase 1 data came from publicly available documents that contained no individual identifying information, therefore institutional Research Ethics Board (REB) approval was not required (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research

Council of Canada, 2010). A Tri-Council Policy Statement (TCPS 2) Course on Research Ethics certificate of completion can be found in Appendix A.

Phase 2 of this study directly involved humans; therefore, REB review was necessary prior to data collection (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010). As Phase 2 of this study aimed to engage Mi'kmaq First Nations policymakers and stakeholders involved in healthy aging, in addition to full board review at Dalhousie University, an application was also submitted to Mi'kmaw Ethics Watch at Cape Breton University. To further mitigate any risk, the principles of the Tri-Council Policy Statement on ethical conduct for research involving humans (Chapter 9, TCPS2, 2014) were upheld where applicable. Ethics approval for Phase 2 was granted by Dalhousie University Social Sciences and Humanities REB (#2017-4303) and by the Mi'kmaw Ethics Watch, Unama'ki College, Cape Breton University (February 1, 2018).

Phase 2 met the standard of minimal risk as the potential risks of participating in this study were no greater than the risks that would be encountered during the activities of everyday living. While there were no direct benefits to participating, potential indirect benefits included contributing to the formation of new knowledge on the topic. For the participants in Phase 2, informed consent and the right to withdraw from the study at any point was explained by the lead researcher during the initial selection criteria confirmation, which took place over the phone or by email, followed by an email delivery of the informed consent document. Informed consent and the right to withdraw were explained again at the time of the interview and verbal consent was obtained from the

participants before any data collection began. To maintain confidentiality of the participants' identities, any identifying information was not included in the transcripts of the interviews. The transcripts were stored on a secure, password-protected and encrypted hard drive which was kept in a locked location on Dalhousie Campus.

3.3. Researcher Details and Positionality/Reflexivity

The lead researcher (Christie Stilwell), with guidance from supervisors Drs. Debbie Martin and Brad Meisner, was active at each stage of the study including: preliminary research; research question development; ethics application submission; participant recruitment; collecting, coding, and analyzing the data; describing and interpreting the results; and dissemination. The supervisors provided assistance with the analysis and interpretation of the data and provided critical feedback throughout the entire process. Supervisory committee members Drs. Amy Bombay and L. Jane McMillan also had a key role in research question development, sharing knowledge, providing resources, and giving feedback.

The researcher, a Master of Arts candidate in Health Promotion, brought prior research knowledge and experience to this study. She has completed a Bachelor of Science (Honours) in Health Promotion with a curriculum that included introductory and applied research methods courses, as well as a course each in healthcare ethics, health policy, and multicultural health promotion research and policy. The researcher has also completed the TCPS 2: CORE Ethical Conduct for Research Involving Humans certification (Appendix A).

The researcher has previous experience studying aging as well as using qualitative methods. Aging with the diagnosis of a chronic disease was the focus of her published

honours thesis (Stilwell, Hutchinson, & Meisner, 2019), which adopted a qualitative methodology and used similar methods as in the current study (i.e., semi-structured interviews, content analysis). She has spent the last two years working as a research assistant and coordinator for gerontologist Dr. Lori Weeks and assisted with a study investigating supports for diverse older women who experience intimate partner violence. In addition, she spent nearly two years collecting data on behalf of the Canadian Longitudinal Study on Aging. She is also a student research scholar in the Healthy Populations Institute at Dalhousie University, and a student member of the Canadian Association on Gerontology. The researcher actively immerses herself in other scholarly communities that focus on healthy aging and policy research, including conferences presented by the Canadian Association of Health Services and Policy Research and the Canadian Association on Gerontology.

The researcher acknowledges that she is of settler heritage. However, her worldview is not congruent with the beliefs or values associated with colonization, and she is pursuing this study as a way to contribute to addressing the calls to action for reconciliation (Truth and Reconciliation Commission of Canada, 2015). In addition to being of personal and academic interest to the researcher (which was fostered in an undergraduate multicultural health course taught by Dr. Debbie Martin), Indigenous rights and health are the professional focus of other family members. This includes her uncle, who worked as a lawyer fighting for fair remuneration for survivors of residential schools in the prairies, and her grandfather, who conducted feasibility studies for healthcare provision to Northern, rural, and remote communities in Canada to address health inequities.

3.4 Summary

The methods described in this chapter facilitated the examination of current healthy aging policies applicable to Elders and older Mi'kmaq, how the perspectives of Elders and older Mi'kmaq are considered and integrated into these policies, and how these policies support and promote healthy aging among older Mi'kmaq. These methods were applied to explore the research questions.

CHAPTER 4 RESULTS

4.1 Results: Phase 1

Policy Analysis

The first research question explored was: *What are the current federal, provincial, and First Nations government policies in place intended to support aging Mi'kmaq in Atlantic Canada?* To answer this question, the most current provincial, federal, and First Nations health policies, strategies, frameworks, and action plans pertaining to older Mi'kmaq living in Atlantic Canada were retrieved from official websites of the federal and Atlantic region provincial governments, as well as First Nation communities and relevant First Nation organizations. Importantly, it should be noted that the policies included in this analysis are, for the most part, visionary or aspirational policies that describe a government or organization's goals and priorities. This is not necessarily the same as a policy that is written and used in a legislative or regulatory capacity to enforce certain actions. In total, 11 documents met the inclusion criteria and qualitative content analysis of the documents generated four key themes related the first research question (see Figure 1). This chapter begins with a general overview of these documents to familiarize the reader to the affiliated jurisdictions and organizations, followed by a description of the themes developed through the data analysis methods outlined in Section 3.1.2. The documents are listed from broad to specific jurisdictions (i.e., national to regional to provincial to community).

4.1.1 Policy Document Overviews

1. First Nations and Inuit Health Strategic Plan: A Shared Path to Improved

Health (Health Canada, 2012). This is a national policy from the First Nations and

Inuit Health Branch, located within the federal government department of Indigenous Service Canada, which is responsible for providing healthcare funding and services to all First Nations and Inuit. This plan has four strategic goals: (a) Quality Health Services; (b) Working Together; (c) Improved Efficiencies; and (d) Supportive Environment. Providing care and supports to aging First Nations populations is mentioned specifically in the second strategic goal, *Working Together*.

- 2. Blueprint on Aboriginal Health: A 10-Year Transformative Plan** (Government of Canada, Provinces, Territories, Assembly of First Nations, Congress of Aboriginal Peoples, Inuit Tapiriit Kanatami, Métis National Council, & Native Women's Association of Canada, 2005). The purpose of this national document is to provide guidance for health-related decision making with the goal of improving health services for Indigenous peoples in Canada, calling for a coordinated effort from the federal, provincial, and territorial governments regarding service provision and funding. The blueprint describes five principles: (a) Vision of Health; (b) Distinctions-based; (c) Partnership; (d) Funding; and (e) Living Document, and six approaches: (a) Building on Indigenous Knowledge; (b) Women's Participation; (c) Determinants of Health; (d) Engagement and Inclusivity; (e) Sustainability and Accountability; and (f) Description of Current Mandates. Consideration for the specific needs of First Nation Elders and aging populations are included in the principles *Vision of Health* and *Partnership*, as well as the approaches *Determinants of Health* and *Engagement and Inclusivity*.
- 3. First Nations and Inuit Home and Community Care (FNIHCC) 10-Year Plan (2013-2023)** (Health Canada, 2015b). This plan identifies the priorities for the Home

and Community Care Program, which is funded by the federal government and provides homecare services to First Nations and Inuit with chronic or acute conditions of any age, although users of this program tend to be older. Designed to align with the goals of the FNIHB Strategic Plan (Document 1), this plan includes five goals: (a) A Home and Community Care Program that Includes a Holistic Wellness Approach Within a Circle of Care Offering High Quality Services and Culturally Safe Care to Clients Through all Phases of Life; (b) New and Innovative Partnerships and Planning that Aligns with and Enhances Existing Programs and Services to Improve Health Outcomes for Home and Community Care clients; (c) Promote Sustainable and Appropriate Work Environments in which Home and Community Care Professionals and Para-Professionals Continue to be Informed, Competent, Engaged and Supported; (d) A Sustainable Program that is Supportive of Client, Family, a Community and is Adaptable to Changing Needs, Emerging Trends, and is Responsive to the Home Care needs of First Nations and Inuit; and (e) A Program that is Dedicated to Quality Improvement Based on High Quality, Consistent and Standardized Data Collection and Assessments. This plan focuses on the program structure and staffing (i.e., employing new technologies, training staff to be culturally safe), which has a direct impact on the quality of care received by older adults who use Home and Community Care services. The first goal makes specific reference to learning more about preventive visits for at-risk populations at or over the age of 60 years.

- 4. Atlantic First Nations Elder Care Strategic Action Plan: Atlantic First Nations Elders are Supported and Engaged in Health Aging** (Atlantic First Nations Health Partnership, 2015). Elder Care is identified as a health priority by the Atlantic First

Nations Chiefs. A review process led to the second edition of this plan, which aims to promote healthy aging among Elders and older First Nations in the Atlantic region over five years (2015-2020). The plan consists of three primary goals: (a) Engagement; (b) Planning; and (c) Support; and associated activities that correspond with each goal. Each year of the plan focuses on a specific health topic (i.e., Mental Health and Addictions, Home and Community Care, Chronic Disease Management) relevant to promoting the health of older First Nations.

- 5. Shift: Nova Scotia’s Action Plan for an Aging Population** (Nova Scotia Department of Seniors, 2017). This provincial plan describes three goals and an implementation plan to guide Nova Scotia residents and government departments in valuing, promoting, and supporting the aging adult population. The goals of the plan are: (a) Value the Social and Economic Contributions of Older Adults; (b) Promote Healthy, Active Living; and (c) Support Aging in Place, Connected to Community Life. Although no goal has an action specific to older Mi’kmaq, it is noted in the implementation plan that all decisions and actions must be based on evidence and an *“...understanding of the historical context of various populations – in particular Mi’kmaw and African Nova Scotia communities”* (p. 18). This approach is meant to promote the need for culturally safe programming that also considers and addresses barriers to participation. Wellness services and programs provided by the province are available to all residents, including older Mi’kmaq living on-reserve.
- 6. We Are All In This Together: An Aging Strategy for New Brunswick** (Province of New Brunswick 2017). This provincial plan describes three goals with four initiatives each created with the intent to promote a positive approach to aging

through person-centred communities of care and support for residents of New Brunswick. The three goals are: (a) Enable Seniors to Live Independently, (b) Achieve Sustainability and Innovation; and (c) Embrace a Provincial Culture of Person-centred Care and Support. In the introductory section of the strategy, there is a section on learnings from consultations with First Nations communities in New Brunswick that highlights the important role of Elders in First Nations communities. There is also attention drawn to the lack of senior care infrastructure, caregiver burnout, language barriers in healthcare provision, and lack of communication between on-reserve health centres and off-reserve healthcare facilities. Listed in the first goal, *Enable Seniors to Live Independently*, is a call for action to engage with First Nations communities to share best practices and learn about different cultural approaches to aging.

7. **Provincial Healthy Aging Policy Framework** (Newfoundland Labrador Aging and Seniors Division, 2007). The province of Newfoundland and Labrador describe healthy aging as promoting physical, social, mental, emotional and spiritual wellbeing to improve the quality of life while aging. The province has established six priorities containing 28 goals that promote healthy aging: (a) Recognition of Older Persons; (b) Celebrating Diversity; (c) Supportive Communities; (d) Financial Well-being; (e) Health and Well-being; and (f) Employment, Education, and Research. There is a specific goal to recognize and respect Indigenous Elders and seniors listed in the second priority, *Celebrating Diversity*. There is also a goal to address the housing requirements of Indigenous Elders and seniors in *Supportive Communities*.
8. **Promoting Wellness, Preserving Health: A Provincial Action Plan for Seniors,**

Near Seniors, and Caregivers Living on PEI (Government of Prince Edward Island, 2018). This is the first healthy aging plan for Prince Edward Island, which was created with the vision of an age-friendly health and social system that promotes wellness and preserves health. The plan contains four priority pillars: (a) Age-in-place Initiatives; (b) Age-friendly Communities; (c) Active Aging; and (d) Support Upstream Endeavours. No pillar or related actions directly mentions older Mi'kmaq living on- (or off) reserve in Prince Edward Island; however, it is stated that the Mi'kmaq Confederacy was consulted during the formation of the overall action plan.

9. Paq'tnkek Mi'kmaq Nation Strategic Plan (2012-2015) (Han Martin Associates, 2012). The purpose of this strategic plan is to improve physical, spiritual, emotional, cultural, and mental well-being of the residents of Paq'tnkek. The plan begins by describing a long-term vision for the community, which includes the provision of assisted living to Elders within the community. The plan has seven themes: (a) Governance and Management; (b) Communication; (c) Infrastructure; (d) Enterprises; (e) Programs; (f) Human Resources; and (g) Values, Language, Culture. In this plan, Elders are acknowledged as a resource for Mi'kmaq language revitalization with youth, and the needs of older community members are considered when improving accessible housing infrastructure (Theme C) and transportation options (i.e., medical drivers, shuttle service), and primary healthcare programs (including Home and Community Care) (Theme E).

10. Glooscap First Nation Community Plan (Horizons Community Development Associates Inc., 2013). The purpose of the Glooscap Community Plan is to address community-established priority areas to create a balanced and well community for all

members. The plan consists of seven strategic areas: (a) Thriving People; (b) Thriving Culture and Language; (c) Thriving Infrastructure; (d) Thriving Leadership; (e) Thriving Partnerships and Relationships; (f) Thriving Economic Development; and (g) Thriving Lands. Elders are listed as partners and resources in a number of actions within *Thriving People* and *Thriving Culture and Language*, and as a group who would benefit from *Thriving Infrastructure*, especially related to healthcare.

11. Sipekne'katik Band Strategic Plan 2014-2019 (LeBlanc & Roness, 2014). The purpose of the strategic plan is to address challenges and improve quality of life (based on the strategic priority areas) for all residents. The plan has 13 strategic priorities: (a) Leadership; (b) Finance and Administration; (c) Early Childhood Development; (d) Education; (e) Health Services; (f) Health Promotion of Healthy Practices; (g) Employment, Training, and Income, (h) Cultural Revitalization; (i) Social Inclusion and Social Supports; (j) Infrastructure and the Environment; (k) Housing, Emergency Preparedness and Business Continuity; and (l) Economic Development and Business Ventures. Elders are recognized as collaborative partners in promoting language and culture with youth in *Education* and in *Cultural Revitalization*, by sharing traditional teachings, ceremonies, and knowledge with the community as a whole. Services to promote the health of Elders and older Mi'kmaq are mentioned in *Health Services*, specifically regarding transportation, but generally in terms of improving access to health services, and also in *Health Promotion of Healthy Practices*, where there is a call to develop age-appropriate fitness and wellness programs.

