2

Abstract
This paper presents a conceptual framework and model that merges Anishinaabe and non-Anishinaabe perspectives regarding balance promotion for health. Inspired by Freire's concept of liberating education and Antonovsky's concept of salutogenesis, the conceptual framework and the model incorporate the Anishinaabe view of health as rooted in cultural, spiritual and philosophical values that focus on balance to attain and maintain health at the individual and community level. Hypothetical examples of health issues are presented with accompanying questions designed to launch an emancipating dialogue with Anishinaabe clients, which may also be suitable for other Aboriginal clients. The model and questions target three major areas of balance promotion for health: overcoming stereotypes, restoring a sense of belonging, and developing resilience and adaptive behaviours. To counteract the harms provoked by stereotypes and marginalization, the type of dialogue suggested by the model builds on Anishinaabe strengths to develop and mobilize community assets and to achieve a meaningful and coherent health perspective.

Keywords Anishinaabe, balance promotion for health, Canada, emancipation, salutogenesis

An Emancipating-salutogenesis conceptual framework & model of Anishinaabe balance promotion for health

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Introduction

The conceptual model presented in this paper originated in discussion among nurses and social scientists on how to advance nursing knowledge of promoting health in Aboriginal communities in ways that are humanistic, culturally, politically and morally sensitive. Our ideas coalesced around exploring the appropriateness of the application of Freire's ideas of emancipatory pedagogy[1] in combination with Antonovsky's concept of salutogenesis[2] (the latter being adopted worldwide by researchers in the field of health promotion) to the context of health promotion in Canadian Aboriginal communities.

This paper aims to show the transferability of both Freire's and Antonovsky's ideas to the design of a new perspective on promoting Aboriginal health in ways that are intended to counteract the deleterious effects on Canadian Aboriginal peoples of historical oppression and ongoing marginalization. Through examples of how the model could be used in practice, we demonstrate how an Anishinaabe community could be supported to contribute to health services, redesign their own health education, and transcend the current lack of solutions to their issues. The advantage of adopting a salutogenesis orientation to health initiatives is that social vulnerabilities can be transformed into strengths, thereby positively impacting both short- and long-term health outcomes.

Both the framework and model were created in an intellectual

partnership between a graduate nurse of Anishinaabe descent (MS) and nursing and sociology professors. The key principles from Anishnaabe culture are that balance is necessary for health, and that health is achieved through connection with others; the philosophical contributions from Freire's and Antonovsky's view of health as a metaphor for liberation and change (emancipation) and focus on factors that support human health and well-being (salutogenesis). Both conceptual tools were inspired by the experiential health knowledge of MS, as developed and practiced in her own Anishinaabe community (in Toronto, Canada); they are culture-bound and can be applied to initiatives in the area of health education for Anishinaabe (and likely other Aboriginal) individuals, families and communities.

We sought to establish the epistemological adequacy of the model by confirmation from a cultural insider's perception of the Anishinaabe health reality. This means that health is understood as a process that respects the Anishnaabe community life trajectory and acknowledges the historic roots of current health issues and social vulnerabilities. We acknowledge those social vulnerabilities as reflections of the harm done to individuals, groups, relationships, and community resources — all of which, in turn, damage community capital and provoke social disorganization.[3]

We drew on Freire's emancipating pedagogy[1] to expand our understanding of education for health and to counteract the current health inequities and challenges experienced by Anishinaabe and other Aboriginal communities. We adopted Antonovsky's salutogenesis model of health,[2] which emphasizes the sources of risks, vulnerabilities, as well as potential strengths, to sustain the promotion of initiatives towards health in a broad, holistic perspective.[2] We posit health as a state of balance that promotes individual and collective empowerment and resilience. We believe that promoting Aboriginal people's sense of integrity, equilibrium, and well-being may provide an appropriate health perspective to address a wide range of health issues, transcend limitations, and support the self-management of health and life issues.

Definition of terms

Anishinaabe: composed of Aboriginal people of the Algonquin, Chippewa, Delaware, Mississaugi, Ojibway-Cree, Ojibway, Ojibwa, Odawa, and Potowatomi tribal groups or First Nations. In Canada, they live in the provinces of Alberta, Manitoba, Ontario, and Quebec.[4] They originate from the Great Lakes region and are considered to be one of the largest Indigenous nations in North America.[5] They are noted for having an intense spirituality and being deeply independent. The particular Anishinaabe community that inspired and supported this project is part of the 63 First Nations located in the province of Manitoba,[6] with a population of approximately 7,200 individuals living on reserve and in urban areas.

Balance for health: the empirical definition, as adopted in this paper, is grounded in Anishinaabe Medicine Wheel knowledge. Balanced health results from a complex interaction between one's life, other individuals, and all of creation (e.g., the environment, living beings, and inanimate things); it is a four-dimensional state including mind, body, spirit, and emotion, as embedded in the Seven Grandfathers Teachings and the Medicine Wheel.

Conceptual framework: an abstraction, a mental image[7] displaying a logical grouping of concepts into a knowledge form within the empirics pattern,[8] linked in sets of propositions.[9] The concepts composing a framework may originate from one or more theories, previous research results, or the researcher's own experiences.[9] Explanation of the relationship between concepts may be presented in a less well-developed structure than for a theoretical framework.[10] A conceptual framework acts as a background or foundation for a study with a presentation of related concepts in a logical manner by the researcher.[10] Overall, as a basic conceptual structure (e.g., including assumptions, concepts, values and practices), it constitutes a way of solving or addressing complex issues.

Conceptual model: a conception of reality[7] composed by "a set of abstract and general concepts and propositions that provides a distinctive frame of reference for the phenomenon of interest to a discipline" and that implies a disciplinary matrix or a paradigm.[11 p83] By containing all variables of a subject matter and describing reality more fully,[9] a conceptual model uses a set of concepts and propositions integrated into a meaningful configuration. Therefore, a conceptual model provides a systematic structure and rationale for activities, including the search for relevant questions about phenomena, and indicates solutions to practical problems.[12] By being highly abstract, a conceptual model serves as a "set of lenses" to view reality, thus assisting the description, explanation and understanding of a given phenomenon of interest.[13]

Considerations of qualitative modelling

As a systemic view of the complex health reality of Anishinaabe people, the proposed conceptual model acknowledges a

structural complexity while respecting its essential features to inspire courses of action based on simplicity. The health reality of Anishnaabe people is complicated by the forces that limit the improvement of community capacity. These forces include a range of historic and ongoing unresolved issues and traumas, grounded in experiences of exploitation and oppression, and current legal and political dependence that fosters mistrust of authorities, as well as collective feelings of powerlessness and compromised self-esteem. Multiple social determinants of health (e.g., geographic and social isolation, childhood development, poor housing, coping mechanisms, gender) contribute to health inequities between Anishnaabe and other Canadian populations. A simple course of action could be to restore their believed sources of health and self-determination, and to acknowledge their roles as responsible citizens by supporting the mobilization of their self-agency and honouring their values and beliefs in the appropriate care and protection of their people, families, and communities.

