Decolonizing Diabetes

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Abstract

This article presents insights into the colonial experience of Indigenous Peoples living with type 2 diabetes within seven First Nation communities in Northern Ontario. A constructivist grounded theory methodology guided by a decolonizing approach to conducting research with Indigenous Peoples was used in this study. Twenty-two individuals with type 2 diabetes were interviewed. The main research question explored the impact of colonization on the lived experience and perceptions about developing type 2 diabetes for Indigenous Peoples. Using semi-structured interviews, the three main categories that emerged from the analysis of the interview transcripts were changing ways of eating, developing diabetes, and choosing your medicine. A substantive theory was developed that suggests that Indigenous Peoples living with type 2 diabetes often live with the perception that there is ‘no going back’ to the way things once were prior to European contact whether one wanted to or not. As a result, they have adapted the way they live with diabetes which can, at times, be at odds with Indigenous world views. An adaptation that considers a complementary approach to the way individuals live and manage diabetes including both Traditional and Western ways may provide a framework for a decolonized model of type 2 diabetes care for Indigenous Peoples.

Keywords

Type 2 Diabetes, Indigenous Peoples, Colonization, Colonization, Cultural Safety, Decolonization

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Introduction

Diabetes and its complications have a disproportionate impact on Indigenous Peoples around the world (Crowshoe et al., 2018). A “radical redefinition of what diabetes is and what it represents for Indigenous people” is necessary (Ferreira & Lang, 2006, p. 8). What also seems to be lacking is greater emphasis on the prevention of this disease. Rice et al., (2016) have suggested that “community ownership of the intervention was found to be essential for project success” however “diabetes-focused intervention research in Indigenous communities appears to be a low priority for Canadian funders and policymakers” (p. 217). The conventional way of treating diabetes has been mostly through a western biomedical approach which has, to some extent, been quite successful and necessary (Diabetes Canada, 2018). This method however is rooted in colonial western approaches and often excludes Traditional ways of knowing (Fortier, 2017; Socha et al., 2012; Waziyatawin & Yellow Bird, 2012).

Colonization, which continues today, is the outcome of centuries of oppression and marginalization of Indigenous Peoples and should not be understood as a temporal concept. Rather it should be viewed as a way of critically explaining the ways in which Indigenous Peoples were impacted in the past and how this continues to be so today, particularly as it relates to diabetes care (Cote-Meek, 2014). Given that there is overwhelming evidence that such events are ongoing for Indigenous Peoples, colonization should be given particular attention when trying to understand what it is like to be an Indigenous person living with type 2 diabetes. (Manitowabi & Maar, 2013).

Corntassel (2012) contends that colonization is a ‘disconnecting force’ whereas “decolonization offers different pathways for reconnecting Indigenous nations with their traditional land-based and water-based cultural practices” (p. 89). The significance of acknowledging colonialism as well as promoting self-determination are both important elements of decolonization (Smith, 1999).

For most health care providers diabetes is most commonly considered from a medical perspective (Ferreira & Lang, 2006) and much less so from a social, political, systemic or cultural perspective (Maar et al. 2011a). It is with this view in mind that this study was undertaken in order to better understand the extent to which colonization has impacted Indigenous Peoples living with type 2 diabetes in seven First Nation communities in Northern Ontario. The aim of this study was to explore the complex relationship between type 2 diabetes as a disease in relation to Indigenous culture and colonization in a northern and rural setting.

Methods

Historically the traditional Western approach to conducting research has led to a culture of mistrust and resentment among many Indigenous people because often research is conducted on them rather than with them (Fortier, 2017; Koch & Kralik, 2006; Martin & Mirraoop, 2003; Waldram et al., 2007; Wilson, 2008). This position was perhaps best articulated by Smith (1999) who wrote: “research is probably one of the dirtiest words in the indigenous world’s vocabulary” (p. 1). Therefore, “there is an urgent need for the perspectives of Indigenous Peoples to be adopted and valorized in the research process” (Bartlett et al., 2007, p. 2372). Being aware of this perspective is essential if research is to be conducted in a meaningful and culturally safe manner (Browne et al., 2006).

