Decolonizing our Food Systems: Narrative Inquiry into the Barriers to Accessing Foods that Reverse Chronic Diseases.

Authors

Name: Nicolette Richer
Title: MAEEC, PhD Candidate
Institution/Organization: Sea to Sky Thrivers Society
Email: nicolette@richerhealth.ca

Corresponding Author

Name: Nicolette Richer
Institution/Organization: Sea to Sky Thrivers Society
Telephone: 604-902-7238
Email: nicolette@richerhealth.ca

Authorship Statement

I, Nicolette Richer, hereby confirm that the author listed above has contributed significantly to the research, analysis, and development of the article enclosed in this journal article submission. Furthermore, I confirm that I am the sole author of the article and have granted permission for the final version to be published.

Original Submission Statement

I, Nicolette, hereby confirm that to the best of my knowledge, the work presented in the manuscript has not been published elsewhere and is not currently being considered by another journal.

Potential Peer Reviewers

All submissions require the authors to suggest four potential peer reviewers – two that are university based and two that are community based.

University-based

1. Name: Russell Johnston
   Institution/Organization: Royal Roads University
   Email: Russell.Johnston@royalroads.ca

2. Name: Tracy Underwood
   Institution/Organization: University of Victoria
   Email: trunderwood@uvic.ca

Community-based

1. Name: Cheximiya Allison Burns Joseph
   Institution/Organization: Squamish Lil'wat Culture Centre
   Email: allison.burnsjoseph@slcc.ca

2. Name: Dan Wilson
   Institution/Organization: Whistler Centre for Sustainability
   Email: DWilson@whistlercentre.ca

Acknowledgements

I would like to thank our colleagues at the Royal Roads University for their helpful comments and discussions throughout the course of this research. Additionally, I am grateful to the anonymous reviewers for their insightful comments and suggestions, which helped to improve the quality of this manuscript. I extremely grateful to all the individuals who offered their writing assistance and general support. Lastly, I would like to extend my heartfelt thanks to every participant for generously volunteering their time and energy to participate in this study. Without their willingness to share their invaluable contributions, experiences and insights, this research would not have been possible.

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Abstract

This study examines the obstacles that Indigenous, Black, and People of Color (BIPOC) face when attempting to obtain fresh, clean, traditional, whole foods that have the potential to prevent and reverse chronic diseases. Chronic degenerative diseases have become more prevalent over the past eight decades, particularly among BIPOC populations, with rates that are four to eight times higher than those of non-BIPOC individuals. The study utilized Indigenous Research Methods and Narrative Inquiry to interview nine participants with expertise in chronic disease reversal, nutritional health, and food security.

The findings suggest that the underlying factors contributing to chronic degenerative diseases among BIPOC populations are not merely a function of individual-level characteristics, such as age, race, gender, obesity, genetics, or lack of exercise, as identified by Canadian and USA agencies. Rather, these diseases have much more complex and systemic origins, and data shows that the underlying causes of these diseases are rooted in historical trauma resulting from colonization and displacement of BIPOC peoples from their traditional lands, ancestors, cultures, and traditional knowledge systems.

The study emphasizes the need for a comprehensive, systemic approach to chronic disease prevention and management that addresses these root causes rather than focusing solely on individual-level risk factors. By doing so, this approach has the potential to mitigate the incidence and prevalence of these diseases and promote health equity for BIPOC communities.

Keywords

Indigenous
Black
People of Color
Chronic Disease Reversal
Traditional Whole foods
Colonization
Trauma
Health Equity

Glossary

Black, Indigenous, People of Colour (BIPOC)

Introduction

We are facing a chronic disease crisis that disproportionately affects members of the Canadian population. The International Diabetes Federation has declared diabetes "one of the most challenging health problems in the 21st century." (Tiwari, 2015, p. 7). This is the first time in history that humans face rates at these levels and diabetes is projected to increase globally by 214% from 2000 to 2030 (Leung, 2016).

A Public Health Agency of Canada (PHAC) study completed in 2018 stated that in comparison to non-Indigenous adults, "the prevalence of Type 1 and Type 2 diabetes combined is nearly three times greater for First Nations adults living on reserve and in northern communities, and two times greater for First Nations adults living off reserve" (Halseth, 2019, p. 7).

According to Halseth (2019) "Indigenous Peoples in Canada bear a disproportionate burden of diabetes due to the complex interaction of multiple determinants of health, many of which are rooted in colonial processes and structures that have altered socio-economic, political and cultural systems" (p. 7).