This stance resonates with the scientific paradigm of complexity — wherein complexity and simplicity are at play[14] — that currently challenges researchers to propose new understandings and responses to intriguing questions and conflicting ideas. The proposed conceptual model represents the occurring modifications, variations, or configuration about the elements that compose the phenomenon under modelling.[15] It also represents an existing system with functional and structural properties.[16-18] Moreover, this model acts fundamentally by reducing the phenomenon of interest to its more significant characteristics.[19] Using a model archetype's features,[14] the model identifies the phenomenon of interest and differentiates it in the surrounding environment; it designs the phenomenon's active nature, the phenomenon's self-regulation and internal stability, the phenomenon's operational mode to information-gathering within its own environment, as well as the way the phenomenon's mode of conduct functions through the elaboration of decisions about actions.

We want to inspire readers to see through our proposed conceptual lens, a joint work with Anishinaabe people to promote balance for health as feasible and compatible within the three aforementioned perspectives. Our aim is to re-frame the concept of health as a matter of balance in Anishinaabe people's life, within a holistic paradigm of life in balance, as it is embedded in all forms of their teachings. This approach is reflected in Freire's perspective of an emancipating philosophy and in Antonosvky's perspective of promoting resilience and adaptation. We propose an amalgamation of Anishnaabe and Western forms of knowledge and philosophies to create an innovative lens with which to explore health promotion; neither of the aforementioned perspectives emerges as the dominant one in the proposed conceptual tools.

Literature review

This section briefly outlines current views of Aboriginal health by international and national health organizations, as well as the scope for Aboriginal autonomy in designing and implementing health-related initiatives in Canada. An Anishinaabe approach to achieving balance for health, as shown in Figure 1, incorporates multiple dimensions; all must be addressed to adequately deal with the deleterious effects of colonization and marginalization of Aboriginal peoples. (It is beyond the scope of this paper to include literature on the historic roots of Aboriginal oppression in Canada or the current range of issues regarding Aboriginal health status and self-government.) This section also presents the Anishinaabe's view of balance for health that inspires this paper.

Worldwide issues regarding Aboriginal health

An estimated 370 million Indigenous individuals live in more than 70 countries worldwide, in developing and industrialized countries alike, but across the board, their health status varies greatly from that of their non-Indigenous counterparts.[20] The current health status of the Canadian Aboriginal population reflects significant health inequities; their life expectancy, for both men and women, is five to ten years lower than for other Canadians.[21] These inequities are closely related to the social determinants of health, notably low socioeconomic status and adverse political factors that are linked to the historic oppression of Aboriginal peoples.[22,23] The Aboriginal population in Canada faces poor health outcomes according to almost every indicator used to assess health outcomes.[24]

Autonomy for health related initiatives in Canada

The historic neglect of Aboriginal population health care in Canada is linked to major issues and disputes regarding who is responsible for tackling health disparities.[25] Aboriginal dependence on the federal government has undermined initiatives to improve Aboriginal quality of life.[26] A critical issue is that Aboriginal communities have lost self-determination in policy development for their own people.[27] As a strategy to promote self-determination, governments, policy makers, practitioners and researchers are urged to seek Aboriginal input on their communities' concerns, needs, and possible solutions,[26,27] especially in the creation of culturally appropriate mental health recovery

services.[28]

Aboriginal autonomy also relates to the ability to navigate the Canadian health system since the Aboriginal population also faces problems with accessibility to health services. Despite the establishment of provincial and federal support policies, the current education structure (including the health-specific one) does not prepare Aboriginal individuals to fit within the mainstream society. One of the most damaging adverse consequences of historic oppression of Indigenous peoples is the development of feelings of shame rather than respect for their ancestral culture.[29] Adopting a critical perspective and understanding of the politics, culture, and history that underpin Aboriginal communities' current struggles to live in health, while respecting their culture in its enormous diversity,[30] is a necessary and promising avenue to their improved health.

Health promotion opportunities

Health promotion projects that recognize and honour Aboriginal people's history and celebrate their traditional ways are needed to help with the healing process.[23] For Aboriginals living off-reserve, such projects could nourish their sense of belonging and connect them to their culture.

Health Canada recently adopted a new research direction for projects that fit the balance model of health. A success-focused approach in the First Nations and Inuit Health Branch claims to support the "positively focused aspirations of Canadian Indigenous communities". The current focus is on the generation of hypotheses and research questions that will "strengthen First Nations' capacity to apprehend, anticipate, and heighten positive potential".[31 p1] First Nations peoples are known to share traditional values such as balance, harmony and interconnectedness as part of their Aboriginal culture.[32] This acknowledgement of a culturally appropriate, preventative, holistic, and strength-based approach corroborates the suitability of our emancipating-salutogenesis conceptual framework and model which recognizes the need to honour the voice and potential of Anishinaabe communities to achieve balance for health.

Anishnaabe balance for health

The synchrony between the external, social and cultural environments in Anishnaabe worldviews highlights the Aboriginal emphasis on the necessity to maintain a connection with 'Mother Earth'.[23] It is expressed in the idea of balance and harmony within and among the domains of social, spiritual, emotional and physical health. The concept of balance relates to the whole of creation and, ultimately, to health and wellness. Everything that Aboriginal people interact with in their daily lives is considered to be alive and to have a spirit.[33] The use of traditional ways of maintaining health and provision of culturally-focused care are important to Aboriginal people since both emphasize the importance of respect for all life. Appreciation for interdependence is also important for balance since it situates human relationships as a better source and reflection of well-being than material wealth or status.[34]

For Anishinaabe people, the cultural image of balance comes from the Medicine Wheel.[5] Balance involves each aspect of being in connection with the four directions and incorporates associations with plants, spirits, animals, colors, minerals, and the lifecycle. Balance must exist between the spiritual, physical, mental, and emotional dimensions for individual good health. Balance impacts health through an individual's participation in traditional activities, and with the establishment of significant relationships. Balance includes the observance of 'seven generations teaching' which places a high value on respecting ancestors and accepting stewardship on behalf of future generations.[23] Such cultural practices can mitigate the harmful consequences of loss of culture and language, discrimination, injustice, poverty, and social inequality.[35]

Inspirational conceptual frameworks and the design of conceptual tools

Freire's emancipating pedagogy[1,36} and Antonovsky's salutogenesis model[2,37,38] framed the development of the conceptual tools (i.e., a framework and a model) that we integrated for an Anishinaabe perspective of emancipating-salutogenesis balance for health. Freire's pedagogy espouses social justice, equality, freedom and democracy through the development of critical consciousness, resulting in emancipation, a state of awareness and conscientization about one's potentialities and agency. For Freire,[1] education must stimulate a desire for action that addresses inequality and oppression. Since traditional forms of education tend to support the status quo in terms of social and political structure, it is essential that education be reoriented towards promoting social change. In Freire's pedagogy, learners are encouraged to reflect on their own experiences in life and on the individual and collective injustices encountered. They are then asked to reflect on the underlying reasons for these problems and to identify prominent ideas that would foster a change in their social reality. Liberation from oppressive forces can be achieved by framing one's reality through "seeing-judging-acting" in the world.[39] For Freire,

the best way to help others to identify and become aware that a problem exists, as well as understand it, is through developing critical judgment from which solutions can be formulated. It is through an understanding of their specific and broad issues that individuals can develop critical consciousness and solutions to their problems.

