

CULTURAL VARIATIONS IN HEALTH CONCEPTIONS: A QUALITATIVE APPROACH

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ABSTRACT

This research studied health conceptions among three cultural groups — Anglophones, Francophones, and First Nations. A total of 60 participants were individually interviewed in an urban area of central Canada. Intriguing findings include the following: (a) health was defined both as an achievable end state and a continuous process towards better health, (b) the specific structures needed both in the process of becoming healthier and to achieve the state of health were clearly identified, and (c) apparent cultural differences were noted: Anglophones and Francophones defined health as a self-contained concept, whereas First Nations participants viewed health as transcending the self to include their family, their community, and the environment at large. One theoretical implication of these findings is that health can no longer be viewed as a static state; it is a constantly changing process to maintain and improve one's health. A practical implication is that it is imperative for health professionals to learn the differing conceptions of health of their culturally diverse patients to provide culturally sensitive care. For health policy makers, these findings highlight the need to develop culturally appropriate policies and programs that reflect the concerns of members of cultural minority groups.

Keywords: health conception, health practice, culture, Canadian context

INTRODUCTION

Health practices are guided by certain beliefs about the meaning of health (Hufford, 1992; Kleinman, 1978), which are often referred to as health conceptions. These health conceptions include beliefs about what being healthy means and how health can be maintained or promoted (Hakim and Wegmann, 2002).

In Western societies, the biomedical model represents one of the dominant conceptions of health (Alonso, 2004; Engel, 1977; Laffrey, 1986). In the biomedical model, health is simply defined as the absence of illness, more specifically, at the physical level. Accordingly, it is believed that health can be maintained or promoted by eliminating or treating illness (Alonso, 2004; Engel, 1977).

However, since the second half of the last century, the biomedical model has been the target of increasing criticism. One major objection lies in its reductionist nature, which fails to represent the general population's views on health (Alonso, 2004; Engel, 1977; Goins et al., 2011; Hufford, 1992; Laffrey, 1986; Mansour, 1994). Many studies have shown that members of the general population tend to define health in a more complex way; their health conceptions include other dimensions besides the mere absence of illness (Goins et al., 2011; Mansour, 1994; Rubenstein et al., 1992; Woodgate and Leach, 2010).

As a result, multidimensional health models were created to capture a variety of health conceptions. For instance, the biopsychosocial health model, advocated by the World Health Organization (WHO, 1948, p. 1), defines health as "a state of complete physical, mental and social well-being

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and not merely the absence of disease or infirmity.” Although these multidimensional health models offer a more comprehensive view of health, they may not reflect the views of members of cultural minority groups, as these models were developed based on studies that examined health conceptions among Caucasian, English-speaking populations (Ailinger and Causey, 1995; McCarthy et al., 2004).

A lack of concordance between the health conceptions provided by these models and those of minority patients can have important implications for the quality of care they receive. Indeed, past studies have shown that health professionals and their cultural minority patients often face communication and relational difficulties (Schouten and Meeuwesen, 2006). It has been suggested that these difficulties can be partly attributable to cultural differences between health professionals and their patients, especially with respect to their views on health, illness, and treatment plans (Pavlish et al., 2010; Reiff et al., 1999; Schouten and Meeuwesen, 2006). For instance, cultural differences in health views have been linked to low satisfaction with health care among minority patients (Pavlish et al., 2010; Reiff et al., 1999), a lack of trust in their doctors (Pavlish et al., 2010; Rubenstein et al., 1992), and low adherence to doctors’ recommendations (Kerse et al., 2004). To improve the quality of care for cultural minority patients and, in turn, to promote their health, it is important that health professionals, community planners, and policy makers understand their health views.

French-speaking and First Nations Canadians were the targets of this study because recent statistics have shown that, in Canada, individuals in these two cultural groups are in relatively poor health compared to the English-speaking population (Bouchard et al., 2009; Health Canada, 2009; Kopec et al., 2001; Tjepkema et al., 2011). The goal of this study was to investigate the health conceptions and practices of Francophone and First Nations Canadians, as well as Anglophones, the latter mainly serving as a reference group. First, representative literature looking at the influence of culture and acculturation pressure on health conceptions is reviewed, highlighting cultural variations in health views and practices. The research questions addressed by this research project are then stated.

HEALTH AS A CULTURAL CONSTRUCT

THEORETICAL FRAMEWORK

According to the theory of personal constructs (Kelly, 1963), people do not have direct access to reality, but instead create their own understanding of their surrounding world. Kelly suggested that based on their personal experiences, people develop their own representations of the nature of people, objects, and events to explain and make sense of their universe (Kelly, 1963, [1970] 2003).