Fortunately, the Canadian Federal Government is finally addressing the connection between diet and disease. As of 2019, the Canadian food guide recommends higher consumption of unprocessed carbohydrates, fresh fruits, vegetables and whole grains and lower consumption of processed carbohydrates, meat, dairy, and other refined foods to help manage and lower chronic disease rates in Canada (Barr, 2019). While the new food guide cannot be everything to everyone, one major downfall is that the guide does not consider cultural, social, economic, and historical factors specific to BIPOC members.

According to Young et al. (1990, 2000), "while diabetes was rare among the Aboriginal population in North America prior to 1940, the rates increased rapidly after 1950 and have now reached epidemic levels in some communities" (p. 561). Traditional Ecological Knowledge (TEK) methodologies have played a significant role in preventing lifestyle diseases like diabetes and heart disease in Indigenous communities for centuries. My research investigates that if BIPOC communities return to traditional decolonized diets, and non-BIPOC members follow suit to remember and live by TEK methodologies, the incidence and prevalence of chronic diseases can decrease to pre-1940 rates in Canada.

Methods

This project used narrative inquiry with Indigenous research methods and the framework Indigenous wholistic theory to explore the barriers that BIPOC populations face in accessing foods that can reverse chronic lifestyle diseases. These methods and framework are supported by scholars such as Clandinin (2006), who argues that narrative inquiry is an effective means of understanding the lived experiences of individuals and communities. Narrative inquiry allows participants to share their stories and experiences in their own words and in a way that reflects their unique historical and cultural contexts and perspectives that underlies these issues and can help to identify potential solutions that are grounded in community values and practices.

Additionally, Absolon (2010) emphasizes the importance of using Indigenous methodologies, including storytelling, to conduct research with Indigenous communities, as it prioritizes Indigenous ways of knowing and being. This approach can capture multiple voices and provide a more nuanced understanding of the complex issues surrounding food access and health in BIPOC communities. Furthermore, San Pedro and Windchief (2019) assert that using Indigenous wholistic theory as a framework for research can provide a more comprehensive understanding of health and well-being from an Indigenous perspective.

In the context of researching barriers to accessing traditional foods, narrative inquiry can capture multiple voices with lived and academic experience in the field of food sovereignty, chronic disease reversal, and traditional foods as medicine. By prioritizing the knowledge and experiences of BIPOC individuals, Indigenous research methods ensure that the voices of those most impacted by food insecurity and chronic disease are centered in the research process. Additionally, using Indigenous wholistic theory as a framework recognizes the interconnectedness of health, culture, and the environment, and emphasizes the importance of understanding these factors when exploring barriers to accessing traditional foods.

By using these qualitative methods and framework, the research was able to gain a deeper understanding of the complex relationships between history, food, health, culture, and the environment, which can then develop interventions that are culturally appropriate and relevant to BIPOC communities.

Methodological Approach

The methodological approach adopted for this research was centered on knowledge mobilization, which aimed to actively engage with participants and disseminate the research findings through multiple channels. To achieve this, the research utilized a qualitative approach, where nine participants were interviewed for 90 minutes each. The data collected through these interviews was then used to produce a synthesized dissertation paper, a podcast series, a TED talk, and this academic journal article, all of which are hosted on a public website, ensuring that the research findings remain available to a broader range of individuals beyond the confines of academia.

The choice to utilize these knowledge mobilization outputs was motivated by the aim of reaching a wide array of audiences and effectively conveying the research findings to those beyond the academic sphere who may not have privileged access to this knowledge. Academic podcasts have become an increasingly popular medium and have the potential to spread research discoveries, highlight scholarly proficiency, and connect with wider untapped audiences. (DeMarco, 2022; Harter, 2019; Udovicich et al., 2018).

The TED talk was chosen as a knowledge mobilization output because it has been shown to be an effective platform for communicating research findings to a broad audience (Rice, 2018; Anderson, 2016; Anderson, 2013). Finally, the academic journal article was chosen as a traditional knowledge mobilization output to ensure that the research findings were disseminated to the academic community (Udovicich et al, 2018; Verhagen et al, 2014).

Overall, the use of multiple knowledge mobilization outputs was essential for ensuring that the research findings on the barriers that BIPOC face in accessing healthy foods that can reverse chronic diseases were disseminated to and impactful on a diverse range of audiences, both the academic and non-academic.

