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2003

# The Health Status of Aboriginal Peoples in Canada: Reflection, Realization, and Response

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“[A] great many people have little access to health care [...] and spend their lives fighting unnecessary morbidity” (Sen, 1999:15). To Nobel-laureate Amartya Sen, this is a fundamental form of ‘unfreedom.’ To many Aboriginal<sup>1</sup> people, it is a characteristic of contemporary existence within the boundaries of Canada. Because the health status of Native people has continued to register as inequitably poor, despite the existence of socialized medicine and a proliferation of government health programs, claims that a simple increase in health services or a reorganization of the health care budget will have a positive impact are no longer sensible. And with Indigenous peoples bearing a disproportionate amount of excess and premature morbidity and mortality, such claims are no longer ethical.

## Historical Background

*[I]ndigenous peoples of the Americas knew many cures for illnesses long before medicine in Europe became a science (Colomeda and Wenzel, 2000:247).*

Before the arrival of Europeans in North America, “there were already in existence various Aboriginal medical systems, each with its theories of disease causation, its categories of practitioners, and its diagnostic and therapeutic techniques” (Waldram et al., 2000:261). In these systems, “[m]edicine was closely integrated with other aspects of Aboriginal culture and was often indistinguishable from spirituality” (Waldram et al., 2000:261). Many principles employed by Native people were a revelation to, and have subsequently been empirically validated by biomedicine. Although willing to adopt and

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<sup>1</sup> For the purposes of this paper the words “Native,” “Indigenous,” and “Aboriginal” will be used interchangeably. The term “Aboriginal” is used in Canada to include Indians, Métis and Inuit (per the Constitution Act of 1982), while the term “Indigenous” is more commonly used in international treaties and agreements, (e.g. the U.N. Convention on Biological Diversity). The term “First Nations” refers specifically to status Indians. Quotations are an exception to this; the work of other authors is, naturally, their own.

even claim to have discovered various Indigenous therapies,<sup>2</sup> anthropologists, scientists and medical professionals, “tended to view healing rituals as manipulative conjuring rites that would be superseded by Western medicine, once science had triumphed over superstition” (Kennedy, 1984:22). Nevertheless, several Indigenous medicines persist among the ‘gold standard’ preparations and therapies of modern allopathic medicine, of which acetylsalicylic acid (aspirin, the most widely used medication in the world), digitalis (an isolation from foxglove, used in treating various heart ailments) and curare (a muscle relaxant employed as an adjunct to general anaesthesia) are but a few.

“The traditional healer’s role combines the Western roles of physician, therapist, priest, coroner and judge” (Weeramanthri, 1997:1005). Characterized as ‘gifted’ “because of their ability to communicate with and be guided by spiritual beings,” many have specializations, or areas in which they demonstrate treatment expertise (Garro, 1995:37). Native communities, due to violence and disease in the wake of colonization, lost a significant number of traditional healers and untold amounts of Indigenous healing knowledge – a relatively fragile entity, individual and idiosyncratic, learned slowly and transmitted orally. The practice of Aboriginal medicine was further eroded by mounting restrictions on ceremonies central to Native health (for example, the sun dance and sweat lodge), while governmental health policy sought the consolidation of political power and its requisite undermining of the autonomy of the community. Ultimately, the dominant society’s drive toward assimilation forced Aboriginal healers underground. Far from being eliminated or rendered obsolete however, in recent years Native traditional medicine has been found “at the centre of a cultural renaissance in health care” (Gregory, 1989:163).

### Contemporary Health Status

*The health status of our aboriginal people is one of Canada's major unresolved challenges* (Haddad, 2001).

Aboriginal peoples in Canada show a higher incidence of illness than the general population, no matter what statistical measure is employed in the determination (Newbold, 1998). Young writes that,

In broad terms, the recent epidemiologic history of Native American populations can be characterized by several key features: the decline but persistence of infectious diseases, stabilizing at a level still higher than that of the non-Native population; the rise in chronic diseases, especially diabetes; and the overwhelming importance of the so-called social pathologies – violence, unintentional injuries, and the ill effects of alcohol and drug abuse (Young, 1997:147).