Following the rationale of the theory of personal constructs, people should construct their own representations of health based on their experiences. Although there might be a clinical reality to health phenomena, from the vantage point of members of the general population, health is a subjective experience (Strandmark, 2007; Tripp-Reimer, 1984). As individuals have unique health experiences, they create their own representation of what being healthy means and how best to promote health (Angel and Thoits, 1987; Goins et al., 2011; Strandmark, 2007). Past research has shown a great deal of variation among individuals in the way they conceptualize health (Goins et al., 2011; Laffrey, 1986; Provencher, 2003; Woodgate and Leach, 2010).

Since culture shapes personal experiences, it is reasonable to posit that culture plays an important role in the way people conceptualize their health experiences (Angel and Thoits, 1987; Jobanputra and Furnham, 2005; Kleinman, 1978). In fact, in addition to personal experiences, Kelly recognized the potential influence of sociocultural factors on personal constructs. He suggested that because they share similar experiences, people of a common cultural denomination often have similar constructs (Kelly, 1963, [1970] 2003; Scheer, 2003). Even though health conceptions tend to be unique to each individual, some commonalities can be found among those coming from the same cultural background.

EMPIRICAL EVIDENCE

There is ample evidence showing that health conceptions tend to vary across cultures (Ailinger and Causey, 1995; Jobanputra and Furnham, 2005; Pavlish et al., 2010; Torsch and Ma, 2000). For instance,

Hakim and Wegmann (2002) interviewed elders who identified themselves as Americans of African, Latin, Vietnamese, or First Nations descent. Although they all defined health as a balance within the self, they disagreed as to what elements should be in balance. The Vietnamese-Americans emphasized the balance between elements within the body, while the others talked about a balance between the body and other aspects of the self, including the mind, the spirit, and the social self. The absence of pain was discussed by the participants in every cultural group with the exception of First Nations. African-Americans were the only ones to conceptualize health as a relative concept that can be inferred by comparing themselves to less healthy individuals they know.

McCarthy et al. (2004) compared the health views of older Anglophone and Latino women living in the United States. The authors found that the health conceptions of the Anglophone women reflected individualist and independent values, emphasizing the ability to function and to be independent, while the views of Latino women were more in line with collectivist and interdependent values. For them, being healthy meant having healthy relationships with others and having a connection with God. Latino women also emphasized the interconnection between their own health and the health of their close ones.

HEALTH AND ACCULTURATION

THEORETICAL FRAMEWORK

Given the potential influence of culture on health conceptions, the impact of cross-cultural contact among members of different cultural groups cannot be ignored; people are subject not only to the influence of their culture, but to other cultures as well (Jobanputra and Furnham, 2005). Berry described the process of acculturation as the transformations that take place in one's primary culture as a result of contact with other cultural groups (Berry, 2005; Berry et al., 2002). Although he believed that the impact of acculturation is bidirectional, most scholars have focused on the impact of majority groups on cultural minorities (Berry et al., 2002). The acculturation and adaptation model suggests that cross-cultural contacts can affect the way people concep-

tualize health, especially among members of cultural minority groups who have a long history of contact with the majority group (Berry et al., 2002; Phillips, 2005), such as Francophones and First Nations in Canada.

Although Canada now embraces the value of multiculturalism, before the 1970s, the Canadian government pursued an assimilationist agenda (Berry et al., 2002). For instance, the Official Language Act of 1890 declared English to be the only official language in Manitoba and, as a result, education in French was forbidden until 1970 (Bédard, 2002). Starting in 1874, residential schools were established across Canada, the intention being to assimilate Aboriginal individuals (Indian and Northern Affairs Canada, 2003). Assimilationist pressure can erode cultural traditions, including cultural conceptions of health and traditional health practices (Phillips, 2005). In the case of Francophone and Aboriginal Canadians, it is clear these policies failed to completely eradicate these cultures as many individuals in these communities managed to maintain their traditions to some degree (Morrisette et al., 1993; Stebbins, 2000). Thus, a mix of traditional as well as Western health beliefs can be expected.

EMPIRICAL EVIDENCE

Some researchers have provided evidence of the influence of acculturation processes on health and illness views among members of cultural minority groups, especially immigrants (Castro et al., 1984; Jobanputra and Furnham, 2005; Phillips, 2005; Reiff et al., 1999). The results of these studies tend to reveal a mix of traditional and dominant cultural health beliefs among minority members. For instance, Jobanputra and Furnham (2005) conducted a study on the beliefs about the explanatory factors of health among a group of Gujarati immigrants and a group of British Caucasians. The authors expected that British Caucasians would adhere to causal illness beliefs expressed in terms of individual responsibility and the influence of the natural environment, whereas Gujarati immigrants would be more likely to endorse supernatural explanations of health and illness. Although they found support for the greater acceptance of supernatural causes of health among Indian immigrants, they observed

that these immigrants were as likely to accept individual and environmental explanations of health as Caucasians. This pattern of health beliefs is characteristic of an integration acculturation process.