Data Generation and Analysis

This project generated knowledge through one set of qualitative interviews with nine research participants. Purposeful criteria sampling was used to select the expert participants using a specific strategy of criteria sampling (Miles and Huberman, 1994; Çirakli and Özbay, 2020). As the study looked to move beyond the established risk factors of obesity, smoking, alcohol consumption and diet for lifestyle chronic diseases and better understand these conditions as a symptom of colonization, trauma and abuse, and disenfranchisement from the land, this study used the following criteria to select participants:

- Expertise in the field of metabolic nutrition;
- Knowledge and expertise in the fields supporting Indigenous health;
- Direct experience in both these fields with BIPOC populations; and
- Recognition of participants within BIPOC communities as experts.

Selecting participants according to these criteria ensured that this study produced decolonized results that are accepted as a valid way of knowing by the community members they intend to serve (Smith, 2012). The data was collected using storytelling and open-ended interviews (Connelly and Clandinin, 1990).

One set of storytelling, open-ended, qualitative interviews (Seidman, 1991; Connelly and Clandinin, 1990) was conducted as a collaboration between the participants and the researcher. Nine participants - seven BIPOC members and two non-BIPOC individuals who had direct experience working and living their entire lives in BIPOC communities - all had experience in the fields of Indigenous health, nutrition and disease reversal, food security, soil regeneration, and mental health. The storytelling interviews lasted between 90 and 120 minutes to provide ample time for the participants to share all of their stories that they felt were relevant to this project. The interviews were conducted over Zoom and were both audio and video recorded. Completing the interviews remotely enabled access to participants from all over North America, reduced research costs, and prevented any further delays and COVID-19 safety concerns. Each interview began with an open-ended question followed by additional lines of questioning which was determined by the participant's narratives.

The interviews were recorded and transcribed. The interviews used thematic analysis using line by line open coding to allow patterns, concepts and ultimately themes to emerge from the qualitative data set (Parameswaran, 2019; Corbin and Strauss, 2015; Chilisa, 2019). Following all analysis, the themes relevant to the research question were retained to provide a framework for organization and discussion and to report on the findings (Clarke et al., 2015).

Relationships

The researcher is an Indigenous female coming from the remote village of Chiradzulu, Malawi, Africa. She is of mixed race–her mother is half Pakistani and half Malawian, and her biological father is Austrian. In Malawi, her family were subsistence farmers and food was not only used as medicine – it was used as fuel for hard-working bodies, for ceremony, celebration and comfort, and for simply staying alive. At age four, the researcher immigrated to British Columbia, Canada, where she has since lived. At 19, she began her extensive interdisciplinary studies into food systems and security, nutrition, chronic disease, agriculture, women's studies, Indigenous health, and environmental health.

The researcher has more than fifteen years of experience running several different businesses and a charity that works closely with BIPOC communities. The businesses are centered around using metabolic nutrition and traditional whole foods to support clients in successfully reversing their diagnosed chronic disease. After completing her pre-med sciences and passing the Medical College Admission Test (MCAT), she chose to not pursue a degree in medicine and instead followed the path of working with BIPOC communities, teaching physicians, dieticians, naturopaths, and other healthcare practitioners the science and art of using metabolic nutrition to reverse lifestyle chronic diseases.

This research is an act of love and care for her Malawian grandmother and a responsibility that she feels the need to carry forward. It is the researcher's duty as an Indigenous person to preserve valid knowledge and ways of knowing and life stories. This research will help to preserve an aspect of history that would otherwise be lost.