Antonovsky's conceives salutogenesis[38] as the origins of health,[2] particularly with respect to how people deal with the inevitable challenges of life, or pressures toward entropy as human life unfolds in an open system. Within this perspective of health, the emphasis is on the individual's ability to cope with stress, the deciding factor to withstand any pathogens or trauma. Antonovsky[2] defines a sense of coherence as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected"[p3] Moreover, a sense of coherence is formed by life experiences whose meanings depend on social position and culture, type of work, family structure, gender, ethnicity, chance and genetics. Experiences are determined by consistency, load balance, and participation in socially valued decision-making processes.

The focus is on the human capacity to generate health by mobilizing the factors that promote a healthy state. Initiatives for health promotion support the individual's progress toward this goal. An individual uses generalized resistance resources that are the "property of a person, a collective or a situation which, as evidence or logic has indicated, successful coping with the inherent stressors of human existence".[38 p15] The major concept in Antonovsky's model is a sense of coherence: making sense of the world through comprehensibility, manageability and meaningfulness, as well as human resilience in the face of adversity. These features are described by Antonovsky[38 p15] as: "the wish to be motivated to cope (meaningfulness); belief that the challenge is understood (comprehensibility); and belief that resources to cope are available (manageability)".

Freire's and Antonovsky's conceptual perspectives are compatible with the Anishinaabe idea that balance for health implies resilience and empowerment. Both of these perspectives would encourage and sustain critical awareness of the possible connections between Western scientific thought and traditional Anishinaabe knowledge, in consonance with Anishinaabe people's dreams and goals to recreate dignifying life perspectives for current and future generations.

An emancipating-salutogenesis conceptual framework for Anishinaabe balance promotion for health

Freire's and Antonovsky's ideas resonate with the Anishinaabe view of ecology, rooted in traditional knowledge thousands of years old.[40] As a way of life and a way of knowing,[41] it is action-oriented, dynamic, and adaptive to changes. It encompasses spiritual experience and relationships with the land and religious dimensions. This approach to ecology can be understood by outsiders through the exploration of four interrelated levels of knowledge and management systems. The first level is localized and is cross-culturally accepted in terms of local knowledge of land and animals. The following layers are land and resource management systems, social institutions, and lastly, world view. Each layer encompasses the previous and provides interpretation of the underlying layers.

The meaning of the land or ecology to Aboriginal people is tied to "living a good life" since it is culturally and spiritually based on the way Indigenous people relate to their ecosystem.[40] This idea of "living a good life" is evident in every traditional teaching, directly linked to people's spirituality, and is widespread within Indigenous pedagogy. Another relevant aspect of critical Indigenous pedagogies is the Native American view of "exist[ing] in in-between, border, marginal, and liminal spaces, the crossroads where colonializing and decolonializing frameworks intersect and come into conflict with one another.[42 p211] This pedagogy enacts politics of liberation and empowerment, as well as spaces of engagement; creates sacred spaces;[42] and reinforces Native intellectualism, identity, self-determination and sovereignty.[43] As Indigenous knowledge conceptualizes the resilience and self-reliance of their people and emphasizes the importance of their philosophies, heritages and educational processes,[44] it can become instrumental in reaffirming collective capacities to overcome oppressing poverty and support sustainable development.

We need to appreciate and respect the Indigenous view that everything on Mother Earth has a purpose. Their environment is important to them as the provider of the basis for life (medicines, food, and shelter). Aboriginal people's connections to the land are both practical and sacred, and deeply meaningful.

From an Anishinaabe perspective, the following concepts in the conceptual framework are all interconnected: resilience, individual and collective empowerment, self-determination, holism, interdependence and support, sense of coherence,

security, and cultural identity. These concepts can inspire transformative health education initiatives that aim to create a meaning of health compatible with traditional native health knowledge. There is a dynamic connectivity between the intellectual, spiritual, emotional and physical aspects of Aboriginal identity and worldview,[33] which is reinforced by traditional teachings. The Aboriginal identity incorporates a positive self-image and a healthy cultural identity.[22]

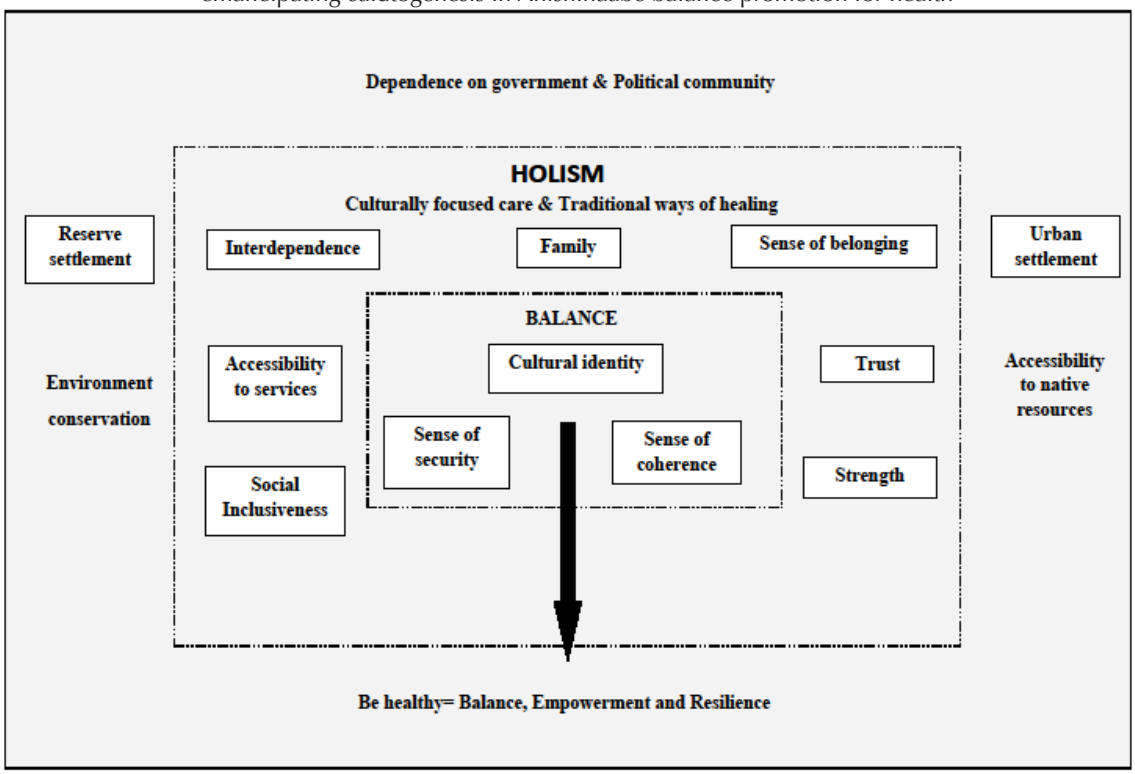
Based on the Anishinaabe view of balance, the proposed conceptual framework integrates traditional teachings and philosophy within a macro level, ecological perspective of living. The emancipating-salutogenesis conceptual framework we propose for Anishinaabe balance for health promotion operates at three levels:

-A macro-societal level where political relations between levels of government and the Aboriginal community determine health conditions related to physical and social environments. The reserve or urban context will shape target emancipating actions related to the environment, accessibility to Absoriginal services, and governance issues regarding land claims and conservation. These elements relate to Aboriginal people's sense of coherence.[26]

-A meso-community level where processes of emancipation and salutogenesis are rooted in Aboriginal culture and traditional healing. Social inclusion and accessibility to health and social services are interlinked, while interdependence among community members reinforces trust. Living in balance with self and others is rooted in the sense of belonging, and psychological strengths are instilled within the family unit. The family is considered to be one of the most influential sources of nourishing feelings of love, affection, and belonging, all of which are symbols of Aboriginal safety, strength and comfort.[45] Healthy family relations also contribute to the development of a positive cultural identity, spirituality, and resilience by promoting a holistic view of life, resistance against forces of oppression, and forgiveness, all of which, in turn, can help communities to overcome longstanding silence.[46]

-A micro-individual level, where a sense of security, coherence, and cultural identity are expected to reinforce the development and consolidation of balance. Balance embodies notions of action to prevail in one's motives to achieve psychological and spiritual resilience. Resilience also refers to the community and cultural contexts, as well as to positive adaptation in facing adversity and navigating life well.[47] Balance that is rooted in security, coherence, and cultural identity involves resilience through self-transcendence and faith that is rooted in Aboriginal cultural identity and spirituality.

Figure 1: Features of the conceptual framework displaying the processs of emancipating-salutogenesis in Anishinaabe balance promotion for health



Harmonizing Western and Anishinaabe ideas in the conceptual model

Our conceptual model amalgamates Anishinaabe philosophy with Freire's and Antonovsky's ideas to inspire native and non-native individuals to marshal their assets to rebuilding an alliance for health within the process of balance promotion. We identified a philosophical alignment between Freire's and Antonovsky's ideas with the Seven Grandfathers and Medicine Wheel Teachings, particularly in that each approach values knowledge, courage, harmony, self-coherence, and respect for a natural flow of life events that honours the sacred essence and dignity of individuals. Freire based his thinking on the Brazilian people's experiences of social oppression and resistance; Antonovsky based his thinking on resilience and well-being in the face of stress and trauma. So, both authors explored ways for people to thrive in the face of extreme forms of suffering, oppression and extermination. Anishinaabe experiences and ideas recall equally painful memories, but like the Western authors, celebrate individuals' and communities' strengths, possibilities, and assets to overcome difficulties.

Among Aboriginal nations, the Medicine Wheel is known as a post-colonial teaching to explain to non-Indigenous people their way of life, not their culturally specific traits. The Medicine Wheel's major ideas vary from Indigenous culture to culture, including those conceived and embraced by Anishinaabe people. Since each tribal nation can use this tool in a distinctive way, the relevance of the Medicine Wheel relies on the existence of trans-tribal concepts (sacred medicines, seasons, directions, stages of life, and aspects of a person). Anishinaabe people also rely on Seven Grandfathers' Teachings while outline the seven characteristics that constitute the good life: living life with courage, truth, honesty, wisdom, respect, love and humility. In other words, it is a way to traditionally live one's life in balance with oneself and one's surroundings.

By transmitting knowledge about man's wholeness in the world, the Aboriginal life paradigm goes beyond the sacred dimensions[48] to embody the political dimension of living with constant experiences of marginalization, oppression and injustice, which have been widely documented by Aboriginal and non-Aboriginal scholars. Since the Western and Aboriginal ideas introduced in this paper both address living with adversity, their similarities can be identified to inspire a synergy of ideas.

Freire's dialogical learning approach based on educator-learner dialogue was considered integral to a revolutionary critical praxis by Grande,[48] who also emphasized that despite its profound, participatory and creative nature, Freire's critical pedagogy could be in tension with Indigenous knowledge and praxis. Our disagreement about this is supported by pointing to the historical roots of Freire's pedagogy for liberation, which evolved from his literacy work with Brazilian rural workers deprived of rights to land and who had struggled for decades with powerful landlords and suffered generational inequities resulting in hunger, extreme poverty and illiteracy.[1] We note the similarities between a human misery lived in a Western, middle income country and the social inequities that Canadian Aboriginal people face in their high income home country. In both social contexts, life, human dignity, suffering, health and death have similar moral meanings.

Re-focusing on the application of Freire's ideas to Aboriginal health promotion initiatives, and seeing Aboriginal individuals as learners for health, we reaffirm the appropriateness of emancipatory ideas from Freire's critical pedagogy. According to Freire, the learner becomes a political agent in his/her own world in that "…critical pedagogy encourages students to learn to perceive the tolerable as intolerable, as well as to take risks in creating the conditions for forms of individual and social agency that are conducive to a substantive democracy".[49 p186] In a critical pedagogy context, learners are assisted to confront the threat of fundamentalist and accepted ideas to imagine and formulate different ways to intervene in their private and public life. So, as a matter of living life with courage, truth, and honesty, the politically aware Aboriginal learner can see balance for health as an individual project for well-being that has a collective benefit by having a balanced person in the community.

Furthermore, Freire's ideas refocus the core of a teaching-learning process on the learner's dreams instead of on the teacher's goals,[1] and on the teacher's audacity and courage to challenge the systemic oppression sustained by educational institutions.[50] By doing so, the teacher becomes aware of his/her fears to counteract the injustice faced by learners. These ideas are transferrable to the context of health education and health promotion initiatives and programs that, intentionally or not, impose non-Aboriginal teachings in a new form of imposition of dominant culture and knowledge.

The source for agency and energy to confront oppressive, non-liberating forces is informed by Antonovsky's ideas of resilience, in consonance with Aboriginal teachings on matters of wisdom, respect, love and humility. These teachings

can help an individual to find a way to be resilient and find the "other". Moreover, the traditional mode of talking circles and humble acceptance of advice based on the wisdom of Indigenous elders can be understood as strategies for a narrative resilience,[51] where one's discourse translates the affective value of sharing thoughts and concerns with other individuals in a perceived safe context. The purposeful dialogue within an affective and cultural context among Aboriginal individuals and with non-Aboriginal professionals can exemplify an integration of Antonovsky's ideas related to mental strength to confront adversity. Dialogue as a strategy for building resilience allows the verbalization of a narrative truth from the individual's point of view that may not be exactly the historical truth (from a collective point of view).