There is an increasing body of work promoting Indigenous ways of knowing and challenging the traditional ways of conducting research with Indigenous Peoples (Battiste, 2000, 2008; Brown & Strega, 2005; Cochran et al., 2008; Fortier, 2017; Laenui, 2000; Prior, 2007; Zavala, 2013). There has also been a growing body of work documenting the benefits of community participation in prevention (Satterfield et al., 2003) and the positive outcomes of Community Based Participatory Research (CBPR) approaches to diabetes research with Indigenous populations throughout the world (Famer et al., 2015; Rice, Hiwi, Zwarenstein, Lavalley, Barre, & Harris, 2018; Tremblay et al., 2018). According to the Canadian Institute of Health Research [CIHR] Guidelines for Conducting Health Research with Aboriginal Peoples, communities should be provided with the opportunity for a participatory research approach (Government of Canada, 2014).

Although this study did not use a CBPR approach, there was engagement with key community stakeholders on an ongoing basis throughout the entire research process. With collaboration in mind, there was a continuous sharing of authority and whenever possible, responsibility for the project (McHugh & Kowalski, 2009). The central research question that emerged was: *What is the impact of colonization on the lived experience and perceptions about developing type II diabetes for Aboriginal peoples living along the North Shore of Lake Huron?*

Initial consultations with the communities regarding this project began in 2009. Approval to conduct this study was obtained from the Tribal Council First Nation communities before proceeding to the university ethics review process. According to Maar and collaborators, (2011), “adhering to a proper process of gaining community authorization for a study, which requires permission from the community leadership, is essential” (p. 751). The engagement with the communities and the Tribal Council took place between 2009 and currently continues in the form of ongoing community presentations and consultations.

This study employed a constructivist grounded theory approach (Charmaz, 2016) and grounded in decolonization theory which supported by the idea that human beings generate meaning through the way they interpret their experiences and ideas (Koch & Kralik, 2006; Minkler & Wallerstein, 2008; Sium, A., Desai, C., & Ritskes, E. 2012). This approach promoted a shift from gathering data on oppressed people, to carrying out research with participants, “placing capabilities in the hands of disenfranchised people so they can transform their lives themselves (Koch & Kralik, 2006, p. 12).

For the purposes of this study, constructivism is viewed as the research approach in which the researcher was situated, and grounded theory was used as a method of analysis of the data (Charmaz, 2014). When utilizing a constructivist approach the assumption being made is that the researcher comes to the field with preconceived ideas, notions, experiences and theories about any given topic. It is important that researchers are aware and able to not only reflect but address these throughout the research process (Charmaz, 2009, 2014, 2016; Mills & Birks, 2014). According to Sinclair (2003) the purpose of location in Indigenous research means “revealing our identity to others; who we are, where we come from, the experiences that have shaped those things, and our intentions for the work we plan to do. Hence ‘location’ in Indigenous research, as in life, is a critical starting point” (p. 122).

Participants in this study were adults over the age of 18 living with type 2 diabetes. They were invited by local community health centre staff to take part in this study through their community health centres. A nurse from the local Diabetes Education Program in conjunction with clerical staff in each of the health centers were asked to initiate contact with the prospective participants. Involving the communities in the recruitment of participants provided an opportunity for participation into the process. The research question and interview guide were developed by the principal investigator (PI) and presented to a group of key community stakeholders prior to entering the field.

Consent to participate was collected by the PI at the time of the interview. Data was collected through recorded in-depth semi-structured interviews using an interview guide (Appendix A). The participants were asked broad and open-ended questions such as what it was like being an Indigenous person living with type 2 diabetes and what role did their culture, values or beliefs play in their experiences. On average, the interviews lasted one hour. Field notes and memos were collected after each interview and considered during the analysis. It became evident after interviewing 22 individuals that continuing to collect data was no longer required as there were no further categories and properties that seem to be emerging (Charmaz, 2016).