Ethical Protocol

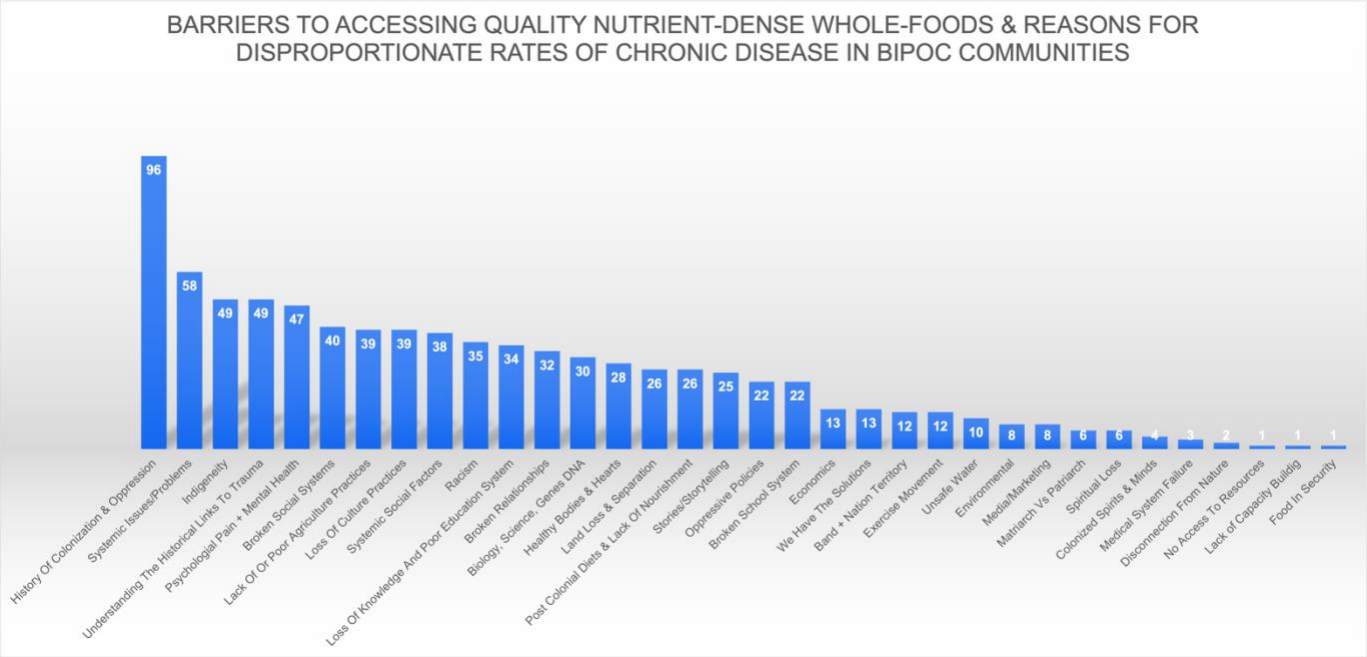
This research was reviewed by the ethics committee at Royal Roads University. BIPOC communities and TEK research have codes of practice that extend beyond the ethical protection of individual participants and extend into the interconnected space between human communities and their ecosystems, seeking to respect the need to maintain and pass on knowledge received through generations. Respect for Persons was achieved by ensuring the voluntary, informed, and ongoing consent of participants throughout the duration of the research.

This project acknowledges the central role of Indigenous communities and leaders in promoting the welfare and interests of both individuals and broader communities (Chilisa, 2019). The study focused on interviewing individuals who were sharing their personal experiences and knowledge related to food sovereignty, chronic disease reversal, and traditional foods as medicine. Therefore, community approval was not necessary, as participants were not speaking on behalf of a wider community. However, ethical considerations were still considered.

Results

The Canadian and USA health agencies have identified age, genetics, obesity, race, and gender as key risk factors for lifestyle chronic diseases. However, the results from this research study challenges these risk factors and suggests that chronic diseases, particularly those affecting BIPOC communities, are not solely attributable to these individual-level factors. Participants in the study reported that the root causes of these diseases are much more complex and systemic and must be addressed to meaningfully reduce the incidence of chronic diseases. Overall, the participants identified 35 different barriers to accessing healing foods and matters that first need to be addressed in managing and treating chronic diseases in BIPOC communities. Table 1 below presents a clear and concise overview of the themes extracted from the narrative inquiry interviews with participants from BIPOC communities. The chart displays how often the participants mentioned the various reasons for the disproportionate rates of chronic diseases and the barriers to accessing quality nutrient dense foods in their communities.

Table 1 Frequency of Themes Mentioned Regarding Barriers to Accessing Quality Nutrient-Dense Whole-Foods & Reasons For Disproportionate Rates Of Chronic Disease In BIPOC Communities.



The table's layout allows for easy comparison of the frequency of each theme, making it simple to identify the most mentioned reasons and barriers. The information presented in this table provides valuable insight into the experiences and perceptions of individuals from BIPOC communities regarding chronic disease and food access disparities.