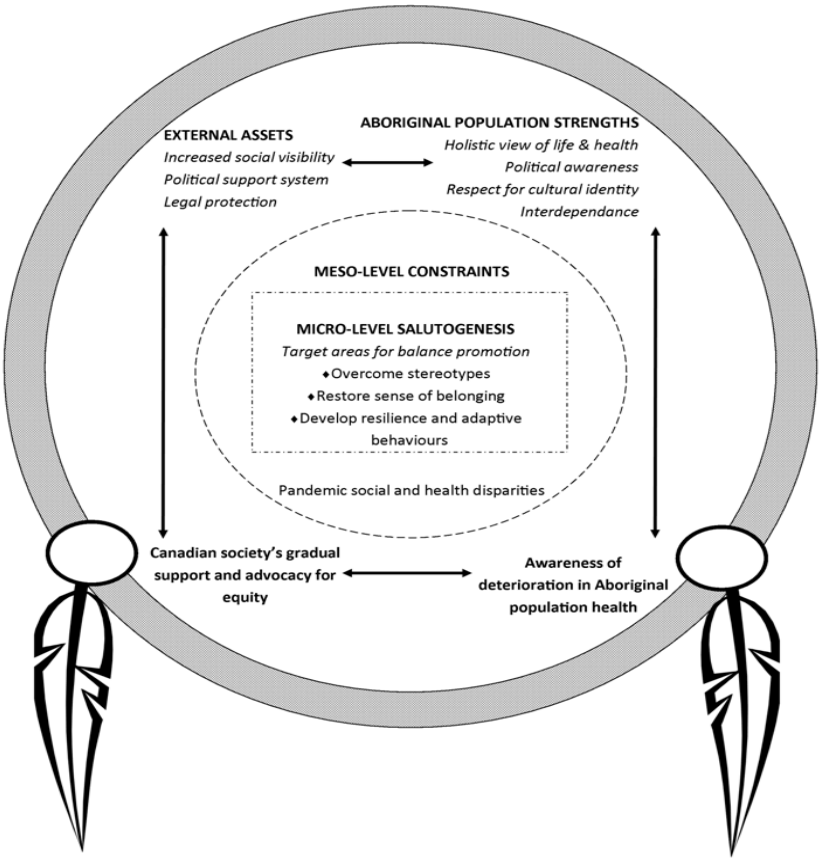
Within such a space of disclosure, dialogue, and conscientization, it is possible to foresee a process of healing taking place, as stated by the Aboriginal Medicine Wheel paradigm. The traditional teachings see the individual as a free and responsible agent who chooses whether and how to use and incorporate the teachings in their life. It is possible to say that the sources of elements for wellness and health are identifiable to Aboriginal individuals by their affective and spiritual proximity.

Ultimately, individual resilience can also foster community resilience, for instance when Aboriginal families and groups or communities resist oppressive forces and bring about positive outcomes, such as "strengthening social capital, networks and support; revitalization of language, enhancing cultural identity and spirituality; supporting families and parents to insure healthy child development; enhancing local control and collective efficacy; building infrastructure (material, human and informational); increasing economic opportunity and diversification; and respecting human diversity.[52 p62]

An emancipating-salutogenesis conceptual model on Anishinaabe balance promotion for health

In this section, we introduce the design features of the proposed conceptual model and decode the model's language to show a feasible course of action to promote balance for health for Anishinaabe people.

Figure 2: An emancipating-salutogenesis conceptual model on Anishinaabe balance promotion for health



The model

The model acknowledges Aboriginal people's strengths regarding their life and political philosophies, as well as Canadian society's gradually increasing support and advocacy for equity for Aboriginals. The co-existence of these strengths, support and advocacy may be seen as key components of the systemic social environment where the process of balance promotion for health will unfold.

The model refers to a progression in critical awareness, recognizing that individuals can range from being largely unaware of the implications of their daily reality, to being more engaged in the world, to finally reaching a stage of reflexivity and action.[53] External factors, such as external governance of Aboriginal policies or even the inappropriate actions of a band council, will not diminish or even jeopardize the progression of individual or collective critical consciousness leading to empowerment. This is because a community's political emancipation will lead inevitably to a quest for freedom to act on internal issues of management (or mismanagement), as well as influence efforts at change at the level of federal, provincial, and territorial governments.

The core of the conceptual model is composed of three major areas for individual and collective change as a result of health education initiatives: overcoming stereotypes, restoring a sense of belonging and developing resilience and adaptive behaviours. Applying an emancipating-salutogenesis conceptual model to suggest and guide actions in partnership with Anishinaabe communities can potentially promote innovative critical health initiatives. These initiatives could mobilize community awareness of emancipation as a pathway to promote health through improved social conditions.

The key significance of this model derives from the origin of its components. The components of the conceptual framework emerged from the Aboriginal co-author's experiences and assumptions about the balance promotion for health. The elements of the conceptual model are based on the integration of two Western theoretical/conceptual approaches, amalgamated with Indigenous knowledge about balance for health, sources of health, and emancipation for health.

Exploring the prospective contribution to practice

Initially, the professional contribution of the proposed emancipating-salutogenesis conceptual framework was confirmed by a nursing professor who has ten years of experience as a nurse practitioner with Anishinaabe clients. This confirmation resulted from a review of several clinical cases and her professional interventions on a reserve located in the province of Ontario. This corroborated the pertinence of the concepts presented in the conceptual framework. Further, we followed qualitative research procedures for trustworthiness and verification by presenting the conceptual framework to Canadian nursing professionals and educators, composed of approximately 50 practitioners, scholars, faculty members, and decision-makers who attended four Canadian nursing research and community health conferences (in 2010, 2011, and 2012). The model's validity was corroborated by conference participants who reported having expertise in Aboriginal health.

We aimed to apply other testing criteria and procedures of trustworthiness, in case the scientific meetings did not allow us to select or even identify audience members as Aboriginal individuals and confirm their status as cultural insiders or professional experts. Such methodological limitations were attenuated by having only Aboriginal reviewers for the early draft of this paper. Aware of the meaning of validity as synonymous with verisimilitude, identified in the levels of accuracy and truthfulness in the findings, we also targeted the criteria of epistemological and catalytic validity, addressed by issues of text verisimilitude.[54] That is, our presentation of the model provided an incitement to discourse[55] in the form of comments from key informants and auditing by external examiners;[56] the model's interpretative validity was reflected in how it responded to different audiences about issues of culture, ideology, gender, textual language, relevance, advocacy, and standards or respectability.[57] Using feedback from external, professional examiners and their auditing, we verified the framework's incitement to critical discourse with external audiences. Trustworthiness was established by the criteria of credibility and transferability, based on the opinions of various contacts in the field with natural experts (including an Anishinaabe elder and Aboriginal professionals), member checks, and similar conclusions by other researchers and experts. Later, an Anishinaable elder reviewed and corroborated the validity of a primary Anishinaabe outline of the conceptual model in a discussion with the Anishinaabe co-author.

Discussion

As Indigenous knowledge and pedagogy are trans- and inter-cultural, they allow for a multi-disciplinary convergence of sources of systemic knowledge;[44] and they allow for the examination of similarities with non-Indigenous systems of

knowledge. More specifically, there is a logical congruency between the ideas of critical pedagogy and Indigenous learning styles. The application of critical pedagogy with Australian Aboriginal learners was found to the be culturally sensitive.[58] As a human-centred pedagogy, it should observe teaching approaches that are culturally sensitive and inclusive responding to Aboriginal identity. Teaching is expected to address the whole meaning of holistic learning: the role of the images and imagination as learning tools through unstructured thoughts, images and experiences; tactile, experiential learning; communal, collective learning experience; contextual-specific learning; and a person-centred approach involving family and personal relationships. Hence, teachers and learners should integrate into any health promotion initiative an adequate locus to learn about balance for health promotion.