The interviews were transcribed verbatim by a qualified transcriptionist. All interview transcripts were read and analyzed by the researcher using the constant comparative method. This resulted in the

identification of codes, followed by concepts and then the identification of core categories that emerged.

The analysis of the data, which consisted of four phases; thematic, conceptual, dynamic and comparative analysis, was accomplished using a constructivist grounded theory approach. According to Bainbridge, Whiteside, and McCalman (2013) a constructivist grounded theory approach is considered decolonizing since it “can help to legitimize the experience of Aboriginal Peoples as a source of knowledge and facilitate the development of theory directly interpreted from Aboriginal people’s own words” (p. 276). Similarly, Bartlett and collaborators (2007) have suggested that grounded theory in particular has qualities that are consistent with a decolonized approach to conducting research “because the outcomes are generated through a process of reflection that helps to determine new information that is required to build an emergent theory” (p. 2379).

Each interview transcript and recording were reviewed on at least 4 separate occasions. The first review was done immediately after the interview had been completed. The second review was completed once the transcriptions were received and used as means to verify the transcriptions for accuracy. The third review took place during the beginning of the in depth or comparative analysis phase of the transcripts. At this point in time the coding for themes had been done, the principal categories had been identified across all interviews and individual interview diagrams or summaries had been created. A conceptual map of the key points of the interview was developed into a mapping document in order to be able to appreciate the inter relatedness of the categories. At times a fourth review of the audio recording took place in order to ensure that the interview excerpts being used as analytic evidence were an accurate representation of the category or concept being addressed.

The participants from this study did not actively participate in the analytic process. According to Minkler & Wallerstein (2008) communities are often not involved in the actual analysis of the data for several reasons including lack of interest, time, or a clear understanding of the process. I would suggest that all these reasons applied in this study. The intention was always to return to the communities upon completion of the study to encourage further engagement with respect to the findings that emerged and seek community input regarding the elaboration of next steps.

Results

The following section will present and describe the three emergent categories which represented the main findings of this research. Stories about eating, developing diabetes, and treatment options were ever present throughout all the interviews. A total of 22 individuals between the ages of 45 and 78 participated in this study (Appendix B).

The use of transcription excerpts consisting of the participants' own words were used as analytic evidence to help demonstrate and bring meaning to the individual and collective experiences of living with type 2 diabetes. Throughout the analytical process concepts were identified which were subsequently grouped together under increasingly higher order subcategories and eventually categories (Charmaz, 2014). The three main categories that emerged were changing ways of eating, developing diabetes, and choosing your medicine. It was through the application of this process that a foundation for the development of the substantive theory emerged from the experiences of the participants.

Changing Ways of Eating

This category emerged in response to the participants' perceptions of how over time, the way in which they lived had changed. The participants seemed to place a particular emphasis on ways of eating and how this had changed from reliance on the land in the past to having become, over time, more dependent on Western ways of eating. What became clear was that for most of the participants the link between culture and ways of eating then and now were closely related.

For many of the participants the notion of not being able to go back to the traditional ways of eating and living off the land seemed inevitable while for others it seemed to be more of a matter of choice. For example, one of the youngest participants shared:

So, the impact of colonization really did have an impact on what we eat... but when I think about our culture, we can't go back to the way that our culture was, when we didn't have diabetes. You know we hear that all the time that, oh we never used to eat those fatty foods and you know. Our food was never like that or we lived off the land. (P1)

What also emerged from the interviews was that ways of eating including traditional foods and wild game had changed as a result of European contact and colonial impact which had ultimately resulted in a forced assimilation. They were not necessarily embracing the increased food choices and selection but rather seemed to be incorporating the new ways of eating and foods into their daily diets because it had been imposed:

I know Natives are really, the majority of them have diabetes but what I've been hearing is that long time ago we ate off the land and the government brought in welfare and all that, that's why we're all of a sudden diabetic and all that and sugar and salt and everything like that eh ...It's just basically what they brought to

us and we were kind of forced to eat it or we live the hard way and rather than going hunting everything's handed to you so you take it then (...). (P18)

The notion of living between two worlds also seemed ever present for most of the participants. This idea was best captured by a statement made by one participant who shared:

I'd like to kind of think of myself walking around with a moccasin in one foot and a tennis shoe in the other. You know you still have that simplicity but you're still living in the world that it is today. (P4)

For some, this meant wanting to be connected to the land while embracing and welcoming the modern conveniences. For others it seemed more of a forced imposition, that is, they were no longer able to rely exclusively on the land even if they wanted to either because they did not have the access, skills or resources to do so. This new way of living was now the reality and ultimately there was no other choice but to adapt to the new ways of doing things:

Uh, I don't know, probably because we live in the city now and have a, it's hard for some young people to get uh, out in the bush to hunt and they don't know how to hunt ... there was no hunting experiences and well, I think because uh they don't have guns or hard time to get guns and people aren't, some of them live on uh low incomes and can't get out to go hunting and they uh, just, not interested in it anymore". (P11)

... well now you jump in your car and go to the grocery store and get your food. Years ago, your father had to be a hunter. (P2)

The participants provided explanations that seemed to justify how over time their ways of eating had changed. For several of the participants at least the notion of not being able to go back to the traditional ways of eating and living off the land seemed inevitable and had been imposed while for others it was simply a matter of choice.

Developing Diabetes

This second category emerged in response to the participants' explanations of how they had come to develop diabetes which included personal theories of causation often linked to changing ways of eating as well as what diabetes meant for them. Individuals living with diabetes are likely to share

that having to watch their diet or change the way they eat is one of the most challenging aspects of living with diabetes. Initially some of the responses that were elicited might be considered quite typical for individuals living with type 2 diabetes. For example, one participant shared: The eating part is the most difficult part of all.” (P18).

In order to gain a deeper understanding of the experience of living with diabetes it was necessary to avoid asking questions that might elicit typical responses around these challenges. Most of the participants seemed to suggest that developing diabetes was inevitable either as a result of one’s genetic make-up or as a result of their own doing. For example, one of the youngest participants shared:

Well at first, I was just like oh no, here we go and then I was looking back on my mother and then my grandmother and that’s how they got it so I was thinking oh you know. It’s inevitable I guess you’d say like it’s just like oh here we go.” (P19)

The fact that diabetes seemed inevitable or an inescapable destiny for more than half of the participants was ever present throughout most of the interviews. Most had expected to eventually develop diabetes. As with most illnesses there is always a tendency to want to attribute blame or identify a cause. In the literature this is often referred to as theories of causation. This was no different for the participants in this study.

A clear link was also made between changing ways of eating and how this had likely contributed to the onset of diabetes. For example, one of the older participants shared:

When we were young, your meals were mostly meat, fish, deer, and moose, and you’d have your bannock and you’d have your meat and after you started to eat like your macaroni and spaghetti and all that other stuff, that’s when the diabetes came in, you know. I’m pretty sure that’s how it happened because like you know all the extra like you know, what you’re eating ... (P20)

Finally, the notion of not being able to go back also emerged in relation to developing diabetes. For example, a 68-year-old participant shared that despite knowing that living off the land was likely healthier, many individuals would not want to live like that anymore:

You know, then there’s a lot of them that want to go back to the way it was, but we can’t go back there. We’re all living in homes here, we got power, running water, showers, baths everything. We shop in the city and you talk about going back. I don’t think anybody wants to be living in a tepee anymore, you know. (P2)

For one of the participants however a clear link was made between diabetes and the many disruptions that have impacted Indigenous Peoples and a rejection of the common perception shared by many participants that diabetes was passed down from the generations. This provided a great example of the colonial impact of European contact on the development of diabetes through the eyes of this participant.