4.1.2 Phase 1 Themes Overview

For the inductive content analysis of these policy documents, the main unit of analysis was content directly related to older First Nations (and Mi'kmaq), followed by how this unit fits in to the context of the overall document. This approach produced four main themes related to Elders and older Mi'kmaq living on-reserve and how the policies promote healthy aging. These themes are: (a) Transparent Inclusion of Older First Nations During Policy Development; (b) Engaging Elders and Older Mi'kmaq; (c) Determinants of Health Approach, and (d) Services and Programs, as shown in Figure 1. Themes are described below with supporting examples from relevant policy documents.

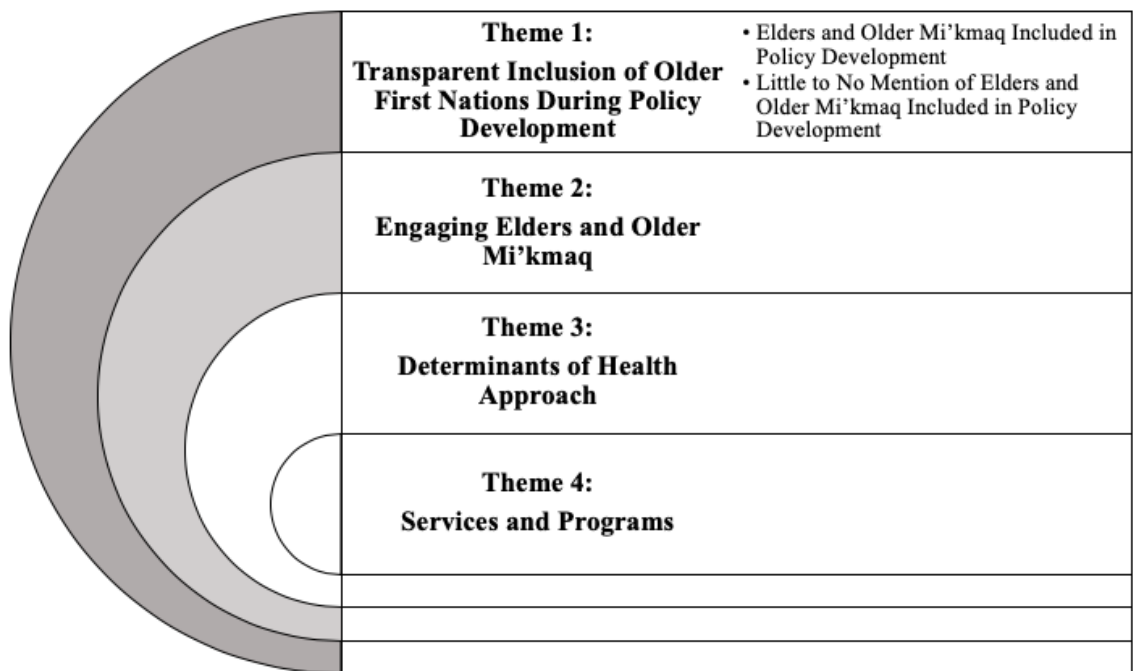


Figure 1. Four main themes and 2 subthemes generated from the 11 policy document relevant to Elders and older Mi'kmaq in Atlantic Canada.

4.2 Theme 1: Transparent Inclusion of Older First Nations During Policy Development

The depth of inclusion and involvement of older First Nations, and specifically

older Mi'kmaq, were not transparent in many policies that have a direct impact on their health. This theme, Transparent Inclusion of Older First Nations During Policy Development, refers to the degree that policies report how, when, where, and why (or not) older First Nations were included and involved during policy development. Several documents described the involvement of Elders and older Mi'kmaq during policy development. Other policies report consultation without clear strategies or objectives that reflect First Nations or Mi'kmaq contributions to the development of the policy. A few documents do not mention any Elder or older Mi'kmaq involvement at all.

4.2.1 Elders and Older Mi'kmaq Included in Policy Development

The Glooscap First Nation Community Plan (Horizons Community Development Associates Inc., 2013) acknowledges *The Elders' Group*, who reviewed a draft of the plan and provided advice. According to the background on the development of the plan, consultation with the Elders took place at an Elders meeting, and their feedback was integrated into the plan before approval by the Chief and Council. Of the three Mi'kmaq communities (Glooscap, Paq'tnekek, and Sipekne'katik) with strategic plans available with content related to healthy aging, Glooscap and Sipekne'katik both have Elders' groups, while Paq'tnekek does not (Atlantic First Nations Health Partnership, 2015).

The *Atlantic First Nations Elder Care Strategic Action Plan: Atlantic First Nations Elders are Supported and Engaged in Healthy Aging* (Atlantic First Nations Health Partnership, 2015) includes perspectives from the Elder Care Working Group and its Elder representatives, and Elders at the community level when possible, in addition to health directors, health technicians, and members of the Atlantic First Nations Health Partnership (including the NIHB Health Advisory Committee). The Province of

Newfoundland and Labrador consulted with Miawpukek First Nation Elders and older Mi'kmaq during the creation of the *Healthy Aging Strategy* and reported that older Mi'kmaq in Miawpukek felt supported by their community and the services offered there (Newfoundland Labrador Aging and Seniors Division, 2006). Elders are acknowledged as participants in the creation of the *First Nations and Inuit Home and Community Care (FNIHCC) 10-Year Plan (2013-2023)* (Health Canada, 2015b), though not specifically Mi'kmaq Elders. Overall, only four of the policies mentioned the inclusion of Elders during the development process.

4.2.2 Little to No Mention of Elders and Older Mi'kmaq Included in Policy Development

The development of the *Sipekne'katik Band Strategic Plan (2014-2019)* began with a two-day workshop during which Chief and Council along with program directors undertook a SWOT (i.e., strengths, weaknesses, opportunities, and threats) analysis of the 13 social health determinants that define the Sipekne'katik First Nation's health and wellbeing (LeBlanc and Roness, 2014). Consultation with Elders was not mentioned in the planning methodology described in the strategic plan, although according to the Atlantic First Nations Health Partnership (2015), Sipekne'katik does have an Elders' program. In the *Paq'tnkek Mi'kmaq Nation Strategic Plan (2012-2015)* (Han Martin Associates, 2012), Paq'tnkek leadership and directors created the strategic plan, but there is no specific mention of Elders being involved.

The government of PEI consulted with the Mi'kmaq Confederacy, along with over 25 other stakeholder groups, during the creation of the *Promoting Wellness, Preserving Health: A Provincial Action Plan for Seniors, Near Seniors, and Caregivers*

Living on PEI (Government of Prince Edward Island, 2018). There are no details on the consultation process, nor any Mi'kmaq-specific action items within any of the four pillars of the plan. The province of New Brunswick spoke with several First Nations communities during the consultation phase of *We Are All In This Together: An Aging Strategy for New Brunswick* (Province of New Brunswick 2017), but is unclear if they were Mi'kmaq communities and/or Wolastoqiyik communities, and if any older community members were part of the conversations. The province of Nova Scotia held community conversations with First Nations while creating *Shift: Nova Scotia's Action Plan for an Aging Population* (Nova Scotia Department of Seniors, 2017), but the policy does not offer any further details on how many Mi'kmaq communities, and if Elders and older Mi'kmaq were specifically engaged in the conversations. Multiple Indigenous groups and government departments were consulted for the *First Nations and Inuit Health Strategic Plan: A Shared Path to Improved Health* (Health Canada, 2012), but Elders were not specifically recognized. A side panel on page 13 of the document includes a quote from an Ojibwe Elder on the importance of language, which hints at some involvement of First Nation Elders.

4.3 Theme 2: Approaches to Engaging Elders and Older Mi'kmaq

The second theme, *engagement*, refers to the different approaches that were used to include and involve older First Nations in policy development, implementation, and evaluation. Engagement with Elders and older First Nations took multiple forms, including: ensuring interests of older Mi'kmaq were considered, learning from Elders, inclusion in community affairs, and integrating feedback from older First Nations (including older Mi'kmaq) in legislation, policies, programs, and services. Engagement

appeared differently in nearly every policy, but it was apparent in the Mi'kmaq community strategic plans that Elders' traditional knowledge and leadership is essential for the overall health of the community.

During the review process of the initial *Atlantic First Nations Elder Care Strategic Action Plan*, efforts to increase engagement of Elders were praised as highly successful by stakeholders and partners; these included: creating the Elder Care Working Group, hosting an Elders' Gathering, integrating the Elders' health concerns raised at the Gathering into various Health Advisory Committee work plans (i.e., NIHB, Mental Wellness) and community health planning, and the creation of the Atlantic First Nations Health Elder Care Policy Lens for FNIHB programs (Atlantic First Nations Health Partnership, 2015). There were also some difficulties with Elder engagement discussed, such as: role clarification for the representative Elders on the Elder Care Working Group, and communication and networking with Elders across the Atlantic region. It was noted that there is no consistent network of community Elder groups or contacts, and not all Mi'kmaq communities have Elder groups or programs (Atlantic First Nations Health Partnership, 2015).

The interests of older Mi'kmaq and other Indigenous peoples were considered in the Provincial Healthy Aging Policy Framework priority direction *Celebrating Diversity*, where the province of Newfoundland and Labrador calls for the "*Uniqueness of Aboriginal Elders and seniors to be recognized and respected*" (Newfoundland Labrador Aging and Seniors Division, 2007, p. 22). Proposed actions include integrating "*feedback from Aboriginal seniors in legislation, policies, programs, and services,*" and to "*work with the Federal Government and Aboriginal peoples to improve the health and well-*

being of Aboriginal seniors” (p. 22). The other provincial aging plans did not outline clear actions or objectives that reflected intent to engage further with Elders and older Mi’kmaq to directly promote healthy aging.

In the *Blueprint on Aboriginal Health: A 10-Year Transformative Plan* (Government of Canada, Provinces, Territories, Assembly of First Nations, Congress of Aboriginal Peoples, Inuit Tapiriit Kanatami, Métis National Council, & Native Women’s Association of Canada, 2005), although it is not clear how or if Elders were consulted at the national level, the interests of Elders and older First Nations are clearly included in the plan. Regarding the health of Elders and older First Nations, the framework calls for addressing unique health needs and challenges of Elders, as well as prevention, health promotion, and other upstream investments (e.g., housing, food security). Although much less specific, the *First Nations and Inuit Health Strategic Plan: A Shared Path to Improved Health* calls for “provinces, territories, AANDC¹, and others, to provide better supports across the continuum of care, including to the aging population in First Nation and Inuit communities” (Health Canada, 2012, p. 14).

Within Mi’kmaq community strategic plans, there was a focus on engaging with Elders to share cultural knowledge and provide youth mentorship. For example, Paq’tnkek described strong intergenerational relationships as a key part of their community vision (Han Martin Associates, 2012). Elder and youth interaction is highlighted as a way to increase Mi’kmaq language skills. Another key community vision Paq’tnkek described is being able to provide assisted-living residences ensuring that older

¹ Aboriginal Affairs and Northern Development Canada. This federal department has been replaced with two new departments: Indigenous Services Canada and Crown Indigenous Relations and Northern Affairs Canada.

Mi'kmaq will not have to leave the community as they age and require increased care (Han Martin Associates, 2012). Glooscap planned on engaging Elders to help create more regular opportunities for community members to be involved in community affairs (Horizons Community Development Associates Inc., 2013). The Elders Committee was also listed as a resource for involvement in Band Committees, working groups, and other projects. Glooscap Elders were identified as partners in identifying cultural gifts and skills within the community and should be incorporated into more activities to share Mi'kmaq history (Horizons Community Development Associates Inc., 2013).

The Sipekne'katik strategic plan includes a call to create an Elders' committee to advise and guide the development of a community cultural revitalization strategy and to transmit traditional teachings, knowledge (e.g., about the land and environment), and ceremonies to future generations (LeBlanc and Roness, 2014). The Health Centre was tasked with leading this piece of the strategy, as cultural revitalization is seen as vital to community health. The plan also includes strategies to collaborate with local Elders to identify ways to promote the use of culture and language in the schools, in students' homes, and in Band-managed public spaces, such as a mentorship program that pairs Elders with youth in the community. This program could help to establish mutual support and respect, which in turn will assist in the transmission of culture and language to younger generations. According to LeBlanc and Roness (2014), Sipekne'katik is losing Elders, which further accelerates cultural loss, and it is unclear who still speaks Mi'kmaq and who possesses traditional, cultural knowledge.

4.4 Theme 3: Determinants of Health Approach

Reference to the Social Determinants of Health appeared in many of the

documents. This theme focused any discussion of the determinants of health, though it was not necessary for policies to cite or specifically refer to *The Canadian Facts* (Mikkonen & Raphael, 2010) or the *Social Determinants of Aboriginal Peoples' Health* (Reading & Wien, 2013). In some cases, the *Social Determinants of Health* approach was used as a lens to understand the health of Elders and older Mi'kmaq, and a call for preventive and upstream approaches to promoting the health of Elders and older Mi'kmaq. The *Social Determinants of Health* approach was also adapted as a framework from which to set goals and objectives to improve community health.

During the development process of the *Sipekne'katik Band Strategic Plan*, the Chief and Council and program managers examined the community's social determinants of health as well as other key areas that directly affect the community's capacity to address challenges and improve quality of life (LeBlanc & Roness, 2014). By using this approach, Sipekne'katik sought to identify strategies that considered the social issues that impact the health of a whole population, citing access to adequate income, employment opportunities, safe living conditions, and a strong connection to one's culture, as important as daily physical activity or nutrition. LeBlanc and Roness (2014) explained, "*Not only is this understanding consistent with Aboriginal worldviews, but it also provided a broader framework from which to undertake planning at the Sipekne'katik Band*" (p. 2).