The findings of this study suggest that chronic disease risk is intimately linked to historical and ongoing processes of colonization and oppression, and that healing from these diseases is a multifaceted problem that cannot be solved through individual-level interventions alone. Participants emphasized the importance of recognizing and respecting Indigeneity, starting first and foremost with addressing the intergenerational trauma associated with the systemic racism and oppression experienced directly through colonization. As well as addressing the loss of indigeneity and instilling culturally appropriate methods for healing from trauma, participants noted that making space for the re-emergence of lost social and cultural practices that were taken away from BIPOC communities is critical to successfully managing and treating chronic diseases.

In addition, participants reported that addressing mental, emotional, psychological, spiritual health is a critical component of chronic disease prevention and treatment. By prioritizing mental health and well-being and recognizing the ways in which chronic diseases intersect with mental health and spiritual oppression, it may be possible to mitigate some of the systemic causes of these diseases.

As is often touted, “a picture is worth a thousand words”, Image 1 presents the results of the themes extracted from the narrative inquiry interviews with participants from BIPOC communities in the form of a word cloud. The size of each word in the cloud represents the frequency with which it was mentioned by the participants and the layout of the word cloud makes it easy to identify the most salient themes at a glance, providing a useful tool for researchers and policymakers seeking to better understand the experiences and perspectives of

individuals. Overall, the word cloud in Image 1 offers a compelling and insightful illustration of the key themes and issues identified in the narrative inquiry interviews.

Image 1 Frequency of Themes Mentioned Regarding Barriers to Accessing Quality Nutrient-Dense Whole-Foods & Reasons For Disproportionate Rates Of Chronic Disease In BIPOC Communities.

The study findings indicate a significant gap in the responses of participants regarding the commonly cited risk factors for chronic diseases, including age, race, gender, ability, genetics, and exercise, which are frequently highlighted by government health authorities. This discrepancy points to the inadequacy of current policies and interventions that primarily concentrate on these risk factors for chronic disease management and treatment. The absence of these factors suggests that the root causes of chronic diseases in BIPOC communities are more intricate and multifaceted than what policymakers currently recognize.

This knowledge gap undermines the development and implementation of effective solutions to address health disparities experienced by BIPOC communities. These observations emphasize the need for adopting a holistic, systemic approach to chronic disease prevention and management that addresses the complex historical and ongoing processes that contribute to the development of these diseases. Such an approach can reduce the incidence of chronic diseases and promote health equity for BIPOC communities.

Limitations

Narrative inquiry was used as a qualitative research approach to focus on the collection and analysis of stories and narratives to understand the lived experiences of individuals and groups. While this narrative inquiry can be valuable in uncovering rich and nuanced data, there are several limitations that need to be considered. Subjectivity is a common limitation as it relies heavily on the researcher's interpretation of the participant's stories. This means that the same data collected could be interpreted in different ways by other researchers which could affect the validity and reliability of the research. As the research focused on nine specific individuals and

their unique experiences and knowledge, the findings cannot be generalizable to other populations or contexts.

As this research relies on participants to share their stories or narratives, the researcher has limited control over the data collection process which made it impossible to guarantee that all relevant information was gathered. The researcher also acknowledges that she is inherently biased as the result of her own personal knowledge, experiences and desires that surround this research which affect the interpretation of the data, and which can affect the validity and reliability of the research. The research was also time-consuming and resource intensive and involved collecting and analyzing over 190 pages of data and 18 hours of interviews that only involved 9 participants. It would have been difficult to conduct this study as a large-scale study as financial and time resources would have been restricted.

Overall, despite the limitations outlined, the researcher took the following necessary steps to ensure that the data was collected and analyzed in a rigorous and systematic way. Multiple sources of data were used to ensure that the data collected was comprehensive and reliable. This included the interviews and doing a comprehensive literature review to triangulate the data and increase the validity of the research. A systematic approach was developed for conducting the data collection and analysis and a set of interview questions and a coding framework for analyzing the data was developed to ensure that all relevant information was gathered and analyzed in a consistent and rigorous manner. The researcher also used reflexivity to help uncover her own biases and assumptions which helped to critically reflect on her own experiences, beliefs, and values that may have influenced the interpretation of the data. Lastly, the researcher sought feedback from the participants, and colleagues, and had two other researchers code the same data to see if the results ended up being similar—which it was. This helped to ensure that the data was collected and analyzed accurately and reflected the experiences of the participants. This also helped to increase the trustworthiness and credibility of the research.