The proliferation of diseases that were unknown in the North American Indigenous population prior to colonization has, “led to the proposal of a ‘New World Syndrome’ of disorders” (Young, 1997:164). Trends in prevalence tend to support such a theory, since the occurrence of these diseases positively correlates with “the rate of acculturation and

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<sup>2</sup> The cure for scurvy taught to Jacques Cartier by the Huron (an infusion of pine needles, delivering the required dose of vitamin C), was patented by Scottish Navy officer James Lind in the 1700s. J. Weatherford, cited in Colomeda and Wenzel, 2000.

proximity to non-Native population” (Sunday and Eyles, 2001:637). Although the epidemic illnesses which decimated populations throughout the last five hundred years have essentially been eradicated, “Native[s] are still at high risk for such infections as meningitis, acute respiratory infections, viral hepatitis, sexually transmitted diseases, and intestinal infections” (Young, 1997:153). Self-identified health problems<sup>3</sup> within Indigenous communities include substance abuse, cancer, diabetes and arthritis (Newbold, 1998). Aboriginal health statistics have improved since World War II, with the exception of diseases and conditions classified as diet- or lifestyle-related (Wolever et al., 1997). Native peoples are now said to be in the midst of an ‘epidemiological transition’ (Garro, 1995).

Life expectancy for Indigenous individuals (at birth) is, on average, eleven per cent lower than for the overall population. Infant mortality rates, although they have fallen dramatically in the past twenty years, remain alarmingly high: 16.3 per one thousand births among Inuit and 13.8 among status Indians, compared with the Canadian average of 7.3 (Newbold, 1997 and 1998). Aboriginal people are markedly less inclined to visit a physician<sup>4</sup> – this fact is particularly meaningful in light of policy intended to assure equitable health for all people of Canada through the standardization of health care across every province and territory. The picture is clarified somewhat with the addendum that Native persons fluent in their native language are significantly less likely to visit a physician (Newbold, 1997 and 1998).

One of the most important barriers to utilization of available treatment is a lack of compliance, and its magnitude intensifies in treatment regimens that incorporate a change in lifestyle. “Managing [illness] becomes problematic when related to everyday concerns, such as limited income” (Sunday and Eyles, 2001:645). Contemporary health promotion focuses on issues of compliance and risk behaviours (such as smoking, nutrition, use of alcohol or narcotics, knowledge of safety, sexual behaviours and level of physical activity), but insufficient data relevant to the Aboriginal population – a persistent hindrance in the examination and understanding of ill health among Indigenous peoples – makes the prevalence of these factors difficult to assess.

### Causal Relationships

*Aboriginal health is a political issue. The poor health status of [Aboriginals] is the direct consequence of invasion by a capitalist society which established its dominance over the indigenous [population and], expropriated their land [...]. Time has only cemented the unequal power relations that exist between the two groups (Saggers and Gray, 1998:ix).*

The accurate determination of causal factors is critical to effecting meaningful change in poor health among Native peoples. The treatment of surface symptoms is a waste of time, effort and money. A balanced investigation into the roots of ill health encompasses both Aboriginal and non-Aboriginal viewpoints, and places the debate of

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<sup>3</sup> The fact that Native Canadians had a self-reported health status almost identical to that of the non-Native population was an unexpected result of the Aboriginal Peoples Survey (APS). An explanation of this anomaly has yet to emerge from the academic literature.

<sup>4</sup> According to the APS, sixty-seven per cent of the Aboriginal population reported visiting a doctor in the past year, compared with eighty-two per cent of the general population (Newbold, 1998:68).

causation within the broader, more appropriate context of political economy and the sociology of health.