The Blueprint on Aboriginal Health: A 10-Year Transformative Plan

(Government of Canada, Provinces, Territories, Assembly of First Nations, Congress of Aboriginal Peoples, Inuit Tapiriit Kanatami, Métis National Council, & Native Women's Association of Canada, 2005) lists the *Social Determinants of Health* as one of the

approaches used guide the development of the plan, specifically because factors that fall outside the traditional health system (i.e., culture, income) are included. *The First Nations and Inuit Health Strategic Plan: A Shared Path to Improved Health* (Health Canada, 2012) also calls for the Social Determinants of Health to be used as a planning approach with evidence-based initiatives but does not offer more details.

The social determinants of health were incorporated in some capacity into the healthy aging policies developed by each of the Atlantic provinces. *Promoting Wellness, Preserving Health: A Provincial Action Plan for Seniors, Near Seniors, and Caregivers Living on PEI* cites the Social Determinants of Health approach as a guide used in the creation of the action plan and briefly explains that population health is driven by socioeconomic factors that shape the environment (Government of Prince Edward Island, 2018). The *Provincial Healthy Aging Policy Framework* is also guided by the Social Determinants of Health and emphasizes the importance of considering these factors when implementing the healthy aging plan (Newfoundland Labrador Aging and Seniors Division, 2007). *An Aging Strategy for New Brunswick* employs the Social Determinants of Health to explain why health status can vary among seniors (Province of New Brunswick, 2017). Broadly, *Nova Scotia's Action Plan for an Aging Population* suggests using the Social Determinants of Health to help develop a population health profile (Nova Scotia Department of Seniors, 2017). None of the provincial policies make any comments about the direct applicability of the Social Determinants of Health in relation to older Mi'kmaq.

4.5 Theme 4: Services and Programs

The final theme in Phase 1, *Services and Programs*, focused specifically on

commonly referenced current initiatives as well as plans for potential future program or service development. The increasing need for health services for Elders and older Mi'kmaq is a concern among federal funding, healthcare providers on and off-reserve, and within communities. The *Home and Community Care* and *Non-Insured Health Benefits* programs are most frequently discussed in healthy aging policies. Other commonly cited issues included appropriate housing or assisted living options and transportation to appointments and services.

The *First Nations and Inuit Home and Community Care 10-Year Plan* recognizes that an increase in aging population coupled with more instances of chronic conditions will pose a challenge in the delivery of *Home and Community Care* over the next 10 years (Health Canada, 2015b). The purpose of this plan is to improve service quality for clients of *Home and Community Care*, which includes older Mi'kmaq living on-reserve. The plan calls for many objectives that could potentially promote healthy aging, such as: providing culturally safe care and training to practitioners, working with communities to support the preventive programs, and integrating technology to improve care delivery.

The *Atlantic First Nations Elder Care Strategic Action Plan* focuses on *Home and Community Care* for a full year out of the five-year plan. This includes providing educational webinars to Elders and older Mi'kmaq on the topic and identifying Elder-specific needs in relation to *Home and Community Care* programs (Atlantic First Nations Health Partnership, 2015). *Paq'tnkek Mi'kmaq Nation Strategic Plan* included an objective in their plan to provide age-specific housing that accounts for lifestyle and income levels, as well as infrastructure services to promote future health, safety, and environmental needs (Han Martin Associates, 2012). Further, improving transportation

access, including medical drivers, will directly promote the health of aging community members by providing reliable access to programs and services. The *Paq'tnkek Mi'kmaq Nation Strategic Plan* has also set an objective to deliver high quality healthcare programs in the areas of chronic disease prevention and management, and Home and Community Care (Han Martin Associates, 2012).

Under the *Provincial Healthy Aging Policy Framework* priority direction *Supportive Communities*, the province of Newfoundland and Labrador calls for a focus on “*provincial housing requirements of Aboriginal Elders and seniors*,” where the province intends to “*encourage the federal government and Aboriginal peoples to improve housing for Aboriginal seniors living on reserves*” (Newfoundland Labrador Aging and Seniors Division, 2007, p. 29). An *Aging Strategy for New Brunswick* articulates that there is a lack of senior care infrastructure in First Nation communities, specifically long-term care and senior’s centres (Province of New Brunswick, 2017). There is also no residential care available in communities, and there are multiple issues that impede quality care for aging Mi’kmaq, including caregiver burnout and language barriers with the provincial health services. A major barrier to quality integrated care between community health centres and the province is that community health centre patient data is not linked to healthcare services outside of the communities, creating a hindrance to the timely sharing of medical information (Province of New Brunswick 2017).

Phase 1 examined 11 policy documents from federal, provincial, and First Nations governments and organizations that intend to support and promote healthy aging among older Mi’kmaq. To further elaborate on these findings, Phase 2 of the study interviewed

policy stakeholders (i.e., policymakers, policy analysts, and policy users) to gain a deeper understanding of how Mi'kmaq perspectives are integrated in the development, implementation, and/or evaluation of aging-related health policies, and to explore how and if these policies can promote healthy aging among older Mi'kmaq living on-reserve in Atlantic Canada.

4.6 Results: Phase 2

Interviews

The second research question explored: *a) How do policymakers integrate and reflect upon Mi'kmaq perspectives in the development, implementation, and/or evaluation process of aging-related federal (and provincial) policies and b) How can these policies support healthy aging of First Nations adults living on-reserve in their communities?* To answer these questions, semi-structured interviews were conducted with nine participants working in First Nation and Mi'kmaq health- and aging-related positions and who are familiar with relevant policies to gather their perceptions on whether or not these policies supported healthy aging. Recruitment efforts attracted individuals from Indigenous or aging-related federal and provincial government departments, First Nation Health Organizations, First Nation Health Centres, and members of provincial aging policy development committees. Participant descriptions are designed to maintain confidentiality when indicated, as several participants agreed to have their full position title identified.

4.6.1 Participant Descriptions

P1. Policy Analyst; Department of Health & Wellness, Aboriginal Health (Nova Scotia)

P2. Non-Insured Health Benefits Navigator and Elder Care Working Group Member;

First Nation Policy Organization (Nova Scotia)

P3. Program Administration, First Nations Inuit Health Branch (Atlantic Region)

P4. Healthcare Practitioner; Mi'kmaq community (Nova Scotia)

P5. Acting Director; First Nations Health Organization (Nova Scotia)

P6. Healthcare Practitioner; Mi'kmaq community (Nova Scotia)

P7. Member; New Brunswick Council on Aging (New Brunswick)

P8. Member; New Brunswick Council on Aging (New Brunswick)

P9. Member, National Seniors Council (New Brunswick)

4.6.2 Semi-Structured Interview Guide Overview

Prior to beginning each interview, oral consent was granted by the participant. All participants were first asked to describe their experience or role in relation to First Nation health and aging related policies. Conversations were guided into a discussion on the needs of aging/older First Nations/Mi'kmaq living on-reserve in existing health and aging policies. Participants were probed on the current policies in place federally/provincially to support healthy aging, influential factors (i.e., political climate, current events) that impact policies, and generally how/if Mi'kmaq perspectives on aging are integrated into age-related policies (and/or what prevents collaboration). When applicable, participants were asked their perspectives on determining and integrating the specific needs of older Mi'kmaq living on-reserve in aging-related policies. Participants were also asked whether and how cooperation and collaboration work among jurisdictions of government (i.e., provincial, federal, First Nation), health organizations, and First Nation Communities. Finally, participants were asked to share any relevant additional information on the topic of aging, health policies, and older Mi'kmaq.

4.6.3 Phase 2 Themes and Subthemes Overview

Analysis of the interview transcript data revealed three main themes related to older Mi'kmaq living on reserve and the policies that promote or prevent healthy aging. These themes were: (a) Governmental Relations and Communication (Subtheme: Consultation); (b) Current Healthy Aging Policies for First Nations (subthemes: Federal Policies and Programs (including Non-Insured Health Benefits); Provincial Policies and Programs; and First Nations Policies and Programs (including Other Community Health Promoting Policies and Programs for Older Mi'kmaq); and (c) Integrating Older First

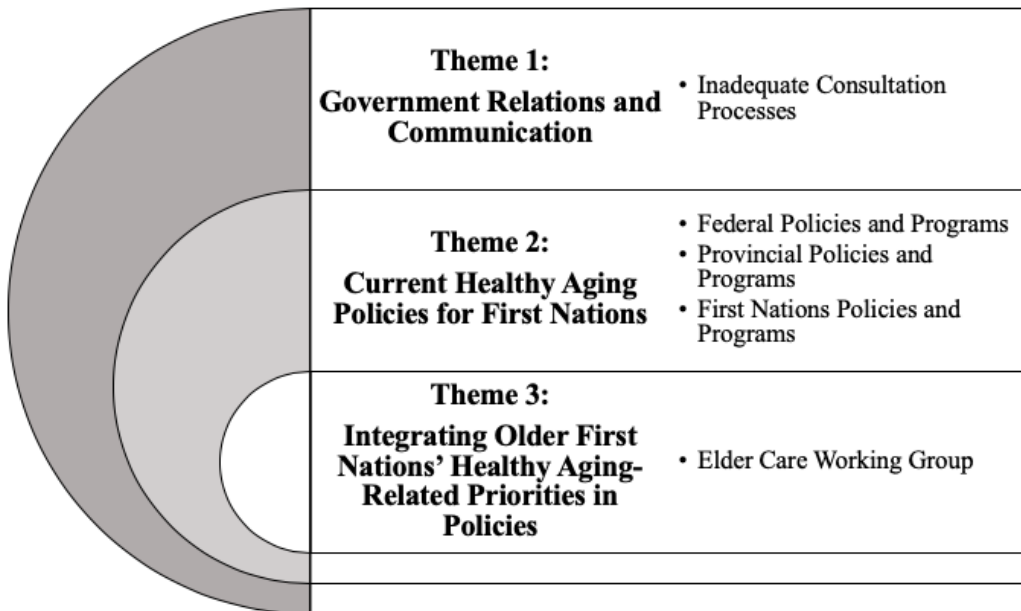


Figure 2. Three main themes and five subthemes generated from the nine interviews with policymakers, policy analysts, and policy users regarding healthy aging policies relevant to Elders and older Mi'kmaq in Atlantic Canada.

Nations' Healthy Aging-Related Priorities in Policies, (subtheme: Elder Care Working Group). Themes and subthemes are presented below in Figure 2 and in text with supporting quotes. Additional information is provided where necessary to give context and important details on some of factors mentioned by the participants.

Overall, participants offered narratives of their experiences, challenges, ideas, and thoughts on aging-related First Nation health policies and programs that have an effect on their work. Participants also articulated multiple barriers and frustrations faced when trying to provide services to older Mi'kmaq community members. Examples include the high turnover of health staff, the lack of programs and care grounded in Indigenous teachings, the workload given to understaffed healthcare providers, and the inability to address the specific needs of each community. Many of these barriers and challenges can be traced back to policies that dictate service provision. Participants also described the miscommunication or lack of communication among the different levels of government, health organizations, and communities. Notably, issues with communication was a prominent overarching topic as it was interwoven throughout each interview and all themes.

4.6.3.1 A Note on Truth and Reconciliation

It was expected that with the release and increased awareness of the TRC's final report and calls to action, that the TRC would be a theme throughout discussions on promoting healthy aging, especially given that many individuals in the current generation of older First Nations are residential school survivors, or were removed from their families as part of the sixties scoop. Despite the obvious need for comprehensive policies that promote healing, health, and wellbeing among this generation, mention of TRC was sparse. Participant 4, a healthcare practitioner on-reserve, explained that many people are ignorant towards Indigenous peoples and traumas caused by residential schools. Although she does her best to educate, she explained that she still encounters a lot of

ignorance outside of the community regarding the impact of those institutions and the purpose of reconciliation. Participant 2, a NIHB navigator, indicated disappointingly that “[Truth and Reconciliation] *means something different to every province, it’s not synonymous across Canada or the Atlantic for that matter.*” Participant 3, who works for FNIHB, briefly mentioned TRC during a discussion on cultural awareness training but gave no indication that the calls to action were guiding policy development. Further, there was no discussion of the Indian Residential School Resolution Health Support Program offered through FNIHB, which offers mental, emotional, and cultural supports to survivors and family members of former students.

4.7 Theme 1: Government Relations and Communication

The federal, provincial, and First Nations governments all have key roles in promoting the health of older Mi’kmaq and other First Nations living on-reserve in the Atlantic region through funding, planning, service delivery, and management. Theme 1 in the second phase of this thesis describes the relationships and lines of communication between and among multiple jurisdictions of government. Within the federal government, the departments of Indigenous Services Canada (ISC) and Crown-Indigenous Relations and Northern Affairs Canada (CIRNAC), are generally responsible for service provision including health and wellbeing. See Figure 3 for a diagram depicting the federal government department structure.