Few studies have specifically examined the health conceptions of Aboriginals and Francophones in Canada. A group of researchers (van Uchelen et al., 1997) conducted a study with 31 First Nations individuals about their views on wellness. The participants described wellness as having a balanced life. They also discussed the importance of spirituality and of having a strong sense of cultural identity. Their social self is involved in the description of wellness as having positive relationships with others and as contributing to one's community.

Labun and Emblen (2007) investigated the concept of health from the perspective of First Nations individuals. The participants defined health as a balance between the different aspects of the self, including the body, the mind, and the spirit. Some of them argued that being healthy means their family and their community also experience good health. In order to promote health, many reported engaging in traditional and spiritual practices and relying on support from their close others.

Provencher (2003) interviewed a group of older Francophone women living in a minority setting about their conceptions of health. The findings revealed that these women tend to define health as the ability to function and to be active. A few of them also discussed the importance of having a sense of meaning in life. They attributed health and illness to biological factors; behavioural factors, including exercise and diet; as well as supernatural factors, such as luck. The author observed differences in health views among women of different social classes, especially with respect to explanatory factors of health and illness. Women in the lower class attributed health to destiny and luck, while those in the middle class believed that health could be promoted by engaging in healthy behaviours.

THE PRESENT RESEARCH

Despite the contribution of past research to cultural conceptions of health, we do not fully understand the role culture plays in the way people conceptualize health. First, most cross-cultural studies focused

on illness beliefs. Few studies investigated health conceptions and these studies tended to involve only one cultural group at a time. Second, researchers conducting comparative studies among two cultural groups or more have rarely controlled for other confounding variables that could influence health conceptions, such as socioeconomic standing. Finally, research on health conceptions has focused mostly on immigrant populations, while long-established minority groups living in Canada have seldom been included in health conception studies.

The present study addresses a gap in the literature on health conceptions among long-established minority groups in Canada. More specifically, the study aimed to answer the following questions:

1. How is health defined according to English-speaking Canadians living in an urban setting and to minority French-speaking and First Nations Canadians?
2. What are the health practices they engage in to promote their health?
3. Does culture play a role in the way health is defined and promoted?

METHODS

PARTICIPANTS

The study was conducted in a city of over 500,000 people located in central Canada with a total of 60 participants. They were recruited from three cultural groups: English-speaking and French-speaking Canadians of European descent — who will be referred to as Anglophones and Francophones — as well as First Nations. First Nations peoples are defined as the descendants of the first inhabitants of the Canadian territory who are neither Inuit nor Métis (Aboriginal Affairs and Northern Development Canada, 2012). Each group comprised 20 participants (10 men and 10 women). They ranged in age from 20–68 years old, with a mean age of 34.6 ($SD = 11.76$).

MEASURES

The participants took part in an open-ended individual interview. The interview questions were borrowed and adapted from past studies (Ailinger and Causey, 1995; Hakim and Wegmann, 2002) to elicit health conceptions. During the interviews, which

followed an interview guide, the participants were asked to talk about the way they define health and the practices they engage in to promote health.

In addition to the interviews, the participants filled a short questionnaire measuring other variables linked to health conceptions in past studies: age, education level, employment status, income, marital status, and perceived health status (Goins et al., 2011; Mansour, 1994; Provencher, 2003).

PROCEDURE

With the approval of a research ethics board, participants were recruited using convenience, snowballing, and criterion sampling. A call for participation was posted in local community centres and newspapers and circulated by emails through local community agencies. Recruitment of First Nations participants required the principal researcher to create a relation of trust with key individuals in the community who then put her in contact with volunteers. To eliminate potential confounders and focus on the influence of culture on health conceptions, volunteers were selected to ensure the three cultural groups were homogenous with respect to other health conception determinants, including socioeconomic standing and place of residence. Criteria for inclusion required that the participants (a) were born or have attended school in the city, (b) were still living in the city, and (c) had an annual income between \$21,000 and \$100,000.

To ensure that the interviews were conducted in a similar fashion across the three cultural groups and reduce the power imbalance between the researcher and the participants, a research assistant conducted all the interviews. She met with the participants at an agreed on time and place. The participants were given the choice to be interviewed in French or in English. The interviews, lasting 40–45 minutes, were audio-recorded with the written consent of the participants. At the end of their interview, participants were asked to complete a questionnaire, which

took approximately 5 minutes, and to inform their friends and relatives about the research project. As a sign of gratitude, the participants received a \$10 gift certificate for their participation.

The research assistant transcribed the interviews verbatim. Before analyzing the data, the participants were asked to review their interview transcripts and invited to remove or add information, provide clarifications, or make changes if needed. This ensured the accuracy of the data and showed the interviewees they have a right to their intellectual and cultural property.