I'm talking about in the 1400s when European contact was made, that was all disrupted you know we were getting to be more commercialized I would say again and breaking away from our traditions...so to me it's the way you live, just because your parents have diabetes doesn't mean you have to have diabetes...it's the way we live I would say, it's up to you to prevent it. (P5)

A clear link was made by the participants in this study between changing ways of eating and how this likely contributed to the onset of diabetes. For some the change was attributed to personal choices while for others it was attributed to the imposition of European ways.

Choosing Your Medicine

The third emergent category was named '*choosing your medicine*'. This category emerged during the participants' explanations of how and which health services they accessed as it related to diabetes as well as their experiences in navigating health care services.

In order to gain a better understanding of health beliefs and practices the participants were asked very broad questions such as what it meant for them to be healthy and what services they accessed. These discussions often prompted the need to further explore the nature and quality of the participant's health care experiences.

Some participants were faced with having to make choices between conventional Western medicine and Traditional ways, which over half were able to justify as being a matter of choice while for others an imposition. More than half of the participants shared that they felt the need to do as they were told by their health care providers. For example, the following excerpt clearly demonstrated that the decision to conform was often associated with an underlying fear that had been instilled in many while attending residential school:

(...) then the colonization, like the intergenerational, all this stuff, we're affected by that. But nobody believes that, nobody understands that. The intergenerational effects because I know myself, I live with a lot of that fear, eh, I live with fear and but since I've done a lot of work on myself, healing myself. I went to residential school too. A lot of the behaviours you live with that, but as we, as I'm going

along, I have to remember that those behaviours still affect me. So, I was talking about this with the doctors. I have that fear of, uh, authority, like they're going to tell you what to do, always telling you how to behave you know. You couldn't behave like yourself because colonization is like the government sends you to residential schools to be like them. (P 7)

Similarly, in the following excerpt the participant clearly demonstrated that she was doing what she was told out of fear of angering her physician:

My doctor, she says take this and that's it. And if you mix anything else {like traditional medicines} [it is} your problem, not mine. I've been scared she'd get mad. She wouldn't like it if I was mixing my medicines. (P3)

This last excerpt appears to be a good example of being told what to do. This would certainly represent a classic example of paternalistic behaviour within the context of a health care interaction.

In some cases, participants shared that when it came to diabetes care their options were limited or perhaps even chosen for them. For example, one of the participants shared an example that clearly demonstrated that for him at least his choices were either limited or imposed upon him:

The white man's medicine forbids a lot of things to the natives...I guess it was a no-no to practise whatever if you knew [traditional] medicine...it wasn't allowed [to practice traditional medicine]. A lot of things weren't allowed. Like when we went to school, we weren't allowed to speak our language... (P7)

Some participants seemed to have more faith in Western medicine:

The western side there they studied it. They probably know more about it because I don't think a traditional person could give you a tonsillectomy or something like that... (P9)

However, other participants suggested that they felt free to choose either Traditional or Western medicine, and some even felt that combining the two approaches was a good option:

There's a balance, the physical part of my being needs medication in order to function and in order to function uh as a as a as a person I want to be I was taught I have to see a I see a healer at least four times a year. (P10)

In this third category the participants helped to shed some light on how they came to choose their medicine. Beliefs and practices, with respect to combining Traditional and Western medicines, were addressed. Most of the justifications provided either for or against the combining of Traditional or Western ways were based on beliefs and perceptions of either having to do what you are told by your health care provider while for others it was once again really a matter of choice.

Discussion

The concept of decolonization informed this study as it served as a lens through which to consider the experience of type 2 diabetes for the participants (Fortier, 2017). Appreciating that colonization is ongoing and that decolonization is essential provided a framework to examine to what extent colonization was impacting the experiences of participants living with type 2 diabetes.