Within ISC, the First Nation and Inuit Health Branch (FNIHB) (in collaboration with Health Canada) offers the Non-Insured Health Benefits (NIHB) program and provides funding for the provision of healthcare services for Mi’kmaq living on-reserve. FNIHB funds health promotion, mental health, and chronic condition programs, and

provides health transfers to First Nations. FNIHB also funds some primary health services (i.e., nursing) for First Nations (and Inuit) living in rural, remote, and isolated locations with no access to provincial services. Funding and payment responsibilities are less clear as it pertains to physicians and nurses working on-reserve in locations that are situated close to provincial health services. The provinces generally do not deliver health services directly on reserves, and it is not financially feasible for every Mi'kmaq community health centre to provide specialized services given the varying population sizes and locations of reserves across the Atlantic region (though some communities do

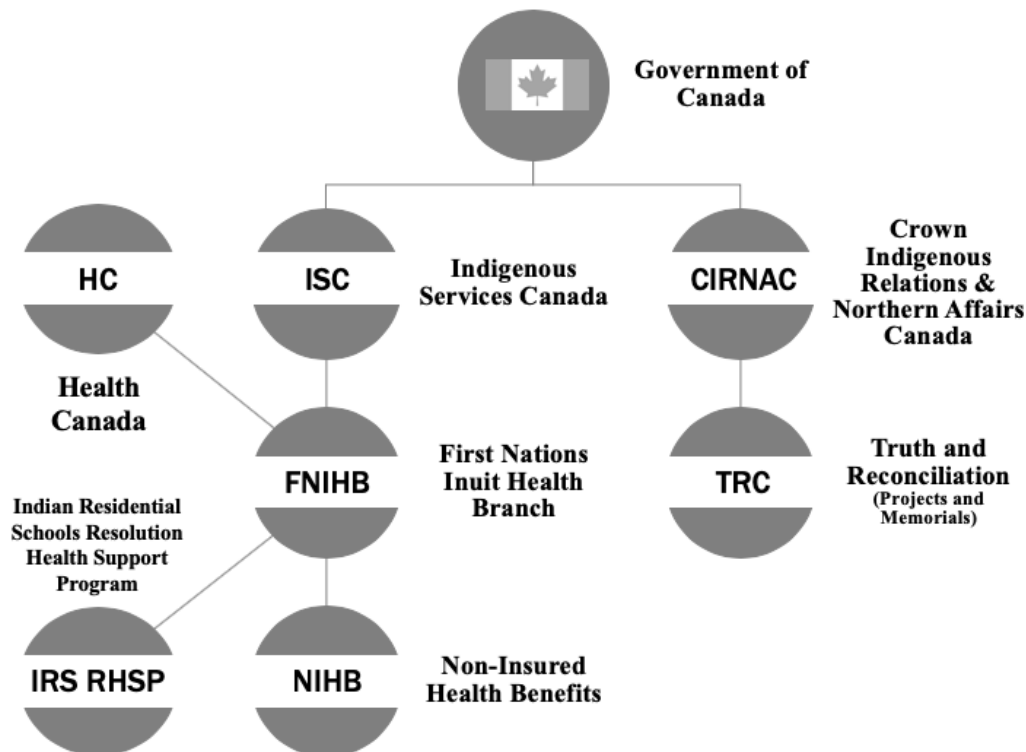


Figure 3. Relevant federal departments, programs, and initiatives that provide services related to Indigenous health and wellbeing (adapted for the purposes of the research questions).

employ nurses and physicians at their health centre). The provincial governments provide health services including primary care (e.g., to see a doctor or nurse), hospital visits (e.g.,

for medical imaging, surgeries, specialists), and rehabilitation (e.g., occupational or physical therapy).

The NIHB program bridges this service gap by providing medical insurance coverage for Mi'kmaq requiring health-related services and products that are not otherwise insured by provincial or private insurance plans. This includes drugs and pharmacy products, medical supplies and equipment, mental health counselling, dental benefits, vision care, and medical transportation. First Nation governments/governmental organizations (e.g., Atlantic Policy Congress of First Nation Chiefs) work with the federal government to plan and manage funded services, navigate the NIHB system, and identify health priorities for the region. However, there is little, if any, communication with the provincial governments on discussing service delivery to older Mi'kmaq in the region. Community health centres located in Mi'kmaq First Nations deliver health and wellness programs based on federal funding, but these services differ depending on resources and specific health priorities identified by each community. See Figure 4 for a diagram depicting the key healthcare provision relationships and lines of communication between governments.

Communication and collaboration among the federal, provincial and First Nation governments is difficult. Even within the federal government, intra-departmental collaboration is lacking. Participant 3, who works at FNIHB, described her experience, *“In the very beginning, a provincial colleague said something around... the Seniors Office did ‘this,’ but then the Indigenous Office did ‘this’.”* She wondered, *“why [are we] not making these collaborative policies?”* When discussing the relationships among governments, Participant 2 explained that, *“Policy-wise, the Chiefs have gone directly*

with the federal government in Atlantic Canada... so they have the Health Partnership.”

The Atlantic First Nations Health Partnership works to manage the programs and services

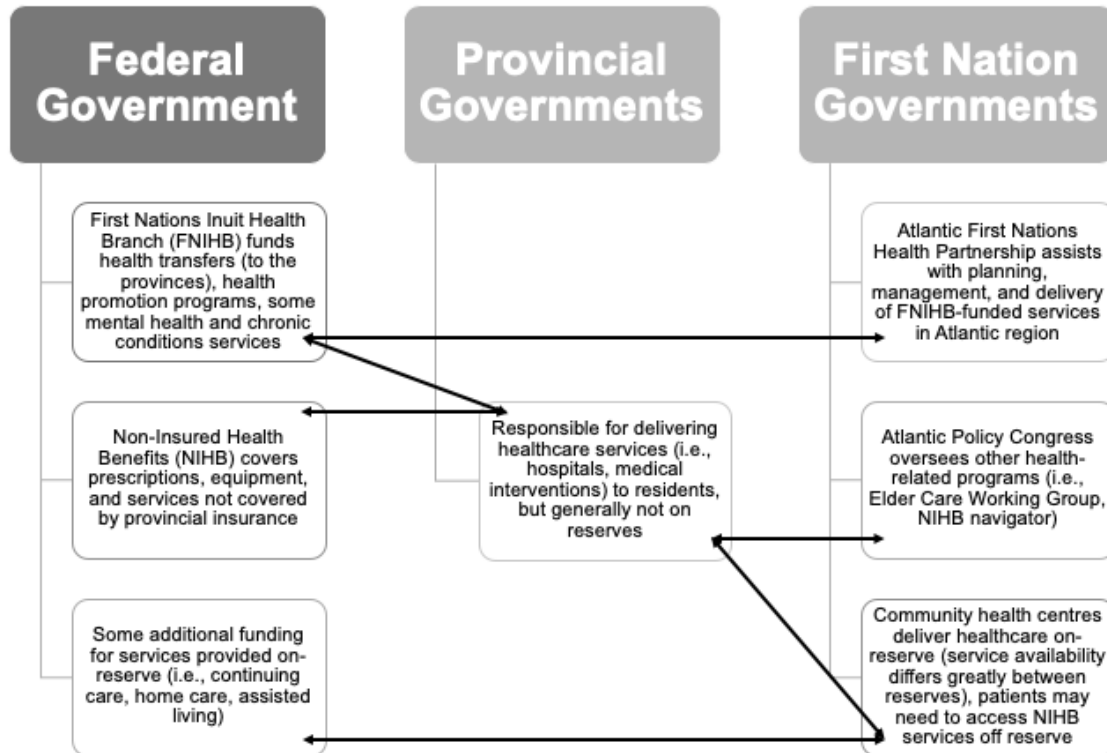


Figure 4. Overview of health promotion roles and responsibilities across governments. *Figure note:* Arrows indicate lines of communication, either for health transfers or service provisions.

funded by the federal government. Participant 2, a NIHB navigator, clarified that, rather than divide the region into four (i.e., by province) to negotiate with the federal government, it is much stronger with 33 communities together. She continued, *“I think it’s strategic, we don’t negate the province by any means”* (P2) and the various committees of the Health Partnership (i.e., Mental Health and Wellness, NIHB) do communicate with the provinces about specific services. Participant 2 confirmed,

For my position, for me to provide a continuum of resources for access to health and better health outcomes, I have to connect with the province, and some

provinces are already involved and connected, and some aren't. So, sometimes it's building a new relationship. Coverage or services vary by province across the Atlantic region, which can be a barrier to accessing certain health services.

Participant 2 explained further,

Not all services come from the federal level, and each province is different. That is a huge barrier for equitable access for First Nations in Atlantic Canada because each province had different policy and practice when dealing with First Nations on reserve, and off reserve, and access to some benefits that maybe aren't covered.

When asking Participant 4, a healthcare practitioner, about how the federal government consults with or gathers information from communities to ensure health-related needs are met, she said that they really do not and, despite her extensive experience working directly with older community members, she has never been consulted on their needs.

4.7.1 Inadequate Consultation Processes

In terms of provincial or federal government formally consulting with First Nations on healthy aging matters as it pertains to the documents discussed in Phase 1, participants reported that there was some reluctance, especially as there is no established process or practice for approaching and arranging a consultation with First Nations in a meaningful way. Participants working for provincial and First Nations organizations not only described distrust between the provincial and federal governments and First Nations, but tensions among the different First Nations themselves. Participant 7, who was heavily involved with the New Brunswick aging strategy consultations, discussed the unknowns of including First Nations in the policy consultation, but ultimately believed that First

Nations needed to be included. As another leading member of the New Brunswick aging strategy committee, Participant 8 realized that they [the committee] would be “*lumped in*” with the rest of government, which he noted did not have a particularly trusting relationship with the First Nations communities. This is one factor of many that may have led to fewer First Nations participating in the aging strategy consultation. Participant 8 elaborated,

We invited quite a number of First Nations leaders and the first thing that came as a surprise to some of the people around our table was that, even though we have a large First Nations component in New Brunswick and many, many reserves all over the province, there’s no such thing as one organization or one person speaking for First Nations in New Brunswick. You gotta talk to them all... and there is one of the issues that make consultation difficult, but you really have to take the time to do it, if you mean business. But you couldn’t take what goes on in one particular community and assume you’re going to replicate that... because in the politics of New Brunswick, the white person’s politics, there’s kind of a one size fits all mentality.

According to Participant 7, a member of the New Brunswick Council on Aging, there was resistance from the provincial government to undertake the necessary steps to make this “*complicated process*” more feasible and, arguably, respectful and inclusive to First Nations. Participant 7 not only described tensions between the provincial government and First Nations, but among the different First Nations themselves. Although this particular healthy aging policy had consultations with over 70 stakeholders, the discussions with the First Nations were held separately. Invitations were extended to

three Nations, two showed up, but would not interact with each other. Participant 8 noted that from the discussion, there was an obvious difference between the two groups in the access to services and supports for aging community members—one group had some and the other did not.

To the knowledge of Participant 7, there is no established process for approaching and arranging a consultation with a First Nation. While it is understood that each First Nation has their own preferences on how a consultation should unfold, there is no guidance on how to extend an invitation to consult. As Participant 8 noted, *“Governments, certainly in New Brunswick, haven’t figured that out yet. They still haven’t figured how to do consultation in a meaningful way”*. Participant 8 also described some of the learnings from the discussions with the participating New Brunswick First Nations, especially around community care, noting the province can learn a lot from First Nations, though he remained skeptical that much action would be taken. *“Whether anything will result from those consultations... therein is the issue”* (P8).

On a more positive note, in relation to future aging-related policy work, Participant 7 revealed,

With a group that I am working with federally, there is already discussion about consulting with First Nations to learn more about aging and to how we can integrate them better in federal policies and things like that. So, it’s already on their radar, although our work has just started. So, I guess we will see how complicated it is federally... I can’t tell you that now because we haven’t started.

4.8 Theme 2: Current Healthy Aging Policies for First Nations

Based on their area of expertise, participants made comments on what they knew

about the health and aging policies related to older First Nations and Mi'kmaq living on-reserve that currently exist. Theme 2 describes the participants' perspectives and experiences in relation to these current policies. Healthy aging, while important, was not perceived by participants as being a top health priority among Mi'kmaq communities, nor a focus of provincial or federal policies. Participant 1, who works in the Nova Scotia Department of Health and Wellness, Aboriginal Health, explained that currently the provincial government's top priorities are mental health and addictions, relationship building, continuing care, and Jordan's Principle. Though Continuing Care is relevant to many older people, it also includes younger and middle-aged people living with disabilities who require more medical care. Participant 1 agreed that healthy aging is important; but, given that the First Nations population is a young "bubble," most attention is given to health concerns for people in the young age demographics. Participant 1 re-iterated that healthy aging, as a health priority, is "lower on the rung."

Participant 9, who has worked on federal and provincial Indigenous policy issues, discussed current aging demographics, "... one of the things that I found quite interesting is it [current statistics] talks about [how] as a group, Aboriginal seniors are the fastest growing of all the Aboriginal [demographics] in the country." However, despite the increasing numbers of First Nations seniors, he noted, "When it comes to Aboriginal peoples, because demographically we are seen as being a young population base, the issues of our seniors is not given due respect" (P9). Other participants echoed this sentiment, agreeing that older community members are respected individuals, yet policies that explicitly promote and support the healthy aging of these community members are sparse in the Atlantic region.

4.8.1 Federal Policies and Programs

At the federal level, it was clear that, at this time, little consideration is given to older First Nations in health-related policy. Participant 3, who works at FNIHB, explained,

... As it related to healthy aging, I would say that, on a spectrum of young to elderly, there appears to more supportive policy or the by-law or band council resolution as it pertains to children and youth, but with the cultural importance of seniors and Elders, in some communities, great respect is given. However, in the form of policies, I don't quite see them.

Participant 3 went on to mention that many health-related policies across the country are now using a “life course” framework, implying that age-related issues are given more consideration, but she was unable to say anything specifically about Nova Scotia or the Atlantic region.

4.8.1.1 Non-Insured Health Benefits

NIHB is the federally-funded healthcare insurance program for First Nations that covers the cost of ‘medically necessary’ health-related services and products. Participants repeatedly expressed frustration with the NIHB program and policies and explained that it acts as a barrier to receiving timely care, which then impacts healthy aging for older Mi’kmaq across the Atlantic region living on-reserve. Multiple examples were given, such as getting a walker for a patient, getting supplies for wound care, and arranging for blood pressure cuffs. Participant 4, a healthcare practitioner, explained,

NIHB is just so time consuming, and a lot of things aren't covered. So, here in [community name], the Band pays for things that aren't covered because they're

able to. So, that also is very time consuming for us, because that means another phone call from us to the pharmacy to approve something... so, yeah, NIHB is a frustration.

Not all communities are able to pay for medical supplies and appliances up front, creating further inequities in access to healthcare. Participants working directly with NIHB as it relates to older Mi'kmaq on-reserve who encounter NIHB-related limitations have applied some strategies to navigate these barriers and advocate for change. For example, Participant 2, a NIHB navigator, stated,

... It depends on what the issue is. If it's a broad-scope community issue, I gather as [many] requests or needs as I can, and then I would take it on as a larger advocacy piece and go straight to the Director at FNIHB and start to have a discussion and try to find a different way.

Participant 2 continued, “... *that's how they managed to get some blood pressure cuffs available and make sure that they're provided.*” Participant 4 provided some examples of NIHB-related challenges, explaining that her older clients often do not realize that they need or are entitled to something, or how to go about getting it:

... such as equipment, and some things aren't covered by NIHB, same with medications. A big part of my job is advocating between pharmacies and clients and NIHB... but it's a lot of extra work, and it's very frustrating... A lot of clients, when they get frail and elderly, they require a walker, right. Well, a regular walker is no problem: Get a prescription, take it to the drug store, it's covered. But, a rollator walker requires an occupational therapy assessment.