RESULTS

DESCRIPTIVE ANALYSES

Descriptive analyses were conducted for the three cultural groups separately on the demographic variables. The results are presented in Table 1.

Table 1 Summary of Frequencies, Means, and Standard Deviations for Scores on the Demographic Variables as a Function of Culture

<i>Variable</i>	<i>Francophones (n = 20)</i>	<i>Anglophones (n = 20)</i>	<i>First Nations (n = 20)</i>	<i>Total (N = 60)</i>
Perceived health				
Excellent	5	4	2	11
Good	8	10	10	28
Somewhat good	6	5	7	18
Not very good	0	0	0	0
Very poor	0	0	0	0
Missing data	1	1	1	3
Education				
Not finish school	0	1	0	1
High school	1	0	8	9
College	5	3	3	11
Undergraduate university	8	12	6	26
Graduate university	6	4	3	13
Marital status				
Single	11	8	12	31
Common law	2	3	2	7
Married	3	8	5	16
Divorced	3	1	0	4
Widow	0	0	0	0
Other	1	0	1	2
Employed				
Yes	16	18	14	48
No	4	2	6	12
Student				
Yes	9	7	10	26
No	11	13	10	34
Income				
< 20,000	0	0	0	0
20,000–40,000	12	7	13	32
40,000–60,000	1	6	3	10
60,000–80,000	4	4	3	11
80,000–100,000	3	3	1	7
> 100,000	0	0	0	0
Age				
M	32.15	35.45	36.20	34.60
SD	10.20	13.93	11.02	11.76

A series of chi-square analyses examined whether the sample was homogeneous with respect to perceived health, education, marital status, employment status, student status, and income. The results, presented in Table 2, reveal that the three cultural groups did not significantly differ from one another when using a Šidak correction for multiple comparisons ($p > .009$).

Table 2. Chi-Square Tests of Homogeneity of Sample

Variable	χ^2	p
Perceived health	1.89	.756
Education	18.63	.017
Marital status	8.00	.434
Employment	2.50	.287
Student	0.95	.622
Income	7.06	.315

Note. $N = 60$.

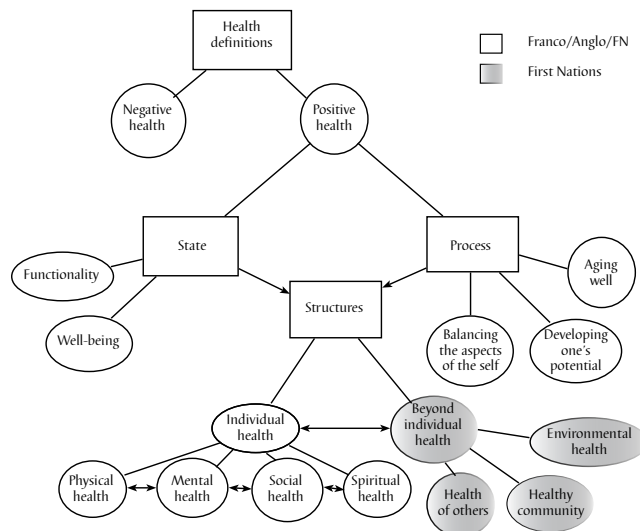
An analysis of variance examined whether the sample was homogeneous for age of the participants. The effect of culture on age was not significant, $F(2, 57) = 0.66, p = .519, \eta_p^2 = .02$.

HEALTH DEFINITIONS: RESEARCH QUESTION 1

Interview responses were analyzed according to recurring themes with the use of NVivo 8. An inductive approach was used during the analysis, which means that the researcher let the themes emerge from the data instead of using theoretical codes identified in advance.

Throughout the interviews, the participants discussed a number of health definitions, which are presented in Figure 1, showing a distinction between a negative and a positive definition of health.

Figure 1. Definitions of Health across Cultural Groups



Negative health

Interview responses that fell into negative health were articulated around the theme of what health is not. From that perspective, health implies the absence of certain characteristics. A total of 44 interviewees defined health as the absence of illnesses, pain, and disabilities. This negative view of health is well illustrated by the following expression used by several participants: “You know you’re healthy when you don’t think about it,” as opposed to when you are sick, injured, or in pain.

However, many believed they could still be healthy despite an illness, as long as their disease is under control and does not interfere with their daily functioning, as explained by one Francophone man:

I think of my grandmother who has difficulty walking because she hurt herself one day, but she goes on being healthy because it doesn't stop her from being active. [translated from French]

Positive health

It appeared that the absence of illness, pain, and disability is not a sufficient condition to consider oneself healthy as every participant also talked about health by referring to what should be present in a healthy individual. One Anglophone woman explained:

I guess some people are technically not ill, nothing's been diagnosed in them, they have no known disease ... but they don't necessarily exude wellbeing ... so I think wellness is beyond, umm, not being ill it's ... it's that one step beyond where you actually have ... an exuberance of health.