It has been clearly demonstrated in reviewing the literature and further confirmed through interactions with the participants that colonization has impacted them in several ways (Bartlett et al., 2007; Crowshoe et al., 2018; Smith, 1999). Despite being provided with a significant number of examples of negative colonial impacts on ways of living, eating, and accessing health care when it comes to diabetes, there was very little discussion of decolonization from the participant's perspectives. Some of the results might suggest that some of the participants' adaptation could be interpreted as a decolonizing approach to living and dealing with diabetes, however this was not ever present. There were a few examples provided of decolonization such as recognizing the benefits of combining Traditional ways of eating as well as medicines in managing type 2 diabetes for Indigenous Peoples.

One of the many outcomes of the analysis of the data was the development of a substantive theory. A substantive theory, which provides a theoretical explanation or interpretation, differs from a formal theory which tends to be more abstract and applicable to a wider range of issues (Corbin & Strauss, 2008). Because of the analysis of the interaction between the key findings of this study, the substantive theory that emerged suggested that Indigenous Peoples who participated in this study and who live with type 2 diabetes often viewed the development of diabetes as an inevitable biomedical or cultural outcome. Health care services and providers should consider the importance of addressing this common misperception when designing and implementing diabetes care by including Indigenous Peoples in the process (Crowshoe et al., 2018). This could be achieved through changes in policies, ideologies and the way services are delivered (Rice et al., 2016) as well as perhaps considering the "life course" which would include the prenatal period, early childhood, childhood and adults (Reading & Wien, 2009, p. 8).

Many also lived with the perception that there was ‘no going back’ to the way things once were prior to contact and that as a result most have had to adapt to new ways. This notion of not being able to go back seemed to suggest that many of the participants felt that the ways of the past were all but gone and that there was little choice but to embrace and accept the ways of the colonial culture. For some there was no desire to return to traditional practices. This perception may in part be influenced by the idea that, for some of the participants in this study, some aspects of Indigenous culture are things of the past and may no longer exist.

The idea of culture as something that is evolving and changing existed for some while not for others. Some of the participants seemed to suggest that some aspects of Indigenous culture had been lost because of colonization. It was readily apparent that the principles of cultural safety were often lacking especially within the contexts of interacting with the health care system and health care providers. This resulted for some of not having a choice and feeling the need to learn to live in the ‘white’ world. For some of the participants this adaptation to diabetes care meant accepting and incorporating Western ways while for others it meant being able to embrace the best of both worlds when it comes to living with type 2 diabetes. This was best explained by those who suggested that combining Traditional and Western ways of living, eating and treating diabetes could be the answer. This perspective represented an example of the presence of self-determination with respect to type 2 diabetes care. This adaptation which appeared to be embracing a complementary approach to diabetes care could possibly serve as an example of decolonized diabetes care.

This adaptation appears to further suggest that a complementary approach that considers both Traditional and Western ways might provide an example for a decolonized model of type 2 diabetes care for Indigenous Peoples. This approach is neither exclusively Traditional nor Western. Such an approach could be open to different ways of knowing and being and decolonizing in the sense that individuals can appreciate the benefit of combining the two approaches. Perhaps more importantly, individuals are given a choice and empowered to determine how they want to live with and receive care for diabetes. This model also emphasizes the importance that health providers appreciate that type 2 diabetes care should go beyond the biomedical perspective and consider the impact that colonization has had on the disruption of many of the ways of living of Indigenous Peoples since European contact (Murdoch et al., 2017). This emerging substantive theory is dynamic in nature and serves to represent the experience of Indigenous Peoples living with type 2 diabetes from the seven First Nation communities. It further helps to explain a variety of participant experiences.

From the analysis and interpretation of the data and the elaboration of a substantive theory, a decolonized model of diabetes care was constructed (Figure 1).