Participant 4 then went on to describe the time and effort it takes to get a rollator walker

covered through NIHB, which included the Occupational Therapist's (OT) referral, waiting for the OT's report, getting a prescription from the doctor, and finding/submitting multiple price quotes on the equipment. Participant 4 concluded, "... *the assessment probably costed me [the Band] as much as the walker costed Health Canada.*" In this example, the Band has money to cover the medical expense up front on behalf of the community member and wait for NIHB reimbursement. Clearly, there is deep frustration over this process, which takes weeks, for a relatively simple and common piece of mobility equipment. Participant 4, who has worked in her position as a healthcare practitioner on-reserve for over a decade, noted another area where policies impede her ability to provide healthcare to community members,

Ever since I started working here, it's been in the works that... we would have this nurse ordering program that there would be trained nurses that could order dressing supplies for clients, but it's never come to fruition.... It's been talked about the whole time I've worked here... so that's kind of frustrating.

Currently, medical doctors must prescribe these supplies, and she mentioned that the pharmacy often runs out. Participant 4 demonstrated the divide between communities that have sufficient supplies and those that have not:

I'm lucky because our Band has some revenue of its own. So, if I need to buy something for a client, I can. We keep a stock of some of that stuff, but not every community is like that. Not every community can afford to have stock of things they can use.

Participant 2, a NIHB navigator, explained how she navigates NIHB limitations:

It's important to me that access to health benefits is real... but, in order to do

that, I recognize that the communities also take it really serious. So, the Health Centres are my key. It's building on resources that already exist, not to overwhelm and burden, but to increase efficiency, so that there's more resources within the same amount of content. The sum of the parts is greater than the whole. That type of thinking.

Participant 2 also described systemic barriers and how she works with the communities, *They actually have everyone going in circles. When I say 'they' it's the system, it's not individuals, it's the system, and it's not helpful. So, you have to get creative. That's why, from my perspective, it's good to be working with community—identifying each community's capacity and desire and where they're at—so, that way, I have an inventory of what the communities are providing.*

Participant 2 continued:

Every community provides some sort of mental health [program]. Some communities provide physio in-community, some don't. I want to have an inventory of all of that so when individuals do call, and I find out what community they're from, I can actually give them an accurate specific individual answer, because that's the biggest barrier... That individual has specific needs and resources depending on where they're from.

Participant 2 also described another issue with access to care and navigating NIHB within Nova Scotia,

Health is divided, both federal and provincial. Generally, the policy for NIHB is if it's covered by the province, NIHB doesn't provide it. So, physio, massage therapy, those types of things are not covered through NIHB. However, to access

them, in the province... it pretty much takes six months minimum. So, that's really not accessible.

Participants described the appeal process if a claim is denied, and the extra work that dealing with NIHB adds to the role of a healthcare provider. Participant 2 described the appeal process,

There is already a process implemented. So, the first step is, if you get denied, the first thing you do (if it's not corrected through an exception, which is becoming a challenge) is an appeal process. So, it's generally, depending on the benefit, dental benefit, it takes much longer to get an appeal done, and it still doesn't guarantee. There's three levels of appeal, so it's still not quick.

Participant 3, who works at FNIHB, had a much more neutral description of NIHB, explaining that,

... NIHB would operate like a call centre. They have a variety of advisors who take calls, and work to process the requests that come through. Again, they have large documents of covered services or equipment or etc. I know that they have nationally strong input into keeping a very updated database, essentially.

Participant 4 explained that in her community someone was hired to work two days a week to process claims with NIHB and try to arrange reimbursements for purchases that should be covered but were made by the Band on behalf of community members.

Currently, there is a joint review going on between First Nations and the federal government about NIHB and the various types of services provided (or not) (i.e., vision, medical transportation, medical supplies and equipment, pharmacy). Participant 2 emphasized, *"we're always looking for better ways to reduce barriers for individuals to*

access NIHB.”

Another issue mentioned was the problematic terminology used with NIHB policies in terms of how “*medically necessary*” does not take into account other social determinants of health. Participant 2 elaborated,

Healthcare is meant for ‘medically necessary.’ That’s the terminology that they use. It doesn’t relate to quality of life. Medically necessary and quality of life aren’t the same thing. That’s where I start to have a problem because, if you look at it from a social determinants of health perspective, quality of life is going to impact all aspects of health. Therefore, it is medically necessary. My head spins everyday... I’m like, ‘are ya serious?’

4.8.2 Provincial Policies and Programs

Some participants described a lack of communication between the federal and provincial governments on certain policies, procedures, and programs that impact older Mi’kmaq which makes the provision of higher quality healthcare challenging. For example, Participant 4, a healthcare practitioner working on reserve in Nova Scotia, described her frustration regarding Continuing Care,

I think there’s a lack of communication between continuing care and the federal programs, because I don’t think they realize that... that I’m it. So, there’s no discharge procedure when someone’s discharged from the hospital. Oftentimes, I only know because the client calls me. Or they have a problem, there needs to be some kind of set up in place so when the client leaves the hospital. They’re kind of notifying us that the client is being discharged.

Further, Participant 4 explained that many of the health policies that affect older First

Nations are out of date, using Continuing Care and Home and Community Care as examples. When prompted, Participant 4 scoffed, “*That Continuing Care Policy in regards to First Nations? Oh yeah, I have a photocopy of it. It’s like a couple of sentences from about probably 20 years ago.*” She went on to explain,

I don’t know how up to date any of the policies that we have are. Like I think the policies that are in place here for Home and Community Care anyway are like, from its inception, like 18 years ago or whenever, it was first started.

The most recent Continuing Care Strategy from the Nova Scotia government published in 2010 was discussed by Participant 1, who works at the Nova Scotia Department of Health and Wellness, as this provincial policy is applicable to older Mi’kmaq living on and off reserve. He explained that the Aboriginal Continuing Care Policy Forum is in the process of finalizing a report that picks up where that previous report left off. Participant 1 said the updated report will include discharge information and notes on cultural safety; but, overall, the Indigenous content is minimal.

Regarding province-wide healthy aging strategies and programs (e.g., Shift: Nova Scotia’s Action Plan for an Aging Population), Participant 1 explained that “*in theory*” the provincial programs are for everyone, including First Nations and Mi’kmaq living on reserve. However, he went on to say that there is difficulty getting that message out and low uptake from community members. There are also additional challenges in adapting existing provincial programs to make them culturally relevant and accessible to people living on-reserve. Participant 3, who works at FNIHB, could not describe how the federal government ensures health services for older Mi’kmaq and other Indigenous peoples are made culturally appropriate, but rather deferred this responsibility to the provinces, “*I*

would say that... in the Maritimes and across the country, various provincial governments take that on themselves to become a more culturally competent facility.” No further details were given.

4.8.3 First Nations Policies and Programs

Discussions on Mi’kmaq community health policies revealed that the wellbeing of older community members is integrated, although not always explicitly, into many First Nations policies. Participant 2, who works as a NIHB navigator for the Atlantic region, explained,

I actually believe that each community—and this is something that I think needs to be recognized more—each community has their own way of addressing and including Elders within their health delivery system. A lot of work is being done around increasing the resources available within communities, so mental health programming, as well as the continuum with the NIHB. Communities are becoming more empowered and autonomous in providing these services, and creating programs and services that will be specifically utilized by their community members. So, I don’t know if it’s policy or just practice... but each community seems to have a way of dealing with and providing supports to Elders.

Participant 2, an Elder Care Working Group member, also mentioned that these policies and practices are not always something that can be shared [publicly], but she emphasized that supports for older community members are considered given the importance of Elders within the communities. Approaches to supporting healthy aging vary within each community, and some approaches are more upstream (e.g., housing, transportation) than others (e.g., home care, chronic condition management).

During Phase 1 of this study, a reference to a *Well Elder Policy* in a Mi'kmaq community was located online. The *Well Elder Policy* was listed in the contents of a community health centre policy manual but was otherwise unobtainable for review. However, when Participant 6, a healthcare practitioner who worked in that community for over a decade, was asked about this policy, there was some concern over the utility of it. This participant, despite having worked in the community for over 10 years, did not know about it. Participant 6 elaborated,

On paper, it looks really good to you that there's a Well Elder Policy... but I don't know when that policy was drafted or when it came into practice, unless it happened in the last six months, which is possible. Even as policies have been developed, and I know there is a person at our health centre that was working on revising and updating our policy manual, there really wasn't any communication with all the health centre staff about that. So... my question is, how is that policy understood and embraced in the work of everybody in providing health-related services to Elders? ... I'm not sure that that's rolling out in a context of a health care team at the community level.

Participants also raised concern about the lack of focused supports for aging in place. As Participant 9, a member of the National Seniors Council, shared,

There isn't any real seniors' programming, care type of programs, on reserves, and that's one of the gaps in the system. Too little for elderly and caregiving at the community level and, therefore, a lot of times when Aboriginal peoples, status Indians, treaty Indians on-reserve get to a certain age, they sometimes leave the reserves to go into the urban environments because that's the only place they can

find nursing homes, health facilities that take care of seniors. When that happens we raise the specter of culturally inappropriate, discriminatory... those sort of things all rear their ugly head. So, that's one of the realities.

Understaffing was mentioned by both participants who were healthcare practitioners as a barrier to promoting health among older Mi'kmaq. Participant 6 mentioned high turnover of healthcare providers, and Participant 4 explained she cannot provide homecare services for Band members living on-reserve in other parts of the province. More specifically, she disclosed,

I'm sure, then, some things might get overlooked because they might fall between the cracks because they're on reserve and the province would probably say 'we're not responsible for them.' But I can't logistically provide service to communities that are over an hour away.

Participant 4 also described the general lack of assistance she experiences in her position. She is the only healthcare practitioner in her position for her community. When she is sick, there is no one to fill in. She is also unable to take days off for further education, which would allow her to offer more services (e.g., IV antibiotics) directly to her patients. When the care needs cannot be met, this directly impacts the ability of older Mi'kmaq to continue to age at home in their community and forces them to seek care elsewhere. Despite challenges related to quality and quantity of healthcare services that support healthy aging, Participant 3, who works at FNIHB, shared this thought,

Communities are at varying states of readiness to take on that administering of their health services, and sometimes communities are coming together, to be

stronger, to do that. I would say that is, of course, a goal for all. It's just moving along a continuum of being in a place to take that on.

However, Participant 5, Acting Director at a First Nations health organization, reminded, “*There are some communities that have, and some communities that do not.*”

4.8.3.1 Other Community Policies and Programs for Elders and older

Mi’kmaq

Participants described other policies and programs (that were not publicly accessible and thus not included in Phase 1) in the communities they serve that promoted healthy aging for older Mi’kmaq. Examples included an increased health spending allowance, assistance with property maintenance, and other programs established to meet the needs of the Elders and older Mi’kmaq living in the communities (i.e., drumming group, singing, medicine walks). More specifically, Participant 6, a healthcare practitioner, described how she connected with the Elders in the Mi’kmaq community she worked in,

I was very fortunate the one program that was already in existence when I got to the community in [early 2000s] was a monthly Elders’ night. So, I went to those Elders’ nights for the first few years until that program actually came to an end and we were doing other things instead. The Elders were very much the first people I got to know, my mentors, my guides, and my helpers in all the work that I’ve done in the community.

By listening and learning what was needed to promote health and wellbeing, Participant 6 was able to provide necessary and appropriate programs and supports,

So, my work involve[d] starting a women's hand drumming group, singing in Mi'kmaw, working extensively with the residential school survivors in the community... doing all kinds of community things, like taking people on medicine walks to reconnect with our traditional medicines that grow in the area. All kinds of things like that.

Participant 6 also explained,

Another sort of main core thing without getting a lot of detail about Indigenous mental health, we understand healing and decolonization is integral, inseparable, and therefore all of our work in healing: mentally, physically, emotionally, spiritually, all has foreground in Indigenous knowledge – front and centre Indigenous teachings.

To support and promote healthy aging in the Nova Scotia Mi'kmaq community Participant 4 works in, she explained that a larger health allowance, which included additional services like physiotherapy and chiropractic, is covered for residents over the age of 65 years. When community members turn 65, they are entitled to have their driveway paved and their heat and electricity bills covered by the Band. In addition, events like chair yoga are arranged within the community to promote physical activity among older residents.

Given that access to financial resources and the ability to provide services and programs varies among communities, Participant 6 pointed out some of the challenges in providing health promoting programs to Elders and older Mi'kmaq. She gave examples such as inconsistent staff availability, lack of 'buy-in' from managers, and insufficient time and attention given to developing relationships and trust with community members.

When talking about her initial time working in the community, Participant 6 took her direction from the Elders and from the community itself, as there was such a high turnover of health directors at the time:

I kind of had to create my own practice, which is what I did. I didn't have a lot of supervision. I created peer supervision among other Indigenous mental health practitioners, but I didn't have a supervisor. So, I created the work that I do there, and the model and the content of my work was really shaped by the relationships I built in the community.

Participant 6 went on to explain,

But I think the main thing is community-based work you have to really commit to some time. We talk about why Indigenous mental health isn't working in a lot of places in Canada. Well, if you're flying in and out a day or a week a month, it's really hard to make relationships in the community to make your work effective.

When a more permanent health director started working in the community, Participant 6 felt that she was not supported by her:

She [was] a non-native women from a managing and in-patient mental health facility in [another country] and she really didn't get Indigenous mental health and she didn't educate herself about it and by that time I was already established in what I was doing so I pretty much continued doing things the way I was doing them... I still did my work the way I understood from the Elders I should do it.

Participant 6's experience of working with a health director unfamiliar with Indigenous health was reminiscent of other concerns brought up by Participant 9 about the availability of culturally-appropriate programs for Elders and older First Nations. At

the community level, Elders are more often able to offer direction for their needs. Yet with the provincial and federal policies and programs, this is not regular practice.

Participant 6 noted that “*It’s so ‘not Indigenous’ the way services are rolled out*” and offered some advice,

If you’re a health care worker or human services worker in an Indigenous community and you want to be revitalizing and honouring and strengthening Indigenous teachings, you are accountable to the Elders. That’s my belief. I’m not sure that health policy as it’s formulated through Indigenous Services now, really reflects that.