The participants discussed this positive view of health in terms of states, processes, and structures.

State: Being healthy

Many participants defined health as an achievable end state. This state of health involves the ability to function in one’s daily life. A total of 44 interviewees described a healthy person as someone who is leading an active life, who can function without difficulties or relying on medications, and as someone who is able to take care of others. One First Nations woman opined:

I'm a mother so I think if I'm physically healthy, I can look after my children and look after my family.

The state of being healthy also involves a general sense of wellbeing, which was highlighted by 34 interviewees. They know they have achieved a good state of health when they feel good, alive, and invigorated and when they feel that everything is going well in their life. One First Nations man stated:

I'm just sitting there and everything just feels right ... I had a good day, and I'm feeling good.... then I know I'm healthy.

Process: Moving towards good health

A total of 36 participants viewed health more in terms of a developmental process as opposed to an achievable end state. Health is an ideal that exists only in theory, but in reality no one is perfectly healthy as there is always room for improvement. They argued that health is a continuous process throughout one's life. They consider a person healthy as long as he or she is growing or moving in the right direction, towards being more healthy, even though this person will never reach a perfect state of health, as explained by an Anglophone woman who said:

I don't know if, if there's *per se* an end goal in being healthy. Like I don't know if there's, there's a be-all-end-all location. Maybe it's more so that you always just strive to make your improvements. Like, you can always ... maybe add something to your life to be healthier, or take something away from your life to be healthier. And it's travelling in the right direction, towards being more healthy.

This developmental process towards good health was defined as aging well, as described by a Francophone man:

Your body will deteriorate when you get older. But if you're able to have ... still have a good enough life when you're 75 or 80, that would be a better example of a healthy life. [translated from French]

Developmental health also involves developing one's potential:

It's about pushing your boundaries as human beings.... I mean, we're here to grow, we're here to learn. (Anglophone woman)

Finally, developmental health was defined as a process of balancing the different aspects of the self,

namely the physical, mental, spiritual, and social self. In that respect, one First Nations woman explained:

It's not just exercising the physical, it's exercising your emotion, your mental, your spiritual side of that ... and when those are all in check and in balance, you'll feel it. You'll feel better.

Structures

Finally, while defining the concept of health, the respondents also specified which components or structures should be in good health. While the majority of the participants defined health from an individual perspective, focusing on individual aspects or structures contained within the boundaries of the self, a number of them saw health as transcending the self.

Individual health

Every participant believed that being healthy means being in good physical health. They described physical health as having good physical appearance; having energy, vitality, and feeling rested; having good physical functions; and being physically fit. A total of 58 participants identified mental health as part of their health definition, which was subdivided into two distinct constructs: emotional health and intellectual health. On the one hand, emotional health involves feeling good emotionally; having healthy thoughts, beliefs, and expectations; and being able to adapt and to cope with life's demands. For instance, one Anglophone woman explained:

Everybody ... gets upset and angry, depressed, like all the negative emotions ... but as long as you keep things in perspective and that it doesn't affect your life.

On the other hand, intellectual health was defined as one's cognitive functions or "alertness, ability to do some reasoning on a quick level," as defined by an Anglophone man. A total of 39 participants also recognized the importance of social health, which was defined as having healthy relationships with others, feeling like socializing, as well as giving and helping others. For instance, one First Nations woman described a healthy person as: "being connected in the community, getting up, and interacting with people." Finally, 36 participants discussed spiritual

health. For most, spiritual health involves some sort of connection with a higher being, with one's inner self, or with nature. For other participants, it meant being in peace, having faith in something, and having a sense of purpose or fulfillment. Finally, 7 participants talked about spiritual health as a strong sense of cultural identity. For instance, one First Nations woman defined spiritual health this way:

Growing up ... I didn't know that part of myself.... I was always seeking that part of me.... to find that, ... that identity of who I am as ... as a person and in this world ... and once I started finding about my culture, because I was never raised up in it, is when I started ... I actually felt that I found myself. And that was when I finally, you know, started to ... have a place in the world. You know, I was starting to identify as becoming grounded.

With the exception of two Anglophone men, all the interviewees highlighted at least two of the four aspects of the self. Many emphasized the concept of wholeness, meaning that health involves the whole person and that all of these aspects are interconnected and can influence each other.