Kryzanowski and McIntyre have noted that the concept of balance in the Medicine Wheel ignores some of the key recognized social determinants of health;[59] they suggested that their Community Life Indicators be added to the centre of the Wheel to incorporate a wider range of the determinants of health. Their Integrated Life Course and Social Determinants Model of Aboriginal Health includes life stages, and categorizes the determinants of health as proximal, intermediate and distal, according to the level of influence on the individual. Their Holistic Model for the Selection of Indigenous Environmental Assessment Indicators includes an environmental assessment of health, not included in previous models. Within the individual, community, and external context levels of the models, specific indicators for each determinant of Indigenous health can be identified.

Our proposed conceptual framework also highlights the roots of balance from multiple social determinants of health, including geographic location, social support, access to health services, and coping strategies. To adequately address the social determinants of Anishinaabe health, health promotion initiatives for their communities as well as education for health could be envisioned as a form of liberation to overcome a hegemonic, biomedical form of health knowledge. Through educational initiatives connecting both scientific and traditional health knowledge, a holistic health practice is already present in native-focused health centres. Such practice brings together a multidisciplinary team that is made up of traditional and modern science-based healthcare professionals. Anishinaabe communities could further develop their assets to become powerful partners in healthcare planning, delivery and evaluation. Critical awareness could facilitate partnerships in knowledge development following what Freire[1] stated is the ultimate goal of an educational process: the achievement of learners' dreams and goals. Acting on the principle of respect for Aboriginal diversity (e.g., generational differences, differences among various groups including First Nations, Inuit, Métis) could provide opportunities for Aboriginal communities to evaluate and critique their own health issues using their own philosophical lenses, and be the basis for culturally sensitive and meaningful decisions and actions.

The applicability of the proposed framework for Anishinaabe balance for health promotion is corroborated by the positive results from a project which promoted 'living in balance' with a group of youth; those who increased their physical activity and spent less time watching television.[60] The authors concluded that prevention should focus on youth development and empowerment to effect positive developmental outcomes such as improved self-esteem, participatory competence, and enhanced learning outcomes.

Within our framework, health promotion involves strengthening the health potential of Anishinaabe communities to achieve balance by involving those affected, thereby increasing their autonomy.[23] Community- and culturally-based Aboriginal models of care should guide the development of evidence-based practice.[61] Respect for Aboriginal traditional culture and cultural activities sensitizes individuals to loss and protects them from the reminders of loss.[47] Appreciation of Aboriginal cultural and spiritual orientation helps to anchor and ground groups to prevent self-destructive ideation, suicide attempts, and alcohol and substance abuse.

Critical to the process of salutogenesis, as perceived by Aboriginal communities, is recognition of the deleterious effects of colonization (e.g., stereotypes and racism) that compromise the social adjustment and participation of Aboriginal people in our multicultural society.[30] An understanding and awareness of salutogenesis features can lead to effective knowledge for social change and a shift of social attitudes toward reducing social and health inequities.[35]

Contributions to health promotion practice and research

With the intention of assessing the feasibility of the proposed conceptual tools to contribute to health promotion practice, we have presented them at nursing scientific meetings. The framework was also used by MS to guide her professional practice as a diabetes nurse educator for almost 4 years. Use of the framework revealed promising avenues for wider

Table 1: Examples of questions to initiate an emancipating dialogue towards

Examples of situational sense of coherence	Target area: Overcome stereotypes	Target area: Restore sense of belonging	Target area: Develop resilience and adaptive behaviours, balance promotion for health
Example A A newly diagnosed young male adult with type 2 diabetes	•How does the client understand his sacredness in creation, which ensures self-care and the ability to overcome stereotypes of the Aboriginal victim of diabetes? •How does he perceive self-caring as a means to live in balance in all quadrants (e.g., tackling stereotypes)? •To what extent does the current discourse on health disparities within Aboriginal individuals influence his awareness of the strengths required to make needed changes?	•How much importance does the client attribute to his sense of belonging? •Who will help him to feel accepted as part of a new social sub-population of men living with diabetes? •What are the expected or perceived benefits of belonging to social and support networks?	•To what extent does he feel supported to adopt needed lifestyle and diet changes after a diagnosis of diabetes? •How does the client perceive his ability to make the changes needed to live a healthier lifestyle? •What and who would help him to manage glycaemia and promote a good quality of life?
Example B A request for guidance to create a self-help group with female teens to battle sexual violence	•How do the dynamics of the perceived image of sexual violence victims affect family and social relations? •To what extent does the client view the social, political and economic environment as supportive, and what personal changes are required to ensure a balanced way of living? •What are the group's goals with respect to changing the community's perception of their abilities for self-recovery?	•To what extent do the teens see their community reflecting a subculture of sexual violence against Aboriginal women? •How will the teens in the self-help group discuss their issues in the face of disrespect for traditional teachings and values, and create social bonds of protection? •How important is the creation of a self-help group to sustain psychological endurance, personal empowerment, and abilities for self-protection?	•What is the impact of participation in the group on decreasing sexual violence? •How does the perception of empowerment and sharing among Aboriginal women influence teens' adaptability? •How do the teens perceive their ability to make changes needed to live a healthy lifestyle, and in what time frame?
Example C A parents' group to address increasing rates of obesity among toddlers in a rural community	•How do cultural and historical perceptions of health, diet, growth, and weight promote social acceptance of obesity? •How do community members perceive their potential to act on underlying economic barriers to following a traditional diet and prevent childhood obesity? •How has the community accepted child obesity as a result of imbalance in children's development?	•How does the psychological environment of the community enable parents' expression of issues and concerns about childhood obesity? •What are the achievable outcomes of implementing a community project targeting the development of parental networks to counteract historical and economic inequities? •What questions could parents ask of themselves and the community to create the changes required to implement healthy diets throughout pregnancy and childhood?	•Who is deemed to have the power to redress inequities in accessing healthy foods? •How much consensus exists among community members with respect to this assessment? •What are the perceived social determinants of community capacity in managing childhood obesity? •How does the community foresee goal-oriented health intervention to adopt a new lifestyle related to food and exercising? In what time frame?

application and practice guidance. An important feature is how cultural identity is directly linked to the need for healing from historic trauma in the Aboriginal population due to the history of colonialism and dependency on government.[62]

In Table 1, we provide three examples of fictitious clients in

situations related to their sense of coherence (as inspired by Antonovsky's ideas) to show how questions can be derived from application of the model to inspire an emancipating dialogue (according to Freire's ideas) between health educators and Anishinaabe clients (and probably with other Aboriginal clients). The questions are intended to foster clients' awareness about their own plan to achieve multidimensional health (inspired by Anishinaabe philosophies). The questions address the major areas of balance promotion for health within the perspective of a sense of coherence (a main feature in the salutogenesis approach). The resulting dialogue is meant to focus clients' actions on feasible lifestyle choices and plans for change, according to an optimistic but realistic continuum of health.