4.9 Theme 3: Integrating Older First Nations’ Healthy Aging-Related Priorities in Policies

Theme 3 describes the participants’ perspectives on some of the constraints related to integrating the priorities of Elders and older Mi’kmaq into healthy aging policies. Participants felt that the current healthcare system posed a challenge. Participant 2 described the healthcare system as “*siloed,*” referring to the multitude of departments that each manage individual health priorities, rather than an integrated system that approaches healthcare holistically. Participant 2 reflected, “*Do you have something that’s especially ‘Elder’ in its own silo or do you take on the task of infiltrating the different silos and ensuring Elders and Eldercare is on their agenda actively?*” She explained that the Atlantic First Nations Health Partnership, that assists with the planning, management, and delivery of FNIHB-funded services and programs in the Atlantic region, keeps Elders and the care of older First Nations on their agenda: “*The Health Partnership is approaching it as having Elders on the agenda in some form actively, so that there is*

always consideration... but this is a challenge, as this is not how the 'system' works"
(P2).

It was mentioned within some communities, Elders and older Mi'kmaq are not as involved in shaping healthcare policies as they would like to be, and they have expressed concerns. Participant 6 relayed,

I can tell you that, unfortunately, I know a number of Elders that I'm very close to in the community who feel that they aren't involved in shaping healthcare [in the] community and they have some very specific complaints about healthcare in our community.

One of the primary issues described by Elders was the number of holidays, both statutory and decided by the Band, which result in the closure of the health centre and provision of homecare services. Depending on the holiday or event, closures can last for days or weeks, which poses a significant issue for many Elders and older Mi'kmaq. Participant 6 explained,

Just because of when Christmas and New Year's fell in terms of the week... we had three weeks off... It's really hard on the Elders, especially at the holiday season. That's something that I think needs to be rethought. To be fair, it's for people whose homecare needs were critical, like wound care. The nurses would arrange to come in one day a week and visit a couple of people who needed to be checked on or whatever; but, the homecare services to all the Elders were just not happening during those times. So, that is something a lot of Elders have expressed concern about.

Though many participants were unable to say or did not say how the health

concerns of Elders and older Mi'kmaq are being considered or integrated into policies, Participant 2 elaborated on the role of the Elder Care Working Group. This group functions as a representative voice for Elders and older First Nations in the Atlantic region, though there are difficulties with filling roles on the group and, at the same time, involving all group members who may want to participate. Even with those challenges, the group manages to bring together many older Mi'kmaq from across Atlantic Canada.

4.9.1 Elder Care Working Group

The Elder Care Working Group (ECWG), created approximately 10 years ago, is housed within the Atlantic Policy Congress of First Nations Chiefs. The purpose of the ECWG is to influence all health-related programs and services (e.g., NIHB, FNIHB) so Elders' and older First Nations' perspectives and concerns on healthcare are considered within policies, practices, and programs overseen by the Atlantic First Nations Health Partnership. One way this is done is through the use of the Atlantic First Nations Health Elder Care Policy Lens tool for appraising FNIHB programs. However, the ECWG does not have a voting voice within the Health Partnership. Also, there are still challenges in representing all older First Nations peoples, but efforts are being made to ensure there is some representation from all nine districts across the Atlantic region (*Note: It was planned that there will be nine Elder representatives by January 2019, but it is unknown whether this has been achieved*). Participant 2 explained that it is difficult to truly involve all Elders who may want to participate, but that Elder representation must fit within the broader operations of the Atlantic First Nations Health Partnership, and the representatives must be comfortable using their voice.

The ECWG helped to create and revise an *Elder Care Strategic Action Plan*

(2015-2020) (described in Phase 1) and each year has a specific aging-related health focus (e.g., mental wellness, chronic disease). The ECWG hosts a video conference three times each year where a health promotion topic is presented (e.g., Alzheimer's disease, type 2 diabetes) from an older First Nation perspective. Although the main purpose of these conferences is to relay health information, Participant 2 explained the added benefits as well:

Each community has the ability within either the Health Centre or Band Office to participate in the video conferencing, so it's an opportunity for Elders to also come together... Isolation is also a huge issue, so they [Elders and older Mi'kmaq] all get to see each other and chat and talk about something that is specifically relevant to them at this point in their lives.

4.10 Conclusion

The analyses in Phase 2 identified three themes and five subthemes stemming from interviews with nine federal, provincial, and First Nations policymakers, policy analysts, and policy users. These findings aimed to better understand how Mi'kmaq perspectives are integrated in the development, implementation, and/or evaluation of aging-related health policies, and to explore how these policies promote healthy aging among older Mi'kmaq living on-reserve in Atlantic Canada. Interviews revealed overly complex, colonial healthcare policies and poor inter-governmental communication, which complicates healthcare provision and health promoting efforts. On paper, there appears to be progress in including Elders and older Mi'kmaq in health policy conversations, especially at the community level, but participants also explained that this does not happen nearly as often as it could or should. Further, few health policies are grounded in Indigenous

knowledges and teachings.

CHAPTER 5 DISCUSSION

5.1 Overview of Findings

This two-phase qualitative study explored how current government policies support healthy aging among Elders and older Mi'kmaq living on-reserve and how their perspectives on healthy aging are integrated into these policies. In Phase 1, a scan of First Nations healthy aging-related policies yielded 11 documents and the analysis produced four themes: (a) Transparent Inclusion of Older First Nations During Policy Development, (b) Engaging Elders and Older Mi'kmaq, (c) Determinants of Health Approach, and (d) Services and Programs. In Phase 2, analysis of the nine interviews with policymakers and stakeholders revealed three themes: (a) Government Relations and Communication, (b) Current Healthy Aging Policies for First Nations, and (c) Integrating Older First Nations' Healthy Aging-Related Priorities in Policies. Together, Phase 1 and 2 produced a number of complementary, interwoven, and overlapping findings, such as consultation and representation in policies. Importantly, the interviews gave some context and backstories to many of the policies that document analysis alone could not provide.

Overall, findings revealed that healthy aging for Elders and older First Nations is not a priority in the current federal and provincial policy environment, and efforts to include them in the policy process is limited. A key finding of the study was the lack of concern for healthy aging and preventive health promotion initiatives or actions within federal policies. Programs such as NIHB, of which many Elders and older Mi'kmaq are clients, cover medically necessary costs (i.e., pharmaceuticals, mobility aids) but does not pay for preventive measures that would improve health (i.e., nutrition, physical activity programming) and potentially reduce the need for medical intervention. Overly complex

programs and jurisdictional disputes continue to interfere with the provision of healthcare services and fail to address other social determinants of health especially relevant to Elders and older Mi'kmaq, such as housing or income, that would promote wellbeing. However, Policies created by First Nations governments were more considerate of the needs of Elders and old Mi'kmaq, and also more likely to consult them in the process.

5.2 The Current Policy Environment

Participants agreed that although healthy aging for Elders and Older Mi'kmaq (and other Indigenous groups) is important, it is not a priority for policymakers. This was due to the young average age of First Nations in Atlantic Canada, and the necessary attention directed at initiatives related to more immediate priorities such as mental health and addictions and the wellbeing of children and youth. This is problematic as it does not consider the future needs of this growing population and perpetuates ageism by placing the needs of others above the priorities of older First Nations. Statistically, older First Nations living on and off-reserve are a smaller proportion of the aging population in Canada (which may account for, but not excuse, the underrepresentation in many policies), but is it worth reminding policymakers that this does not mean that older First Nations needs for aging well hold less importance than other segments of the population. Further, this speaks to the challenges experienced by First Nations communities to position Elders and older adults as priorities in their community, since many of the issues facing youth are related to the history of colonization and associated oppressive policies. Given that only 11 policy documents had content related to older First Nations' healthy aging were located in the systematized search, and only one was entirely focused on older First Nations healthy aging in the Atlantic region, there is evidence to support the claim

that there is lack of attention given to healthy aging among Elders and older Mi'kmaq in the Atlantic region.

An important and recent change in the current policy environment is the restructuring of the former federal department of Indigenous and Northern Affairs Canada, which was separated into two departments (ISC and CIRNAC) in August 2017. The purpose of this split was to have CIRNAC manage treaty relations, and ISC manage the delivery of services, including healthcare, all in an effort to create systemic changes to support Indigenous self-government and de-colonialize governmental structures (Trudeau, 2017). Treaties and paternalistic colonial policies (i.e., the *Constitution Act* – updated to affirm Indigenous and treaty rights in 1982; the *Indian Act*) are still the foundation of current federal policies, and First Nations are still fighting to have their treaty rights recognized and fulfilled. Further, the effects of centuries of unfulfilled treaty rights continue to create health disparities as many essential health promoting services have yet to be properly addressed (i.e., child welfare, water quality issues on-reserve, housing on-reserve, etc.).

5.2.1 Federal Policies

The federal government, specifically FNIHB, has a prominent role in the health and healthcare of Elders and older Mi'kmaq living on-reserve. Two policies that include Elders and older First Nations were located, but aging-specific content was minimal. Interestingly the *First Nations Inuit Health Home and Community Care 10-Year Plan* (Health Canada, 2015b) does mention learning about preventive home visits for older adults, but there is no indication this will become regular practice, especially as Participant 4, who works as a healthcare practitioner on-reserve indicated that adequate

staffing is a barrier to providing care and taking time for additional training.

One of the most exasperating programs stemming from FNIHB policy is the NIHB. Healthcare practitioners have voiced concern over patient coverage benefits, travel, uncommunicated policy changes, and unclear compensation models (Morrison, 2015). Participants working in Mi'kmaq community health centres and liaising directly with NIHB described frustrations with wait times, denials, appeals processes, and complexities of navigating this system. Participant 4 gave multiple examples of the procedural issues she runs into just trying to get basic medical supplies. The Band she works for is able to pay for equipment upfront and wait for NIHB reimbursement, but this is certainly not the case with all Mi'kmaq communities, as income and access to resources vary greatly across the region. This is because Bands do not have a tax base to support the services that they offer members, and generally extra revenue comes from businesses owned by the Band.

It is problematic when Bands rely on their revenue to front the cost of healthcare of its members, which instead could be invested in the community, when coverage should be provided by NIHB. For necessary equipment (e.g., a rollator walker for mobility) there should be no waiting time imposed on the client while NIHB processes the claim. Like Jordan's Principle for children's care access (First Nations Child & Family Caring Society, 2014), a similar piece of legislation aimed at Elders and Older First Nations care access and payment is necessary. The *Blueprint on Aboriginal Health Transformative Plan* (Government of Canada, Provinces, Territories, Assembly of First Nations, Congress of Aboriginal Peoples, Inuit Tapiriit Kanatami, Métis National Council, & Native Women's Association of Canada, 2005) calls for addressing First Nations'

concerns with NIHB, but participants are unconvinced that this plan will turn into actionable change.

Another major issue with NIHB was the narrowed definition of *health* as benefits are limited to *medically necessary* procedures, medication, and equipment. Participant 2 felt strongly that this did not promote healthy aging or address quality of life. As there is so little in the way of preventive initiatives to promote healthy aging at this time, NIHB is merely responding to health crises after they happen, rather than providing funds for upstream programs, equipment, and interventions that could otherwise reduce or delay health risks associated with older age.

5.2.2 Provincial Policies

Provincial healthy aging policies were included in this study because they guide the development and implementation of programs and initiatives that are for all residents, including Elders and older Mi'kmaq living on-reserve. The provinces and federal government also coordinate healthcare provision for services that are not available in community health centres and not covered by NIHB (e.g., physiotherapy, massage therapy). Gaps in provincial policies related to the services often accessed by older First Nations support the patchwork approach to policy described by Lavoie (2013), as provinces make it clear that the federal government is responsible. Participant 4 mentioned that the provincial policies pertaining to programs used frequently by Elders and older Mi'kmaq are outdated, but this comment could also be interpreted as meaning the province's policies are not concerned with the home care needs of older First Nations. One example of a provincial First Nations home care policy was located: *Weaving partnerships: A framework for Aboriginal Home Care in Nova Scotia* (Nova Scotia

Aboriginal Home Care Steering Committee, 2010b), which was published in 2010 and an update was expected earlier this year. The framework comes with a disclaimer stating it is not an official report of the provincial or federal government or reflective of current policy positions, so it was not included in the policy scan.

5.2.3 First Nations Policies

The Atlantic Policy Congress of First Nation Chiefs Secretariat, through the Atlantic First Nations Health Partnership, represents the health priorities of the 33 First Nations communities in the Atlantic region, and negotiates with the federal government on their behalf. This unique approach allows for strength in numbers and ensures First Nations will not have to navigate federal bureaucracies on their own. Since 2007, the Atlantic First Nations Chiefs have named Elder Care as one of the region's health priorities (Horizons Community Development Associates Inc., 2016), which is not reflected in federal policies found in this scan. The Atlantic First Nations Health Partnership created the only Elder Care Strategic Plan to promote healthy aging among Elders and older First Nations in the Atlantic region. The Elder Care Working Group helped with the development of this plan; however, Participant 2 noted that there is difficulty filling all the seats of this group to represent the region.

Of the Mi'kmaq community websites scanned for potential healthy aging content, very few had publicly accessible policies. One Mi'kmaq community had evidence of a specific "Well Elder Policy" but the policy itself was not posted. Further, multiple reports and literature sources made reference to a health framework titled *Providing Healthcare, Achieving Health – Mi'kmaq* by the Tripartite Forum (2005); but, despite repeated searching and inquiry with participants, a copy of this document could not be found.

Participant 2 clarified that although it may not be explicit, every community works to include the needs of their Elders and older Mi'kmaq in their health delivery system in their own way. This is important to note as a scan of the available community policies did not reveal very specific directives about if or how older Mi'kmaq needs were being addressed.

5.3 How do Policymakers Integrate and Reflect upon Older Mi'kmaq Perspectives in the Development, Implementation, and/or evaluation Processes of Healthy Aging-Related Federal, Provincial, and First Nations Governments Policies?

The consultation processes (or lack thereof) was a key indicator of how Mi'kmaq or First Nations perspectives were (for the most part, not) integrated in healthy aging-related policies. Policy documents indicated which groups were involved in the development of each policy, but there was little transparency on the level of involvement and input given and subsequently incorporated. However, the lists of groups involved did not tell the whole story, and participants provided some context as well. There were clear differences in the perspectives of the participants working directly with Elders and older Mi'kmaq in their communities compared to those participants working in provincial and federal sectors of government. Participants working in the communities experienced the everyday realities of policies that hinder healthy aging and expressed frustrations with the system. Participants who had little or no experience working directly with older Mi'kmaq were sometimes unaware of the barriers with, and created by, current policies (e.g., NIHB). Several reasons must be considered as to why there was minimal involvement of older First Nations living on-reserve in the Atlantic region, including: past experiences of research engagement where the principles of OCAP (ownership, control, access,

possession) were not followed (FNIGC, 2014), inappropriate engagement methods were used (Braun, Browne, Ka'opua, Kim, & Mokuau, 2013), exhaustion from over-engagement of the same groups and representatives (Maar et al., 2011), or no invitation for engagement was extended at all.