Beyond individual health

A total of 15 interviewees saw health as expanding beyond the individual self. They included in their definitions of health, the health of their family, their community, and even the environment. They explained how their own health, the health of others, and of the environment are interconnected and how they can influence one another. The connection between one's health and the health of family members is illustrated in the following comment made by a First Nations man:

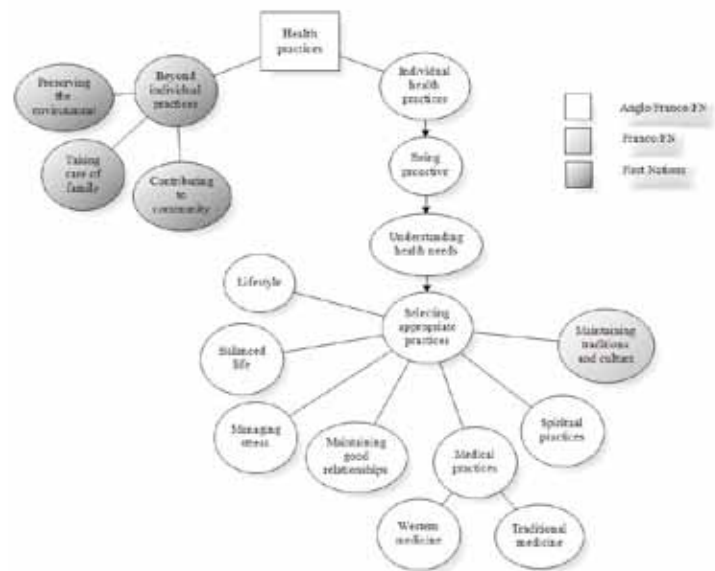
If we're in balance as individuals, then the two of us living together as a couple and as a family, the family can be in balance.

HEALTH PRACTICES: RESEARCH QUESTION 2

With respect to health-promoting strategies, the interviewees reported engaging in a variety of health practices, which are presented in Figure 2. While the majority of them talked about the practices they use to promote their own health, a few interviewees also discussed practices aimed at promoting the

health of their family, their community, and the environment.

Figure 2. Health Practices across Cultural Groups



Individual Health Practices

Being proactive

A total of 40 participants reported believing in the importance of being proactive. They view health as the result of one's actions and they explained that even though they are healthy now, they could become unhealthy in the future if they do not pay attention to their health and if they do not actively engage in health-promoting activities. They believed that being healthy and maintaining long-term health require making constant efforts, engaging in preventive measures, and being informed about health-related matters.

Understanding one's health needs

A total of 38 interviewees thought that one should strive to understand one's particular health needs before adopting any health practice. They reported engaging in a process of monitoring their present state of health, identifying any health problems that may occur, trying to pin point possible causes, and in turn, tailoring their health practices to their health needs. For instance, one Anglophone woman explained:

It's not necessarily the behaviours that ... that are defining your health. But for some people, they might need to do certain things to stay healthy.

A diabetic needs to take insulin to stay healthy ... a person who gains weight very easily may need to participate in fitness plans to stay healthy. And mentally I think people who are more prone to being emotional need to practice certain strategies to stay mentally healthy.

Lifestyle

The most common health practice discussed during the interviews is adopting a healthy lifestyle, which was mentioned by 59 participants. When asked to define a healthy lifestyle, they explained that it involves engaging in healthy behaviours, such as exercising, having a healthy diet, and getting enough sleep; while avoiding unhealthy behaviours, such as consuming alcohol, cigarettes, and drugs. A few participants believed in the value of moderation, arguing that consuming moderate amounts of alcohol, for instance, can be beneficial to health. Others believed it is important to create an environment conducive to good health, especially in their home, which involves avoiding exposure to harmful chemical agents. Finally, a few participants explained how they try to return to a more traditional lifestyle that involves eating traditional or organic food that comes “from the farm and from the land,” gardening, raising their own livestock, fishing, hunting, and living simpler lives as described by one Francophone man:

There's so much complexity in our world today. I don't think complexity is necessary to live in a healthy way.... I don't have a car and I think it's probably the most important thing obviously for your health. I walk and I ride my bike and it changes how I run errands, because then it becomes really a question of what I need to feed myself.... I make everything from scratch. Like my food is all homemade. [Translated from French]

Balanced life

A total of 28 participants explained how they try to keep a balanced life as a means of maintaining their health. Having a balanced life involves engaging in a variety of activities instead of focusing one's energy on only one area. One Anglophone man suggested:

If you're either working all the time or, you know, not working and socializing all the time, either one is not healthy.

They explained how they try to find a balance between their family and their work, and still enjoy free time for themselves.

Managing stress

Managing stress was discussed by 27 participants as a means of promoting their health. They described the strategies they use to manage the stress of daily life, which included planning and organizing ahead of time, living at a slower pace, and avoiding stressful situations as suggested by one Anglophone man:

My job was stressing me out, so I quit my job and found a new one. I found that was an effective strategy to managing my health.