Use of the proposed conceptual tools is meant to inspire health educators, stakeholders, and communities to explore the qualitative impacts of their incorporation to practice. We recommend process and outcome evaluation studies that will be particularly important to document the underlying philosophies, assess the actual application by clients and professionals, and determine whether and how implementation of this innovative process improves Anishinaabe well-being. Such evaluation is needed for services and programs for health promotion with the Aboriginal population,[63] especially by organizations seeking new solutions to their practice-related problems. The documentation and follow-up of impacts, consequences, and influences provoked by such dialogues in individual and community practices could be the object of studies using a variety of methodological designs.

Furthermore, the conceptual model may be applicable in other countries that are dealing with vulnerable populations such as Aboriginal populations around the globe.[64,65] As in Canada, their vulnerability may be expressed by a high incidence and prevalence of chronic, degenerative diseases in all age groups; compromised adaptation to changes in their social and physical environment; lack of access to societal goods, resulting in exacerbated frustration and increased mental illnesses;[66] and limited opportunities to liberate themselves from negative stereotypes that are related to trans-generational moral and spiritual suffering.[67]

Concluding remarks

The relevance of the concept of balance for health as lived by Anishinaabe may be relevant as well for other Aboriginal populations since it relies on positive social constructions.[68] The basis for healthful balance can be offset by imbalances caused by stereotypes, racism, oppression, or marginalization.[27] To bring innovation to practice through the incorporation of new conceptual frameworks and models targeting education for Anishinaabe health, we should integrate philosophical ideas about freedom to recreate healthy, dignifying life conditions for their communities, especially in dealing with chronic or acute health conditions. We should focus on Anishinaabe strengths to guide reciprocal relations with community and professional stakeholders, and take macroscopic points of view on balance promotion for health. In sum, we argue that balance promotion is a precursor, holistic stage to the achievement of health promotion for Aboriginal individuals and communities, as well as to their education for health as a practice of freedom.[39] The social relevance of such innovation relies on its potential to contribute to new responses to the community health challenges facing by the majority of Aboriginal people who live in Canadian urban areas.[69]

References

1.Freire P. Education for Critical Consciousness. New York: Continuum, 1973.

2.Antonovsky A. Health, Stress and Coping. San Francisco: Jossey Bass, 1979.

3.Mechanic D., Tanner J. Vulnerable people, groups, and populations: Societal view. Health Affairs 2007; 26: 1220-1230.

4.Indigenous and Northern Affairs of Canada. Anishinabek Nation Agreement-in-Principle with Respect to governance. Available from URL: https://www.aadnc-aandc.gc.ca/eng/1309200193324/1309200275975 Accessed 7 July 2016.

5.Turton C. Ways of knowing about health: an Aboriginal perspective. Advances in Nursing Science 1997, 19: 28-36.

6.Indigenous and Northern Affairs of Canada. First Nation community listing, Manitoba region 2012-2013. Available from URL: https://www.aadnc-aandc.gc.ca/eng/1100100020539/1100100020544 Accessed 7 July 2016

7.Adams E. Toward more clarity in terminology: frameworks, theories and models. Journal of Nursing Education 1985, 24: 151-5.

8.Chinn PL, Kramer MK. Integrated Knowledge Development in Nursing. 6th ed. St. Louis: Mosby, 2004.

9.Meleis AI. Theoretical Nursing: Development & Progress. Philadelphia: J. B. Lippincott, 1991.

10.Nieswiadomy RM. Foundations of Nursing Research. Upper Saddle River: Prentice Hall, 2002.

11.Fawcett J, Downs FS. The Relationship of Theory and Research. East Norwalk: Appleton-Century-Crofts, 1986.

12.Fawcett J. Analysis and Evaluation of Conceptual Models in Nursing. 2nd ed. Philadelphia: F. A. Davis, 1989.

13.Moody LE. Advancing Nursing Science Through Research. Vol. 1. Newbury Park: Sage, 1990

14.Le Moigne J.-L. La Modélisation des Systèmes Complexes. Paris: Dunod, 1990.

15.Bruter CP. Sur le formalisme différentiel. In: Thellier, PDM (ed.). Élaboration et Justification des Modèles: Application en Biologie (Vol. I). Paris: Maloine-Doin, 1980; 83-92.

16.Hawes LC. Pragmatics of Analoguing: Theory and Model Construction in Communication. USA: Addison-Wesley, 1975.

17.Willett, G. La modélisation. In: Willett, G. La Communication Modélisée: Une Introduction aux Concepts, Modèles et aux Théories. Ottawa: Éditions du Renouveau Pédagogique, 1992; 24-47.

18.Willett, G. La notion de d'information,. In: Willett, G. La Communication Modélisée: Une Introduction aux Concepts, Modèles et aux Théories. Ottawa: Éditions du Renouveau Pédagogique, 1992; 157-178.

19.Mucchielli A. Dictionnaire des Méthodes Qualitatives en Sciences Humaines et Sociales. Paris: Armand Colin, 1996.

20.World Health Organization. 2007. Health of indigenous peoples. Available from URL: http://www.who.int/mediacentre/factsheets/fs326/en/index.html. Accessed 20 April 2012.

21.Macauly A. Improving aboriginal health: how can healthcare professionals contribute? Canadian Family Physician 2009, 55: 334-336.

22.King M., Smith A., Gracey M. Indigenous health part 2: the underlying causes of the health gap. The Lancet 2009, 274: 76-85.

23.Mundel E., Chapman G. A decolonizing approach to health promotion in Canada: the case of the urban Aboriginal community kitchen garden project. Health Promotion International 2010, 25: 166-173.

24.Lemstra M., Neudorf C. Health disparity in Saskatoon: Analysis to intervention. Saskatoon: Saskatoon Health Region, 2008. Available from URL: http://www.caledoninst.org/Special%20Projects/CG-COP/Docs/HealthDisparityRept-complete.pdf. Accessed 20 April 2012.

25.Health Council of Canada. 2005. The health status of Canada's First Nation, Metis & Inuit Peoples. Available from URL: http://www.healthcouncilcanada.ca/tree/2.03-BkgrdHealthyCdnsENG.pdf. Accessed 10 November 2011.

26.Minore B., Katt M. Aboriginal health care in northern Ontario: Impacts of self-determination and culture. Institute for Research on Public Policy 2007, 13: 1-22.

27.Reading J. 2009. A life course approach to the social determinants of health for Aboriginal peoples. Available from URL: http://www.parl.gc.ca/Content/SEN/Committee/402/popu/rep/appendixAjun09-e.pdf Accessed 20 April 2012.

28.Lavallée LF., Poole JM. Beyond recovery: colonization, health and healing for Indigenous People in Canada. International Journal of Mental Health and Addiction 2010, 8: 271-281.

29.Baskin C. Aboriginal youth talk about structural determinants as the causes of their homelessness. First Peoples Child & Family Welfare Review 2007, 3: 31-42.

30.Browne A., Varcoe C. Critical cultural perspectives and health care involving Aboriginal peoples. Contemporary Nurse 2006, 22: 155-167.

31.Kishk Anaquot Health Research. 2007. Successful indigenous community in Canada. Available from URL: http://fnbc.info/sites/default/files/documents/200706_scott_kim.pdf. Accessed 19 September 2011.