Simplistic, naturalistic arguments, hinging on a combination of biological, genetic, cultural and behavioural factors have dominated explanations of the poor health status of Indigenous peoples (Saffron et al., 2002). Such arguments largely serve to reinforce stereotypes. Antiquated and racist theories of 'biological determinism,' "a crude form of social Darwinism in which [Natives] were regarded as less fitted to survival than Europeans and thus doomed to extinction" (Saggers and Gray, 1998:3), are still exercised, with epidemics such as smallpox and tuberculosis often cited as evidence. In reality, an unbiased analysis of causation focuses on material factors such as basic socio-economic and environmental considerations; including income, education, housing and employment. In addition, Aboriginal health must be examined and understood in its historical and political context (Young, 1997:164). A legacy of colonization, dispossession and oppression has led to social and economic exclusion by virtue of geographic isolation or marginalization. Properly viewed as a result of factors external to Indigenous communities, impoverishment in itself negatively impacts health at individual, community and societal levels through a variety of routes. Any claim that Native peoples have failed to properly act on the provision of socialized medicine in Canada, "obfuscates the structural conditions – specifically political, economic, historic, and societal – whereby some individuals are more able to 'act' than others" (Sunday and Eyles, 2001:648).

Loss of land and people immediately after first contact (and, to an extent, continuing to the present day) has had at least two significant impacts on the health of Aboriginal peoples: the aforementioned loss of traditional healing knowledge, and a simultaneous decline in traditional nutritional practice. In addition, "environmental degradation has contaminated many traditional food sources, particularly fish, plants, and game to the extent that their consumption is dangerous to human health" (Colomeda and Wenzel, 2000:250). There are differences between the amount, type and variety of foods eaten by young and old members of Indigenous communities, "consistent with the pattern of rapid cultural change demonstrated in [...] North American aboriginal populations" (Wolever et al., 1997:611).

Although empirical data on the relationship between the status of health and other factors such as employment, housing conditions, environment and education is lacking (Newbold, 1998), broad correlations can be made. Unemployment stands at six per cent for the overall population, and fourteen per cent for Native peoples. While fourteen per cent of Canadians have attained a 'high' level of education (a postsecondary degree), this figure drops to two per cent when the sample is restricted to Aboriginal people (Newbold, 1997 and 1998). The number of Indigenous individuals living below the poverty line (subsisting on less than ten thousand dollars per year) is almost fifty per cent higher than the national norm (Newbold, 1997 and 1998).

## Conceptualizing Health

*[T]he meaning of health and its application in everyday-life is dependent on the culture and worldview of the population being served (Colomeda and Wenzel, 2000:244).*

Sickness, from an Aboriginal perspective, is not necessarily premised on physiology – certain symptoms may be interpreted as a message or opportunity for an individual to reflect upon, and make changes in his or her life. This demonstrates that, in viewing illness, etiology (the assignment of cause), symptomatology (the study of symptoms) and intervention (the need for treatment) are all conceptualized within a socially and culturally determined ‘explanatory model.’ Shared social and historical circumstances contribute to the shared model usually found within a distinct population, which accounts for the current climate wherein “different sectors of the medical system possess distinct explanatory models which may coexist, complement or compete with one another” (Kennedy, 1984:22). In general, Western explanatory models are unlike Indigenous conceptualizations of wellness and illness; in fact, they can be antipathetic, serving to “[...] neither allay the anxieties of Aboriginal family members, nor satisfy their quest for meaning” (Weeramanthri, 1997:1009).

“Historically, traditional cultures recognized the importance of belief and expectancy within the healing encounter and created complex rituals and ceremonies designed to elicit or foster the expectancy and participation of both the healer and patient, as well as the community as a whole” (Wirth, 1995:249). How well a patient follows a treatment program, how positively they view the doctor/healer-patient interaction and how likely they are to seek out treatment in the future, is directly related to how well the explanatory model of the doctor or healer matches or complements his/her own. Healing is most successful when carried out within the patient’s cultural framework, since a lack of familiarity with the individual’s explanatory model renders the medical practitioner unable to provide therapy that is simultaneously physiologically and culturally appropriate (Good, 1996). “[F]rom the [Native] perspective it is unthinkable for any healer to believe that he or she alone does the healing. All parties – the spiritual source, the family, the clan, the patient and the medicine man – were participants in the healing process” (Hammerschlag, 1989:89).

Modern medicine, legitimized in the West for centuries, relies upon “a reductionist, mechanistic and non-ritualistic approach to healing” (Wirth, 1995:249). Biomedicine is aptly named: endowed with an almost exclusive focus on the physical manifestation of illness and subsequent interventive therapies, it often defines ‘health’ as the straightforward absence of disease. In contrast, within the model of traditional Aboriginal medicine, “[...] good health includes practicing cultural ceremonies, speaking their language, applying the wisdom of the elders, learning the songs, beliefs, healing practices and values that have been handed down in the community from generation to generation,” so that, “ultimately, individual “[...] health is linked to the health of the land, health of the culture, and spiritual health” (Colomeda and Wenzel, 2000:247).