Discussion

The Canadian and USA health agencies have identified age, genetics, obesity, race, and gender as key risk factors for lifestyle chronic diseases. However, this research project challenges these risk factors which suggests that these chronic diseases, particularly those affecting BIPOC communities, are not solely attributable to these individual-level factors. Rather, participants in the study reported that the root causes of these diseases are more complex and systemic and must be addressed to meaningfully reduce the incidence of chronic diseases across North America.

The findings of this study suggest that chronic disease risk is intimately linked to historical and ongoing processes of colonization and oppression, and that healing from these diseases is a multifaceted problem that cannot be solved through individual-level interventions alone (Kirmayer et al., 2011; Sharma et al., 2017; Methot, 2019). Participants emphasized the importance of recognizing and respecting indigeneity, starting first with addressing the trauma associated with colonization and loss of indigeneity, and making space for the re-emergence of social and cultural practices that have been taken away from BIPOC communities (Brave, 2003; Tuck & Yang, 2012).

In addition, participants reported that addressing mental health is a critical component of chronic disease prevention and management. By prioritizing mental health and well-being and

recognizing the ways in which chronic diseases intersect with mental health, it may be possible to mitigate some of the systemic causes of these diseases (Steptoe et al., 2013; Chen et al., 2019).

Taken together, these findings highlight the importance of adopting a holistic, systemic approach to chronic disease prevention and management. Rather than focusing exclusively on individual-level risk factors, it is essential to recognize and address the complex historical and ongoing processes that give rise to chronic diseases in the first place. By doing so, it may be possible to meaningfully reduce the incidence of these diseases and promote health equity for BIPOC communities.

Conclusion

The potential uses and users of the knowledge presented from a narrative inquiry study that identified multiple root causes of chronic diseases among BIPOC communities are numerous and diverse. The findings of this research have the potential to inform policy, practice, and advocacy efforts aimed at promoting health equity and reducing health disparities among BIPOC communities.

Firstly, policymakers at the local, state and federal levels could use the findings of this research to inform the development of policies and programs that address the root causes of chronic diseases among BIPOC communities. By prioritizing the six root causes identified in the study, policymakers could take a more holistic and systemic approach to chronic disease prevention and management, rather than focusing solely on individual-level risk factors.

Secondly, healthcare practitioners and public health professionals could use the findings of this research to develop more effective interventions for chronic disease prevention and management among BIPOC communities. By addressing the root causes of chronic diseases, healthcare practitioners could better tailor their interventions to the specific needs and experiences of BIPOC patients.

Thirdly, community-based organizations could use the findings of this research to develop culturally sensitive and responsive interventions that promote healing and well-being among BIPOC communities. By making space for the reemergence of social and cultural practices that were taken away from BIPOC people, community-based organizations could empower BIPOC communities to take control of their health in ways that align with their cultural traditions and practices.

Lastly, researchers could use the findings of this research to further explore the complex interplay between historical and ongoing processes of colonization and oppression, trauma, mental health, and chronic disease among BIPOC communities. By building on this research, researchers could deepen our understanding of the root causes of chronic diseases among BIPOC communities and develop more effective interventions for promoting health equity and reducing health disparities.

Overall, the findings of this research have the potential to inform and shape policy, practice, and advocacy efforts aimed at reducing health disparities among BIPOC communities and promoting health equity. By prioritizing the dozens of root causes identified in the study, stakeholders could take a more holistic and systemic approach to chronic disease prevention and management, and work towards promoting health equity and social justice.

References

Absolon, K. (2010). Indigenous Wholistic Theory: A knowledge set for practice. *First Peoples Child & Family Review: An Interdisciplinary Journal Honouring the Voices, Perspectives, and Knowledges of First Peoples through Research, Critical Analyses, Stories, Standpoints and Media Reviews*, *5*(2), 74-87.

Anderson, C., & Duarte, N. (2013). How to give a killer presentation. *Harvard business review*, *91*(6), 121-125.

Anderson, S., & Hamilton, J. (2016). The theory and practice of 21st century pedagogies in the oral history classroom. *Oral History Education*, *25*, 142-149.

Barr, S. I. (2019). Is the 2019 Canada's food guide snapshot nutritionally adequate? *Applied Physiology, Nutrition, and Metabolism*, *44*(12), 1387-1390.