Figure 1–Proposed model for a decolonized approach to type 2 diabetes care for Indigenous Peoples.

The model considers the social determinants of Indigenous health and life course (Reading & Wien, 2009) and has type 2 diabetes as the central component. It also incorporates the elements of cultural safety, understanding of the historical and ongoing impact of colonization, self-determination and a balanced and holistic approach to health. These are all considered to be essential elements of the proposed model. A model such as this could be viewed as ‘postcolonial’ or a departure from completely embracing the Western bio-medical approach to diabetes care.

The use of a circular approach with a central theme surrounded by interrelated concepts was deliberate and influenced by the Medicine Wheel and the notions of balance and holism (Montour,

2000). All the elements presented in this decolonized model should be considered in relation to each other and in a balanced manner.

Individuals living with type 2 diabetes require specific treatment plans (Sherifali et al., 2018). Ideally each treatment plan should be tailored to the individuals' needs and include a combination of both Traditional and Western approaches. This is especially important when considering the cultural needs of Indigenous Peoples (Murdoch et al., 2017). The existing primarily Western bio-medical approach to health and diabetes care for Indigenous Peoples tends to exclude their input. This approach is problematic since it is often based on a racist and oppressive colonial ideology. This tends to be at odds with Indigenous ways and views with respect to health and wellness which are normally considered in a more holistic manner and strongly influenced by culture (Manitowabi & Shawande, 2011; Ross, 2014).

As previously recommended in the Royal Commission on Aboriginal People (RCAP) (Government of Canada, 1996) report and most recently by the Truth and Reconciliation Calls to Action report of 2015, there should be more Indigenous health care professionals in the health care system. This recommendation does however come with a caution. We not only need to increase the number of Indigenous health care providers; we need to ensure that they can help to transform the current professional culture into one that is more culturally safe.

It was not the intention of this study to explore the common challenges faced by individuals who live with diabetes since it is well known that following a diet, taking medication or having to monitor blood sugars can be quite demanding (Crowshoe et al., 2018). Future research should explore the potential benefits of receiving diabetes care that is decolonized. Strategies for promoting a decolonized model of diabetes care for Indigenous Peoples have not been adequately explored. Further research is required to better understand which decolonizing approaches might work best when providing diabetes care to Indigenous Peoples. Lastly, this research is specific to a group of Indigenous People who live in seven First Nation communities thus future research should also consider including participants from other geographic areas since their experiences may be different.

Limitations

A possible limitation that has been identified is that only English-speaking participants were recruited to participate this study. Individuals who speak their own Indigenous language with very little or no English may have shared different experiences. Therefore, this limitation in sampling may have led to the generation of only a partial picture of the experience.

Although key stakeholders and community representatives were engaged in the research process from the beginning, this study did not employ a CBPR research approach. Additionally, grounded theory studies are not generalizable. However, it is possible that some of the results from this study could be transferred to fit other similar contexts deemed appropriate by the reader.

In spite of the limitations identified, this study contributes to the existing knowledge base of diabetes care for Indigenous Peoples. It will provide some insights into the issues and challenges that often confront Indigenous Peoples who are experiencing and living with type 2 diabetes in an environment that is primarily Westernized and often insensitive or unaware of the realities of historic and ongoing colonial practices. The recommendations that emerged can serve to provide direction for health care providers who deliver diabetes care to this population in a more culturally safe and decolonized manner.

Conclusion

This study found that the interrelation between and within changing ways of eating, developing diabetes, and choosing your medicine might help to explain how Indigenous Peoples often perceive, that when it comes to diabetes care, many often find that they have few choices available to them. Consequently, they may be faced to adapt to ways of doing things that might be at odds with some of their cultural values and beliefs. Despite this, the way some participants elected to combine Traditional and Western ways might represent a more decolonized model of diabetes care.