Maintaining good relationships

Keeping healthy relationships with others was seen as an important approach to maintaining good health by 39 interviewees. For some, maintaining good relationships first involves carefully selecting the people they want to develop meaningful relationships with. For instance, they described avoiding negative people who can “bring them down.” They also discussed the importance of communicating with others to maintain healthy relationships with them. The value of having healthy relationships with others appears to be especially important when facing difficult situations as many participants reported having relied on support from their close ones in the past:

To have a good network of support around you, to have good friends, to have family ... that you can fall back on when issues rise. (Anglophone woman)

Medical practices

A total of 33 participants reported relying on medical care to promote their health. The majority of them discussed using Western medicine. Many reported consulting health professionals on a regular basis as a preventive measure, while others tend to seek medical care when facing health problems. Their major sources of care include physicians, dentists, optometrists, and psychologists. In addition to Western medicine, a few participants reported using traditional medicine, including massage therapists, chiropractors, naturalists, herbalists, Elders, and medicine men.

Religious and spiritual practices

Engaging in religious and spiritual practices was mentioned by 26 participants. Some of them reported praying and going to church, while others described drawing their spiritual strength from their connection with nature. A few participants also described taking the time to step back and to reflect on their lives by practicing meditation for instance:

If I'm home ... there are always lots of things to do, right. And it's, I think, it's important sometimes to just sit down and connect with ourselves.... And that's what I found very useful about meditation.
(Anglophone woman)

Maintaining traditions and culture

Finally, 22 participants discussed the importance of maintaining their traditions and culture as a health-promoting strategy. They saw their quests to promote their health and their cultural traditions as being intricately linked. They explained how they could promote their health by engaging in traditional practices and ceremonies, maintaining relationships with people who belong to the same cultural group, and speaking their maternal language. One Francophone woman described how she feels more like herself when she can speak French with other Francophones: "I'm in my environment, I'm comfortable and at ease and then I'm happy" [translated from French].

Beyond individual health practices

In addition to the health practices to promote one's individual health, 18 participants also discussed the practices they engage in to promote the health of their family members, their community, and the environment. For instance, one First Nations woman explained:

She [Mother Earth] provided for us, she gave us all these gifts to work with to maintain life here on earth.... With our environment, we have to be reciprocal in everything we do ... that's what's called teamwork.

CULTURAL VARIATIONS IN HEALTH

CONCEPTIONS: RESEARCH QUESTION 3

The last objective of this study was to identify possible cultural variations in the way the participants conceptualize health. The three cultural groups were

compared to highlight differences in the dimensions they used to define health or their health practices.

An inspection of Figure 1 reveals that the view of health as transcending the individual was found almost exclusively among First Nations interviewees who often explained that their own health, the health of their families, their communities, and the environment are interrelated and can influence one another. This interdependent view of health was often discussed in relation to the residential school era and the high prevalence rate of diabetes among Aboriginal communities. They believed these community problems could affect the wellbeing of every individual. A few related subthemes were also discussed predominantly by First Nations participants. Within the functionality theme, the great majority of participants who talked about health as the ability to take care of others were First Nations. Moreover, within the social health theme, two subthemes appeared more frequently among First Nations interviewees: having healthy relationships with one's community and contributing to one's community.

In health practices, a few cultural variations also emerged as shown in Figure 2. Maintaining traditions and culture was discussed by First Nations and Francophone participants only. A related subtheme — returning to traditional lifestyle — which fell under maintaining a healthy lifestyle, was also found among Francophone and First Nations participants. Another subtheme, spiritual health defined as having a strong cultural identity, was discussed exclusively by First Nations participants.

Finally, practices to promote the health of others, the community, and the environment were also found predominantly among First Nations interviewees.

DISCUSSION

PRINCIPAL FINDINGS AND IMPLICATIONS

The first objective of this study was to investigate the way the participants define health. It appears that from their perspective, health is a multidimensional concept that includes more than the mere absence of illness, pain, and disability. They all defined health in positive terms by referring to certain characteristics that should be present in a healthy individual.

This positive view of health was described by some participants as an achievable end state, which includes a general sense of wellbeing and the ability to function; while other participants saw health as a developmental process that continues throughout one's life. With the exception of two participants, everyone believed that health is not limited to the body but includes other aspects of the self, namely the mind, the spirit, and the social self. This multidimensional view of health departs from the biomedical health model. This finding suggests that health professionals should not focus only on the treatment of disease as a means of promoting health, as this approach might not lead to a sense of health as conceptualized by the patients. Health strategies should also promote positive health at the physical, mental, social, and spiritual levels. Health professionals should try to gain a better understanding of the practices patients use in their daily lives to promote their health and incorporate these practices into an integrated health program that addresses patients' health-care needs.

The research findings revealed that from the participants' perspective, the best avenue to promote health does not lie in medical practices. Many stressed the importance of being proactive and of taking charge of their own health. In general, the participants agreed that the best way to promote health is to adopt a healthy lifestyle. This finding suggests that simply educating people about the benefits of exercising and eating well may not be sufficient to promote a healthy lifestyle, as every participant in this study recognized the importance of nutrition and exercise. The broader social context surrounding one's choice of health-related behaviours should be taken into account when planning and implementing health promotion programs (Stevens, 2006). For instance, socioeconomic factors may prevent people from accessing nutritional foods, even though they are aware of the potential benefits this diet can have on their health. Thus, health programs should address social barriers preventing people from engaging in a healthy lifestyle.