Elders in the Atlantic region have clearly outlined how they want to be consulted. A list of eight recommendations was created based on an Elders' Mawio'mi held in 2010, when Elders gathered to develop protocols, ethics, and guidelines to inform the integration of traditional knowledges and Indigenous perspectives in community economic development research; but, these recommendations are applicable in other research areas as well (Atlantic Aboriginal Economic Development Integrated Research Program (AAEDIRP), n.d.). Recommendations included involving Elders in community affairs, ensuring Elders' meaningful involvement in community planning (e.g., roles on advisory and steering committees), and allowing Elders to share and pass on traditional knowledges before it is lost.

5.3.1 Consultation and Representation in National Strategies

Multiple Indigenous groups and government departments were consulted for the *First Nations and Inuit Health Strategic Plan: A Shared Path to Improved Health* (Health Canada, 2012) and the *Blueprint on Aboriginal Health* (Government of Canada, Provinces, Territories, Assembly of First Nations, Congress of Aboriginal Peoples, Inuit Tapiriit Kanatami, Métis National Council, & Native Women's Association of Canada, 2005), but Elders were not specifically mentioned or recognized. *First Nations and Inuit Home and Community Care* (Health Canada, 2015b) indicated that Elders were included in discussions but offers no further elaboration. An important consideration given the

direct impact of these policies on the health of older First Nations is the governments' duty to consult when working on First Nations interests (Lawrence & Macklem, 2000). Health is arguably a First Nations interest, given that the federal government must provide health services to First Nations living on-reserve in terms of the *Indian Act*. As the First Nations Chiefs' identified Elder Care as a health priority, FNIHB health policies need to reflect this.

5.3.2 Consultation and Representation in Provincial Policies

Provincial policies varied in their consultation with and inclusion of older First Nations and other Indigenous groups. Of the four Atlantic provinces, Newfoundland and Labrador was the most transparent with their consultation process, releasing a report complementing their aging strategy that described their consultation processes including the First Nation community they spoke with (Newfoundland Labrador Aging and Seniors Division, 2006). New Brunswick had a section explaining what was learned from their consultation with First Nation groups, but the strategy's goals had very little First Nations-specific actions. Conversations with Participants 7 and 8, both members of the New Brunswick Council on Aging who participated in the consultation process provided details on the challenges they faced, explaining that resistance from provincial government to engage with First Nations and the lack of knowledge on inter-nation relationships made for tense moments. Prince Edward Island had no actions specific to Mi'kmaq or other Indigenous groups but listed the Mi'kmaq Confederacy of Prince Edward Island as one of the groups consulted during the development of the plan. Similarly, Nova Scotia named "First Nations" as one of the groups consulted, but there was only one suggestion of considering historical context of certain groups (i.e.,

Mi'kmaq) when planning and implementing programs. Importantly, provincial health and wellness programs are open to all who reside in the province, so consideration for the needs of Elders and older First Nations living off and on-reserve is necessary.

5.3.3 Consultation and Representation in First Nations Policies

Given that First Nations understandings of health are more holistic than conventional health care practices, supporting Elders and older Mi'kmaq went beyond improving provisions for programs like *Home and Community Care* and addressed other health determinants (i.e., colonialism, culture, housing, social connections). Participants from Mi'kmaq organizations mentioned that given the respect held for Elders, consideration is always included in these policies, but may not be overly explicit. Notably, there was a focus on engaging with Elders to share cultural knowledge and provide youth mentorship, reflecting a reciprocal relationship where Elders share their knowledges and teachings to address goals around cultural revitalization outlined in the Mi'kmaq community strategies and plans. This is complementary to several of the recommendations made by Elders about how they want to be involved in community affairs, specifically sharing and encouraging the use of traditional practices and knowledges with youth (AAEDIRP, n.d.). At the same time, considerations for the wellbeing of older community members, such as accessible housing or social opportunities are also integrated into these plans. Working with Elders to engage youth, especially around education and culture, is a commonly used strategy within Mi'kmaq communities. Recent local examples include integrating Atlantic First Nation Elders in educational institutes (Austin & Sylliboy, 2017; Hatcher, Bartlett, Marshall, & Marshall, 2009). Elders also call for their involvement to develop curriculum on traditional

knowledges to be delivered in community, provincial, and post-secondary schools in the Atlantic region (AAEDIRP, n.d.).

5.3.4 Addressing the Social Determinants of Health

In the literature review, the integrated life course and social determinants model of health was described as a way to understand the how different factors affect the healthy aging of Elders and older Mi'kmaq, with a focus on the role of colonialism (Reading & Wien, 2009). The determinants of health were integrated into policies from all jurisdictions of government (see Phase 1 Theme 3 for examples). Although it is promising to see governments acknowledge the factors that influence health status, the use of the social determinants needs to be more robust. Recommendations and actions should aim to address all of the determinants while also considering how the determinants intersect with each other (e.g., gender, income, transportation, culture, colonialism) to paint a more complete and holistic picture of health.

Participant 2 argued that in federal policies and programs like NIHB, a social determinants perspective is not being used if they are only supporting medically necessary care, rather than addressing quality of life. The importance of creating Indigenous health systems based on improving population health has been positively supported (Lemchuk-Favel & Jock, 2013). Acknowledging the importance of the social determinants of health, and especially the distal determinants (the causes of the causes), the Assembly of First Nations (Reading, Kmetic, & Gideon, 2007) called for the development of a Wholistic Policy and Planning Model that puts community at its centre and aims to address health-related issues beyond service delivery. A policy model that is centred on promoting the health of the community, with the integration of AAEDIRP

(n.d.) Elders' recommendations to involve Elders in all areas of community affairs, will also support healthy aging across the life course.

5.4 Can These Policies Support Healthy Aging of Elders and Older Mi'kmaq Living in their Communities?

The final research question asked if current policies can support healthy aging for Elders and older Mi'kmaq living on-reserve in Atlantic Canada. Based on the current policy environment and the lack of inclusive and comprehensive consultations with Elders and older Mi'kmaq to include *their* needs for aging well in policies, promoting healthy aging is currently a challenge. An inclusive and comprehensive engagement process should include time for policymakers to familiarize themselves with First Nations histories and local issues, relationship and trust-building, agreement on how engagement processes will be conducted and how the knowledge generated will be used, and agreed upon terms for providing updates on the policy or program development. Aside from the work of the Elder Care Working Group and Atlantic First Nations Health Partnership, there are few indications embedded in policy to suggest that healthy aging specifically for Elders and older Mi'kmaq is a priority in the Atlantic Region. This finding is surprising given the high percentage of older adults in the general Atlantic population, the current focus on this burgeoning segment of the population, and the recent development of healthy aging strategies and action plans from each of the Atlantic provinces. However, when striking health disparities exist between groups of people – across ethnicity and across age – a one-size-fits-all approach to healthy aging policies is insufficient. Elders and older Mi'kmaq in the Atlantic region have unique health needs and challenges that need to be addressed using a social determinants of health approach combined with

community-driven programs and initiatives. Overall findings from this study yielded recommendations that can address some of the challenges (i.e., policy environment, consultation) to promoting healthy aging among Elders and older Mi'kmaq living on-reserve.

5.4.1 Recommendations for Promoting Healthy Aging Among Elders and Older Mi'kmaq

It is clear from the findings of this study that Elders need to be at the centre of the development and evaluation of healthy aging policy, or any health policy, as it relates to them and their communities, which is a recommendation echoed by the Atlantic Elders (AAEDIRP, n.d.). Policies that aim to promote healthy aging using preventive strategies (rather than responsive actions) among Elders and older Mi'kmaq need to consider Mi'kmaq-specific determinants and contexts to adapt and implement policies appropriately. This was strongly urged by Participant 6, and evidenced by the inclusion of Elders Councils in the development of some First Nations policies. Elders also need to maintain social connections with other Elders (i.e., through Elder groups), and have opportunities to share their knowledges and create a sense of connection across generations. Of the 24 Mi'kmaq communities in the Atlantic region, 17 are noted to have Elder-specific programming, and some had specific residential school survivors' groups (Atlantic First Nations Health Partnership, 2015). Use of the programming funded by FNIHB for resident school survivors and their family, like the Indian Residential Schools Resolution Health Support Program, may also be a useful resource for promoting and supporting healthy aging.

Considerations of the TRC's Calls to Action were absent from the policy

documents, which was to be expected for policies published before 2015, but not from the provincial policies published in 2017 and 2018 (New Brunswick, Nova Scotia, Prince Edward Island). However, this topic was discussed by the participants who work directly with Elders and older Mi'kmaq. Given the personal and intergenerational traumas stemming from the residential schools, the sixties scoop, and other racist policy initiatives from the federal government (Bombay, Matheson, & Anisman, 2014), an important takeaway from this study is that all policies involving Indigenous peoples need to work to address these calls.

Processes for inclusive, comprehensive, and culturally appropriate engagement with First Nation communities, as well as Elders and older Mi'kmaq, are currently unestablished at the federal and provincial governments. Given the history of paternalism and exclusion from these jurisdictions of government, transparent consultation protocols, expectations, and role clarification are needed, and should be co-created in partnership with Elders. Further attention needs to be given to other systemic barriers that could prevent Elders' participation in the engagement processes, such as transportation, accommodation, and compensation. Further, the principles of OCAP need to be integrated into the consultation process. It is possible that federal or provincial guidelines exist (perhaps internally in some departments), but efforts need to be made to ensure all engagements with Elders and older First Nations in regard to their healthy aging needs are respectful, not tokenistic, and that the output from these engagements result in strategic actions that clearly reflect and include their needs.

It should also be acknowledged that community-led 'bottom-up' programs that promote healthy aging (e.g., Elders' groups, additional health and social services) are

more responsive to each community's older adults' needs, and that generalized programs offered by 'top-down' approaches (e.g., federal or provincial governments) are slower or may be unable to adapt to meet the needs of Elders and older Mi'kmaq. With this knowledge, federal funding for health promotion programming should be reviewed and possibly restructured to include more funding for community-led initiatives with adequate staffing, a recommendation which was also included in the First Nations Mental Wellness Compendium Framework (Assembly of First Nations & Health Canada, 2015). In addition, consideration should be given to finding ways to reduce economic disparities across communities in an effort reduce any inter-community tensions and resolve program and service delivery issues related to economic issues experienced by some communities.

Finally, the unique contexts of Elders and older Mi'kmaq living on-reserve need to be considered when developing, implementing, and evaluating policies to promote healthy aging in the Atlantic region. These contexts include current trends of chronic condition diagnoses; accessibility of health services for community members without reliable transportation; the varying levels of unpaid caregiving provided to grandchildren or to other older adults; and other determinants of health that affect the ability to age well.

5.5 Future Research

This study builds from previous Canadian federal and provincial healthy aging policy scans (Jeffery et al., 2018; Wilson et al., 2012) and Indigenous policy scans (Lavoie, 2013), but is unique in that it specifically examined current federal, provincial, and First Nations government policies that promote healthy aging among Elders and

older Mi'kmaq living on-reserve in Atlantic Canada. Further, this study used interviews with policymakers and stakeholders involved in the development, implementation, and evaluation of these policies to add necessary context and description of the policy environment. Future research in this area can go a number of ways. First, as this policy scan was limited to the Atlantic region, a national scan of Indigenous healthy aging policies has yet to be done. A national policy scan may reveal some best practices (or *Ways Tried and True*, see Public Health Agency of Canada, 2015) from other First Nations for promoting healthy aging. Second, it was beyond the scope of this study to include the perspectives of Elders and older Mi'kmaq directly in terms of their experiences with healthy aging and whether they feel that current policies are supportive, but these perspectives are needed. A study framed similarly to the work of St-Jean (2013), which involved living in two First Nation communities over the course of several summers to explore transitions associated with aging, could start to provide these perspectives in an older Mi'kmaq context.

Another area that requires further investigation relates to the challenges of defining Elderhood (compared to an adult who is older without the roles associated with being recognized as an Elder) within Mi'kmaq communities and how this distinction may impact access to services and programs that could promote healthy aging. It is also essential that the concept of 'healthy aging' be revisited to include the perspectives of Elders and older Mi'kmaq to ensure the relevance and applicability of aging-related policies and programs going forward. Given that research on older First Nations is very sparse, more detailed knowledge on the opportunities for and barriers associated with accessing healthy aging supports is necessary.

5.5.1 Dissemination Strategies

Findings are potentially useful to several groups. Researchers can use the results to inform future studies, Mi'kmaq communities seeking clarification on current healthy aging policies can use the results as a resource, and policymakers can apply the findings to catalyze policy reform, development, and evaluation. Findings from this study have been and will continue to be shared using both academic and non-academic modes of dissemination. The study is published in the form of this thesis document and was presented during the thesis defence in August 2019. The preliminary findings from Phase 1 have been already presented nationally at the 2018 Canadian Association on Gerontology's Annual Scientific and Educational Meeting (CAG ASEM) in Vancouver, BC. Findings from Phase 2 are accepted and will be presented at the 2019 CAG ASEM in Moncton, NB. At least one manuscript will be prepared for publication in a peer-reviewed journal such as the *Journal of Aging and Health* or the *International Indigenous Policy Journal*. Findings of this study will also be presented in a brief report format to the relevant provincial, federal, and First Nations government offices that have authored the healthy aging policies in Phase 1, and to the participants in Phase 2. Brief reports are no longer than two pages and present the key facts and findings of the issue. A brief report is the most relevant way of sharing this information as it is a common communication format used among policymakers and government personnel.

5.6 Limitations

There are several important limitations of this study to acknowledge. First, given the frequently changing and homogenous organization of the internet, online searches of grey literature are difficult to accurately conduct. In several cases, potentially relevant

policies that were referred to in other reports could not be located online (e.g., Assembly of First Nations *Health Action Plan; Providing Healthcare, Achieving Health – Mi’kmaq Tripartite Forum; Well Elder Policy – Mi’kmaq First Nation*). The search method chosen was by no means perfect, and documents with slightly different wording or mandates may have been missed. For example, the Assembly of First Nations Mental Wellness Continuum Framework (Assembly of First Nations & Health Canada, 2015) was created in response to mental health and substance use but includes seniors as one of the populations that require tailored services. The framework also acknowledges the importance of Elders for cultural and community healing.