Brave Heart, M. Y. H. (2003). The historical trauma response among natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, 35(1), 7-13. https://doi.org/10.1080/02791072.2003.10399988

Chen, A. T., Roberts, C., & Barnhill, A. (2019). "Why do they give the injection?': Actively engaging American Indian/Alaska Native families in the development of culturally responsive asthma interventions. *Journal of Asthma*, 56(2), 192-202.

Chilisa, B. (2019). *Indigenous research methodologies*. Sage publications.

Çirakli, M. Z., & Özbay, A. S. (2020). A Narrative Inquiry into Spatial Experience: Learners Recollections from pre-COVID-19 Classroom Setting. *Journal of Pedagogical Research*, *4*(4), 508-531.

Clandinin, D. J. (2006). Narrative inquiry: A methodology for studying lived experience. *Research studies in music education*, *27*(1), 44-54.

Clarke, V., Braun, V., & Hayfield, N. (2015). Thematic analysis. *Qualitative psychology: A practical guide to research methods*, *222*, 297-298.

Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry. *Educational researcher*, *19*(5), 2-14.

Corbin, J., & Strauss, A. (2018). Basics of qualitative research. Thousand Oaks, us.

DeMarco, C. (2022). Hear Here! The Case for Podcasting in Research. *Journal of Research Administration*, *53*(1), 30-61.

Halseth, R. (2019). *The prevalence of type 2 diabetes among First Nations and considerations for prevention*. Prince George, BC: National Collaborating Centre for Aboriginal Health.

Harter, L. M. (2019). Storytelling in acoustic spaces: Podcasting as embodied and engaged scholarship. *Health Communication*, *34*(1), 125-129.

Kirmayer, L. J., Dandeneau, S., Marshall, E., Phillips, M. K., & Williamson, K. J. (2011). Rethinking resilience from indigenous perspectives. *Canadian Journal of Psychiatry*, 56(2), 84-91. https://doi.org/10.1177/070674371105600203

Leung, L. (2016). Diabetes mellitus and the Aboriginal diabetic initiative in Canada: An update review. *Journal of Family Medicine and Primary Care*, *5*(2), 259. https://doi.org/10.1016/j.jcjd.2016.02.021

Methot, S. (2019). *Legacy: Trauma, story, and Indigenous healing*. ECW Press.
Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.
Parameswaran, A. (2019). Enabling data science for the majority. *Proceedings of the VLDB Endowment*, *12*(12), 2309-2322.
Rice, C., & Mündel, I. (2018). Story-making as methodology: Disrupting dominant stories through multimedia storytelling. *Canadian Review of Sociology/Revue canadienne de sociologie*, *55*(2), 211-231.
Seidman, I.E. (1991). Interviewing as qualitative research. *Teachers College Press*. New York
Sharma, M., Romas, J. A., & Holle, M. J. (2017). *Theoretical foundations of health education and health promotion* (3rd ed.). Jones & Bartlett Learning.
Smith, L. T. (2012). *Decolonizing methodologies: Research and Indigenous peoples*. London, UK: Zed Books.
Steptoe, A., & Kivimäki, M. (2013). Stress and cardiovascular disease. *Nature Reviews Cardiology*, 9(6), 360-370. https://doi.org/10.1038/nrcardio.2013.46
Tiwari P. (2015). Recent Trends in Therapeutic Approaches for Diabetes Management: A Comprehensive Update. *Journal of Diabetes Research*. DOI: 10.1155/2015/340838.
Tuck, E., & Yang, K. W. (2012). *Decolonization is not a metaphor*. Decolonization: Indigeneity, Education & Society, 1(1), 1-40.
Udovicich, C., Kasivisvanathan, V., & Winchester, C. L. (2018). Communicating your research (part 2): to the wider community. *Journal of Clinical Urology*, *11*(3), 208-214.
Verhagen, E., Bower, C., & Khan, K. M. (2014). How BJSM embraces the power of social media to disseminate research. *British Journal of Sports Medicine*, *48*(8), 680-681.
Windchief, S., & San Pedro, T. (2019). *Applying Indigenous research methods*. New York, United States: Routledge.
Young, T. K., Reading, J., & Elias, B. (2000). Type 2 diabetes mellitus in Canada's First Nations: status of an epidemic in progress. *Cmaj*, *163*(5), 561-566.
Young, T. K., Szathmary, E. J., Evers, S., & Wheatley, B. (1990). Geographical distribution of diabetes among the native population of Canada: a national survey. *Social Science & Medicine*, *31*(2), 129-139.