The last objective of the study was to investigate cultural differences in health definitions and health practices. The content analysis of interview responses

revealed a number of intriguing findings. Compared to Anglophones and Francophones of European ancestry, who tended to define health from an individual perspective, First Nations participants saw health as transcending the individual self to include their family, their community, and even the environment. They also reported engaging in practices to promote the health of others and of the environment. This unique view of health reflects collectivistic values and an interdependent view of the self, while the individual health perspective held by Anglophones and Francophones of European ancestry is more in line with individualistic cultural values and an independent view of the self. The interdependent health view held by First Nations individuals is not reflected in current multidimensional health models. These models should thus be expanded to represent the views of cultural minorities.

Anglophones and Francophones were found to share similar views on health. This finding can be explained by the acculturation and adaptation model (Berry, 2005) with reference to Francophones' historical experiences of contact and proximity with the majority group in Canada, which could have led to a similar way of conceptualizing health.

Finally, Francophones as well as First Nations both recognized the importance of maintaining their traditions and culture as a means of promoting their health, which was not mentioned by Anglophones. Past studies have also shown that members of cultural minority groups often report maintaining their cultural traditions to promote their health (Hakim and Wegmann, 2002; Labun and Emblen, 2007; van Uchelen et al., 1997).

These cultural differences in health conceptions point to the importance of being aware of alternative health views, especially for health professionals who work with members of diverse cultural backgrounds. They should not assume that every member of a given cultural group shares the same views. Instead of relying on mainstream assumptions about cultural representations of health, an alternative would be to have health professionals engage in the practice of inquiring and sharing views of health with their patients. This practice represents one step towards achieving culturally appropriate

health care and creating a culturally safe environment for cultural minority patients (Ailinger and Causey, 1995; Hakim and Wegmann, 2002; Hufford, 1992; Jobanputra and Furnham, 2005; McCarthy et al., 2004; Torsch and Ma, 2000). This has implications for the doctor-patient relationship, possibly increasing satisfaction with health care, building a sense of trust, and promoting adherence to doctors' recommendations among minority patients (Kerse et al., 2004; Kleinman, 1978; Pavlish et al., 2010; Rubenstein et al., 1992). In turn, it can have a beneficial effect on their health.

Finally, the research findings also have important implications for community health planners and policy makers. They should reflect on the health views and needs of their target populations to develop programs and policies that are consistent with their health views. For instance, since First Nations individuals tend to conceptualize health as expanding beyond the individual, health-promoting efforts should not be directed solely at the individual level, but should aim at improving the wellbeing of families and communities as a whole. One health-promoting approach that emerged from the interviews conducted with First Nations participants is the need to maintain and promote their traditions and culture. This finding is in accordance with past research: promoting health among Indigenous communities is intricately linked to efforts to revitalize cultural integrity (Hallett et al., 2007; McMullin, 2005; Taylor, 2008).

LIMITATIONS

Some limitations should be taken into consideration when considering the results of this study. First, the research findings may not be generalizable to other populations. Even among Anglophones, Francophones, and First Nations peoples, health conceptions may vary among other segments of these populations, including those who live in other parts of the country, in rural settings, those who live below the poverty line or among the upper classes.

The use of convenience and snowballing sampling strategies could have led to a sample that is not representative of the Anglophone, Francophone, and First Nations populations living in the city

where the study was conducted. For instance, most participants in this study were in relatively good health and they were well educated.

Third, the researcher's and the research assistant's characteristics, including their own cultural affiliations, could have influenced the participants during the interviews. Some participants may have shared health conceptions that did not accurately reflect their views on health, but were more in line with what they believed was expected of them or represented the "right" way of defining health.

CONCLUSION

This research contributes to the field in three ways:

- a. It provides new insights into how health is defined among members of long-established minority groups in Canada, which is essential for providing culturally sensitive care. Investigating health conceptions instead of illness beliefs departs from the disease-centred paradigm commonly used in health research, especially in Aboriginal communities (Van Uchelen et al., 1997). The present study looks at health in terms of possibilities or an ideal people aspire to achieve, which can guide health-care providers in addressing their health needs. The use of NVIVO greatly facilitated the data analysis, mapping the themes and subthemes in a reader-friendly fashion.
- b. Some methodological considerations of sampling contribute to the strength of the study. For example, we ensured that participants in the three cultural groups were homogeneous with respect to a number of demographic variables.
- c. Finally, this research has provided new evidence supporting the theoretical framework of multi-dimensional health models as well as the theory of individualism and collectivism.

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