The substantive theory that emerged from the analysis of the data is dynamic and can help explain the variations in experiences, conditions, and responses that the participants demonstrated throughout the interviews. In addition, this theory helps to provide some explanation of the very complex reality of being an Indigenous person living with type 2 diabetes.

Finally, the results from this study suggest that despite the historical and ongoing legacies of colonization as well as the dominance of the Western bio-medical approach to diabetes care, consideration of integrating Traditional and Western ways could help to promote a more decolonized and culturally appropriate model of diabetes care. The proposed model of decolonized diabetes care that emerged from this study could serve as a guide for action for current and future health care providers alike.

Since the completion of this study, there has been an increased focus on decolonization in various sectors such as health care and education (Corntassel, 2012; Cote Meek, 2014). Awareness of the historical and ongoing legacies of colonialism continues to grow. Several direct-action campaigns such as Idle no more which was sparked in 2012 and emerged in protest to the introduction of Bill C-45

by Stephen Harper's Conservative government have helped to keep awareness of the need for decolonization to remain at the forefront. Some would argue that these initiatives are a long time coming. The Royal Commission on Aboriginal Peoples made it very clear that racism was a problem for Canada's Indigenous Peoples as early as the 1990s. It is time for a radical change to take place. Since there appears to be a lack of political will, the change will likely need to come from Indigenous Peoples themselves as well as within our various systems and institutions.

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APPENDIX A: INTERVIEW GUIDE
INTERVIEW GUIDE BY THEME

1. CULTURE

- What does culture mean or represent for you?
- What does being an Indigenous /First Nation person mean to you?
- How important is your culture? Why?
- What influence has your culture (that is, being a First Nation person or Anishnawbek) had on your experience with type 2 diabetes?
- Colonization: examples of or experience with:
racism,
discrimination,
oppression,
marginalization,
sexism

2. DIABETES/HEALTH

- What does being healthy mean to you?
- What does type 2 diabetes mean to you?
- Can you remember how you felt when you first found out you had diabetes?

3. RELATIONSHIP WITH HCPS/HEALTH CARE SYSTEM/TRADITIONAL HEALERS

- How would you describe your experience with the health care system as it relates to your diabetes?
- How would you describe your relationship with your HCPs?
- What role do traditional healers, beliefs or practices play in the management of your health?

APPENDIX B : PARTICIPANT DEMOGRAPHICS

Participant	Gender	Age	Year of Diagnosis	# years with diabetes	Education level	Occupation	Treatment
1	F	45	1998	13	College	Admin	Insulin
2	F	65	1994	17	Elementary	Retired	Medication
3	F	66	1999	12	Secondary	Retired	Insulin
4	M	61	1991	20	Secondary	Self-employed	Insulin
5	M	56	2006	5	Secondary	Self-employed	Medication
6	F	60	1997	14	Secondary	Self-employed	Insulin
7	F	61	1997	14	Secondary	Self-employed	Insulin
8	M	61	1995	16	Secondary	Disability	Medication
9	M	56	1990	21	Secondary	Disability	Medication
10	M	78	1998	13	Elementary	Retired	Insulin
11	F	55	2002	10	College	Health care	Medication
12	F	61	2005	7	University	Retired	Insulin
13	F	64	1982	20	Secondary	Homemaker	Insulin
14	M	46	1983	29	Secondary	Laborer	Insulin
15	F	53	2004	8	Secondary	Disability	Medication
16	M	70	1990	22	Elementary	Retired	Medication
17	F	72	1997	15	Secondary	Retired	Insulin
18	M	62	1982	30	Secondary	Retired	Insulin
19	F	68	2004	8	University	Retired	Medication
20	F	59	1985	27	Secondary	Retired	Insulin
21	M	63	1992	20	College	Retired	Medication
22	F	60	1982	30	Elementary	Retired	Insulin
N=22	F=13 M=9	Avg : 61		17.4 years			Medication=9 Insulin=13