32.Government of Alberta. Understanding health and wellness from the perspective of Aboriginal peoples in Canada. Available from URL: http://www.healthyalberta.com/699.htm. Accessed 19 January 2014.

33.AwoTaan Healing Lodge Society. 2007. Aboriginal frameworks for healing & wellness manual. Available from URL: http://www.awotaan.org/publications/Manuals/Awo_Taan_Manual_FINAL_May_30_2007.pdf. Accessed 14 May 2011.

34.Stewart S. Promoting indigenous mental health: Cultural perspectives on health from Native counsellors in Canada. International Journal of Health Promotion & Education 2008, 46: 12-19.

35.Browne A., Smye V., Varcoe C. The relevance of postcolonial theoretical perspectives to research in Aboriginal health. Canadian Journal of Nursing Research 2005, 37: 16-37.

36.Freire P. Educação e Mudança [Education and Change], 23rd ed. Rio de Janeiro: Paz e Terra, 1991.

37.Antonovsky A. Unravelling the Mystery of Health, How People Manage Stress and Stay Well. San Francisco: Jossey Bass, 1987.

38.Antonovsky A. The salutogenic model as a theory to guide health promotion. Health Promotion International 1996, 11: 11-18.

39.Freire P. Educação como Prática da Liberdade [Education as Practice of Freedom], 23rd ed. Rio de Janeiro: Paz e Terra, 1999.

40.McGregor D. Traditional ecological knowledge: an Anishnabe woman's perspective. Atlantis 2005, 29: 1-10.

41.Berkes F. Sacred Ecology, 2nd ed., New York: Routledge, 2008.

42.Denzin NK, Lincoln YS, Smith LT. Critical and Indigenous pedagogies. In: Denzin NK, Lincoln YS, Smith LT (eds). Handbook of Critical and Indigenous Methodologies. Thousand Oaks: Sage, 2008; 211-215.

43.Grande S. American Indian identity and intellectualism: the quest for a new red pedagogy. International Journal of Qualitative Studies in Education, 13: 343-59.

44.Battiste M. Indigenous knowledge: foundations for First Nations. Available from URL: http://142.25.103.249/integratedplanning/documents/IndegenousKnowledgePaperbyMarieBattistecopy.pdf Accessed July 5 2016.

45.Richmond C., Ross N. Social support of material circumstance and health behaviour: influences on health in First Nation and Inuit communities of Canada. Social Science & Medicine 2008, 67: 1423-1433.

46.Tousignan M., Sioui N. Resilience and Aboriginal communities in crisis: theory and interventions. Journal of Aboriginal Health 2009, 5: 43-61.

47.Fleming J., Ledogar RJ. Resilience and indigenous spirituality: a literature review. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 2008, 6:47-64.

48.Grande S. Red pedagogy: the un-methodology. In: Denzin NK, Lincoln YS, Smith LT (eds). Handbook of Critical and Indigenous Methodologies. Thousand Oaks: Sage, 2008; 233-254.

49.Giroux HA, Giroux SS. Challenging neoliberalism's new world order: the promise of critical pedagogy. In: Denzin NK, Lincoln YS, Smith LT (eds). Handbook of Critical and Indigenous Methodologies. Thousand Oaks: Sage, 2008; 181-189.

50.Shor I, Freire, P. Medo e Ousadia: O Cotidiano do pProfessor. (Fear and Audacity: The Teacher's Daily Work. Rio de Janeiro: Paz e Terra, 1986.

51.Cyrulnik B, Jorland G. Résilience- Connaissances de Base. Paris: Odile Jacob, 2012.

52.Kirmayer LJ, Sehdev M, Whitley R, Dandeneau, SF, Isaac C. Community resilience: models, metaphors and measures. Journal of Aboriginal Health, 2009, 5: 62-117.

53.Morrow RA., Torres CA. Reading Freire and Habermas: Critical Pedagogy and Transformative Social Change. New York: Teacher College Press, 2002.

54.Lincoln Y, Guba E. Establishing trustworthiness. In: Bryman A, Burgess RG (eds.). Qualitative Research. Vol III. Thousand Oaks: Sage, 1999; 397-444.

55.Creswell JW. Qualitative Inquiry and Research Design: Choosing among Five Traditions. (2nd ed.) Thousand Oaks, CA: Sage, 2007.

56.Miles MB, Huberman AM, Saldaña S. (2014). Qualitative Data Analysis: A Methods Sourcebook (3rd ed.). Thousand Oaks: Sage, 2014.

57.Altheide DL, Johnson JM. Criteria for assessing interpretative validity in qualitative research. In: Denzin NK, Lincoln YS (eds.). Collecting and Interpreting Qualitative Materials. Thousand Oaks: Sage, 1998; 283-312.

58.Main D, Nichol R, Fennell R. Reconciling pedagogy and health sciences to promote Indigenous health. Australian and New Zealand Journal of Public Health, 2000, 24: 211-213.

59.Kryzanowski J., McIntyre L. A holistic model for the selection of environmental assessment indicators to assess the impact of industrialization on indigenous health. Canadian Journal of Public Health 2011, 102: 112-117.

60.Cargo M., Peterson L., Levesque L., Macaulau A. Perceived wholistic health and physical activity in kanien'keh:ka youth. Primatisiwin: A Journal of Aboriginal and Indigenous Community Health 2007, 5: 87-109.

61.Maar MA, Seymour A., Sanderson B., Boesch L. Reaching agreement for an Aboriginal e-health research agenda: the Aboriginal telehealth knowledge circle consensus method. Rural and Remote Health Journal 2010, 10, 1299. Epub 2010 Jan 27.

62.Alfred GT. Colonialism and state dependency. Journal of Aboriginal Health 2009, 5: 42-60.

63.McCalman J., Tsey K., Clifford A., Earles W., Shakeshaft A., Bainbridge R. Applying what works: a systematic search of the transfer and implementation of promising Indigenous Australian health services and programs. BMC Public Health 2012, 12: 1-7.

64.Mikkonen J., Raphael D. 2010. Social determinants of health: the Canadian facts. Available from URL: http://www.thecanadianfacts.org/The_Canadian_Facts.pdf. Accessed 6 March 2013.

65.World Health Organization. 2008. Closing the gap in a generation. Available from URL: http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf. Accessed 20 April 2012.

66.Canadian Health Services Research Foundation. 2012. Harkness Canadian health policy briefing tour backgrounder. Available from URL: http://www.chsrf.ca/Libraries/Harkness/2012HarknessBackgrounder-EN.sflb.ashx Accessed 5 January 2013.

67.World Health Organization. 2010. Equity, social determinants and public health programmes. Available from URL: Http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf. Accessed 20 April 2012.

68.Reading C. Wien F. 2009. Health inequities and social determinants of Aboriginal peoples' health. National Collaborating Centre for Aboriginal Health. Available from URL: http://www.nccah-ccnsa.ca/docs/social%20determinates/NCCAH-Loppie-Wien_Report.pdf. Accessed 20 April 2012.

69.Indigenous and Northern Affairs of Canada. Urban Aboriginal peoples. Available from URL: http://www.aadnc-aandc.gc.ca/eng/1100100014265/1369225120949 Accessed 7 July 2016.

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