The second limitation of this study was the delays and difficulty with ethics and recruitment. Ethical approval was sought from both Dalhousie University REB and Mi’kmaq Ethics Watch. Due to a change in reviewers and the review process, ethics applications took five months from submission to approval. Initially this study aimed to speak primarily with community health directors, but given the lack of response, recruitment efforts were expanded to include people from the federal, provincial, and First Nations governments and organizations that have worked with healthy aging policies relevant to older Mi’kmaq living on-reserve. Positively, this provided a unique opportunity to hear multiple perspectives that may not have been included if recruitment had been limited to health directors. However, recruitment efforts did not result in any participants from Prince Edward Island or Newfoundland and Labrador, which impacted the scope of the findings as perspectives from these provinces were unable to be included. Given the focus on the participants’ perspectives on how the needs of older Mi’kmaq are integrated into healthy aging policies, some topics related to healthy aging

were not discussed like elder abuse, domestic violence, or the intersection of identities (i.e., gender, disability, etc.). These topics were not mentioned by any participants and was only broadly mentioned in a few policies (with a focus on elder abuse rather than domestic violence). The intersection of these multiple identities can add to the complexities of aging, which is rarely described in the identified policy documents.

A final limitation worth noting was the lack of operational definitions of key terms and concepts (e.g., “positive aging” or “healthy aging”) in many of the federal and provincial policies. Without clear parameters of what is meant by healthy aging, it can be unclear how or if certain actions or goals will support older adults, including older Mi’kmaq, with positive or healthy aging. Further, without clear definitions, it is difficult to compare these policies or evaluate their potential impact.

5.7 Conclusion

The purpose of this research was to examine how current government policies support healthy aging among Elders and older Mi’kmaq living on-reserve and to explore how their perspectives on healthy aging are integrated into these policies. A total of seven themes resulted from this study. A scan of First Nations healthy aging-related policies yielded 11 documents with reference to First Nations, which were analyzed and resulted in four themes: (a) Transparent Inclusion of Older First Nations During Policy Development, (b) Engaging Elders and Older Mi’kmaq, (c) Determinants of Health Approach, and (d) Services and Programs. Nine interviews with policymakers and stakeholders revealed three themes: (a) Government Relations and Communication, (b) Current Healthy Aging Policies for First Nations, and (c) Integrating Older First Nations’ Healthy Aging-Related Priorities in Policies. This research showed the complex and

confusing policy environment and lack of inclusive and comprehensive engagement, but also highlighted the importance and cultural values associated with the roles of Elders in First Nations communities that continue to this day. Federal health policies stem from a history of colonization, where the intent was not to promote health, but to acquire land and resources at the expense of the lives of Indigenous peoples. In spite of this, Indigenous peoples have survived, older Indigenous peoples are a burgeoning demographic, and now they must navigate overly complicated systems to access the provisions they were promised over 150 years ago.

Canada is currently in the research stages of a National Seniors Strategy. To ensure the healthy aging needs of Elders and older Indigenous adults are included, Indigenous methods (i.e., *Ways Tried and True*, Elders Councils) for inclusive and comprehensive engagement will need to be heavily integrated. However, a national strategy will not be enough. Provincial governments, who provide many health services to Elders and older First Nations living on-reserve all need to commit to working closely with Elders in the evaluation of current policies; and the development, implementation, and evaluation of future healthy aging strategies as well. Lastly, both federal and provincial governments must support (where necessary) First Nations communities in developing and implementing their own, Elder-led and community-based healthy aging policies.

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APPENDIX A

**PANEL ON
RESEARCH ETHICS**
Navigating the ethics of human research

TCPS 2: CORE



Certificate of Completion

This document certifies that

Christie Silversides

*has completed the Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics (TCPS 2: CORE)*

Date of Issue: **30 October, 2016**

APPENDIX B

Recruitment Instrument

Health and Aging Policies in Atlantic Canada

What is the purpose of this study?

The purpose of this study is to gain a better understanding of the perspectives of First Nations health organizations and community health directors in relation to how age-related policies support the health and well-being of older Mi'kmaq living on-reserve in Atlantic Canada.

How is the study being done?

If you choose to participate, you will be asked to take part in a one-on-one interview. The interview will be more like an in-depth conversation and you will be asked to share some information about your thoughts and experiences related current First Nations health and aging policies. Interviews will take place over the phone. The interview itself will take approximately 45 to 60 minutes and will be private and confidential. Participants have the right to withdraw before starting or at any point during the interview, and up to one week after taking part.

Can I participate?

To participate in this study, we are seeking individuals who are employed by a First Nations health organization or who work as a community health director of a Mi'kmaq community. Potential participants must feel comfortable talking for up to 60 minutes. The interview questions can be given in advance of the interview by request; however, no specific preparation is required

How do I get more information?

Please contact:

Christie Silversides, MA Health Promotion Candidate (Dalhousie University)

Telephone: 902-402-9139

E-mail: christie.silversides@dal.ca

Supervised by Dr. Debbie Martin and Dr. Brad Meisner
School of Health & Human Performance, Dalhousie University

Approved by Dalhousie University's Social Sciences and Humanities Research Ethics
Board Approval (#2017 – 4303) and Mi'kmaw Ethics Watch



APPENDIX C

Consent Document



Project title: A qualitative content analysis of current federal, provincial and First Nations government policies that promote Mi'kmaq conceptions of healthy aging in Atlantic Canada

Lead researcher: Christie Silversides, Masters of Arts Health Promotion Candidate, Dalhousie University, Christie.Silversides@dal.ca

Supervisors:

Dr. Debbie Martin, PhD, Assistant Professor, School of Health and Human Performance, Dalhousie University, Debbie.Martin@dal.ca

Dr. Brad Meisner, PhD, Assistant Professor, York University; Adjunct, School of Health and Human Performance, Dalhousie University, MeisnerB@yorku.ca

Introduction

We invite you to take part in a research study being conducted on First Nation health and aging policies by Christie Silversides who is a graduate student at Dalhousie University. Taking part in the research is entirely up to you and you can leave the study at any time. There will be no consequences if you decide not to participate in the research. The information below tells you about what you will be asked to do and about any benefit, risk, or discomfort that you might experience. You should discuss any questions you have about this study with Ms. Silversides.

Purpose and Outline of the Research Study

This research looks at current policies that impact the healthy aging of Mi'kmaq in Atlantic Canada. Using one-on-one interviews, the study aims to gather information on how these policies aim to support healthy aging for older Mi'kmaq living on-reserve by speaking with approximately 12 stakeholders from First Nations health organization and community health directors.

Who Can Take Part in the Research Study

You may participate in this study if you work at a First Nations health organization or as a community health director and are comfortable speaking for up to 60 minutes in a one-on-one interview setting.

What You Will Be Asked to Do

To help us understand current health and aging policies relevant among older Mi'kmaq living on-reserve, we will ask you to answer a series of open-ended questions. This one-time interview will take about 45-60 minutes, and takes place in a private location of your choosing. This interview will be conducted over the phone. Interviews will be audio

recorded and the researcher may take notes through out. If you are uncomfortable with being recorded, the researcher will instead take detailed notes during the conversation. If you would prefer to have your interview in Mi'kmaq, this can be accommodated with the use of a translator.

Possible Benefits, Risks and Discomforts

There are no anticipated direct personal benefits to participants. Participating in the study might not benefit you, but we might learn things that will benefit others. Your experiences will add to the description of the current health policies that impact aging Mi'kmaq.

The risks associated with this study are minimal, and there are no known risks for participating in this research beyond possibly becoming fatigued or bored. There is no exposure to harm any greater than would be experienced in your daily living. If you feel uncomfortable, you may choose to skip the question, take a break, or withdraw from the study at any time with no consequences.

Compensation / Reimbursement

There is no compensation or reimbursement provided for participating in this study.

How your information will be protected:

Information that you provide to us will be kept confidential. Only the research team at Dalhousie University will have access to this information. We will describe and share the findings in the thesis, at conference presentations, and in a brief report. We will be very careful to keep your participation private and confidential and all personally identifying information will be removed. Given the small number of potential participants for this study, it is possible that your response to a question may make you identifiable. The people who work with your information, the researcher and the supervisors, have special training and have an obligation to keep all research information private. Audio files of your interview will be stored on a password-protected USB in the supervisor's locked office, and will be deleted upon completion of the study. Also, we will use a participant number (not your name) in our written and computerized records so that the information we have about you contains no names. All your identifying information will be removed from your interview. Following the completion of the study, all electronic records will be kept secure on a password-protected hard drive locked in the supervisor's office. The hard drive will be destroyed after 5 years. Where indicated, contact information will be stored securely and separately from any study-related information you share in your interview.

If You Decide to Stop Participating

You are free to leave the study prior to beginning and at any time during the interview. If you decide to stop participating at any point in the interview, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. You can also decide for up to one week if you want us to remove your data. After that time, it will become impossible for us to remove it because it will already be de-identified, transcribed, and analyzed.

How to Obtain Results

We will provide you with a brief report of the overall results when the study is finished. No individual results will be provided. You can obtain these results by indicating your interest when providing verbal consent prior to the beginning of the interview. You can also contact the researcher at christie.silversides@dal.ca. The contact information you provide will be stored in secure, locked location separate from the information gathered during interview. After the report has been sent to you, your contact information will be securely shredded.

Questions

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Christie Silversides (at 902 402-9139, christie.silversides@dal.ca) or Supervisor Dr. Debbie Martin (Debbie.Martin@dal.ca) at any time with questions, comments, or concerns about the research study. We will also tell you if any new information comes up that could affect your decision to participate. If you have any ethical concerns about your participation in this research, you may also contact Research Ethics department at Dalhousie University by calling (902) 494-1462 or by email ethics@dal.ca

Signature

To promote confidentiality and privacy, informed consent will be confirmed verbally, and recorded at the beginning of the interview.

Informed Consent Page

Project Title: A qualitative content analysis of current federal, provincial and First Nations government policies that promote Mi'kmaq conceptions of healthy aging in Atlantic Canada

Lead Researcher: Christie Silversides, MA Health Promotion Candidate, Dalhousie University

Consent Statement: I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in one interview that will occur at a location acceptable to me, and that the interview will be recorded. I understand direct quotes of things I say may be used without identifying me. I agree to take part in this study. My participation is voluntary and I understand that I am free to withdraw from the study at any time, until 1 week after my interview is completed.

Prior to starting the interview, **your verbal consent** will be obtained for the following questions:

Did you have a chance to review the consent form I emailed to you after our initial conversation?

Yes No, resend consent form

Do you have any questions about the consent document?

Yes No

Can you please confirm that you understand that you have been asked to take part in one interview occurring at a location acceptable to you?

Yes No

Do you consent to having this interview recorded?

Yes No

Can you confirm that direct quotes from this interview may be used with identifying information removed?

Yes No

Can you please confirm that you are voluntarily participating in this interview and you would like to continue?

Yes No

Would you like to receive a brief report of the results when the study is complete?

Yes, share the results to the contact information you have No Participant will contact researcher

Yes, share the results to a different contact address

APPENDIX D

Oral Consent Script

My name is Christie Silversides and I am a MA Health Promotion Candidate at Dalhousie University conducting research for my Masters thesis. Thank you for your interest in participating in this study, titled “A qualitative content analysis of current federal, provincial and First Nations government policies that promote Mi’kmaq conceptions of healthy aging in Atlantic Canada.” I am looking to speak to you about your perspectives on First Nation health policies related to healthy aging, whether that be development, evaluation, implementation or in other capacities. Interviews will be held over the phone. As a reminder, participation in this study is completely voluntary, and you may withdraw at any time prior to and during the interview, and up to one week after taking part in the interview. If you wish to withdraw, please contact the researcher by phone or email within one week of your interview date. You will be given the option to have your data destroyed, or retained but not analyzed.

This interview should take between 45-60 minutes and will take place at a location and time of your choosing. The interview will be audio-recorded and later transcribed and I may also take notes while we speak. Everything you say will remain confidential and no personal identifying information will be included on the transcription of the interview or in the final report of this project, we will use a participant number (not your name) in our written and computerized records. However, due to the limited number of participants in this study, it could be possible to be identified based on your responses. This may have repercussions if colleagues or employers become aware of any views that differ from that of your organization. To mitigate this, be reminded that you are not obligated to answer anything you are not comfortable with and you may skip questions if you choose.

Did you have a chance to review the consent documents I emailed to you after our initial conversation?

Yes No, resend consent documents

Do you have any questions about the consent document?

Yes No

Can you please confirm that you understand that you have been asked to take part in one interview occurring at a location acceptable to you?

Yes No

Do you consent to having this interview recorded?

Yes No

Can you confirm that direct quotes from this interview may be used with personal identifying information removed?

Yes No

Can you please confirm that you are voluntarily participating in this interview and you would like to continue?

Yes No

Would you like to receive a brief report of the results when the study is complete?

Yes, share the results to the contact information you have No Participant will contact researcher

Yes, share the results to a different contact address

Notes:

APPENDIX E

Interview Guide

Questions:

1. Tell me about your experience (generally) in relation to First Nation health and aging-related policies?

2. To your knowledge/in your experience, have the needs of Aging First Nations, and specifically Mi'kmaq, been considered in the development of existing health and aging policies?

What are the current health policies in place that are intended to support healthy aging for Mi'kmaq in Atlantic Canada (and in this province)?

Are there any general or specific contextual or influential factors that impact these policies (e.g. political climate, current events)?

How do you integrate and reflect upon Mi'kmaq perspectives on aging in the development, implementation, and/or evaluation processes of these aging-related policies? Are there barriers or other reasons that prevent collaboration?

3. How do/could you *determine the specific needs* of the aging Mi'kmaq population living on-reserve in the development, implementation, and/or evaluation process of aging-related policies?

4. How do/could you *integrate the needs* of the aging Mi'kmaq population living on-reserve in the development, implementation, and/or evaluation process of aging-related policies?

5. Given that 3 jurisdictions of government (potentially) have a say in policy development, how do you collaborate and cooperate with other governments and health organizations/communities?

6. Can you suggest some ways to best share the information generated by this study with the Mi'kmaq communities?

7. Is there anything else about this topic that we have discussed today that you want to add?