## Canadian Health Policy

*Non-aboriginal beliefs and behaviours have largely determined the position of [Aboriginals] in society – some of those beliefs and behaviours must change* (Saggers and Gray, 1998:xi).

Governmental responsibility for provision of Aboriginal health care, particularly interpretations of the ‘medicine chest’ of the 1876 Treaty Six, has been the subject of considerable debate and controversy. Overarching discourse ended prematurely when the implementation of socialized medicine in Canada rendered the underlying question a moot point, yet left the matter unresolved (and insufficiently understood). Because of a narrow Western definition of health, Canadian “health policy has been predominantly health *care* policy, reacting to *departures* from health” (Newbold, 1998:70, *emphasis added*); primarily taking the form of fiscal planning and politicking. In the Aboriginal Peoples Survey (APS), “less than 1% of all respondents suggested that the lack of health care facilities was the most important health issue” (Newbold, 1998:68), and a growing number of research documents state that “excess mortality and morbidity cannot be explained solely on the defects in the health-delivery system [and are] probably beyond the ameliorating influence of personal health services” (Young, 1997:126). Yet governmental reform has tended to address only the financial minutiae of the health-delivery system.

Despite an established fiduciary responsibility and acknowledgement of the disproportionately poor health status of Native peoples in Canada, governmental response has been slow. The roots of inadequate positive action run deep within the political arena, where “paternalistic conservatism [...] pervades their approach to aboriginal health. Many of the causes of aboriginal ill-health are [...] to be addressed by educating [Natives] and, were it feasible, by exercising control over how they spend their citizen entitlements” (Saggers and Gray, 1991:15). Policy choices are influenced by the electorate, and the concept of ‘vertical equity’<sup>5</sup> seems to anger the general population, who are generally ill-informed of the nature, extent and origin of existing inequalities and troubled by large expenditures on a ‘small minority group.’<sup>6</sup>

Too often, discussion of health care has been coloured by the emotionally charged, delicate and racially polarizing debate over Indigenous sovereignty, with federal and provincial governments continuing a long-standing tradition of refusing to take discourse to a national level. Unfortunately,

If the government deals with Indians solely on a band-by-band basis, there can be no unified expression of Indian interests in the field of health care. An important role for the larger constituency organizations exists in monitoring government policy, disseminating information, and formulating collective recommendation (Garro et al., 1986:283).

The Alma-Ata Declaration of 1978, signed and therefore explicitly endorsed by the government of Canada, set health as one of the fundamental human rights. It further

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<sup>5</sup> Vertical equity is defined as ‘the unequal but equitable treatment of unequals.’ Wiseman, V. and S. Jan. “Resource Allocation within Australian Indigenous Communities: A Program for Implementing Vertical Equity.” *Health Care Analysis* 8 (2000): 217-233.

<sup>6</sup> Aboriginal peoples represent four per cent of the population of Canada (Newbold, 1997:67).

proposed that people have both the individual and collective right to determine the provision of their health care (ICPHC, 1978). The federal policy issued a year later acknowledged, for the first time, that an increase in overall services would not improve the health status of Native peoples in Canada, and that 'health' had a spiritual component. The stepwise transfer of health services initiated shortly thereafter was a convoluted, time-consuming and frustrating process. Its inconsistently applied principles, "developed without formal input of Indian organizations" (Garro et al., 1986:281), were ultimately of questionable impact. The entire endeavour drew criticism for disguising a "unilateral decision [which] does little to engender trust and cooperation between government and Indian groups," and ultimately, for being a cost-saving "abrogation of the federal government's responsibilities for Indian health" (Waldram et al., 1995, pp. 237-238).

### Medical Pluralism

*When we professionals think we are the only ones doing the healing, we are setting ourselves up for pain and disillusionment* (Hammerschlag, 1989:6).

Medical pluralism, being under the service of more than one healing paradigm, is becoming widely practiced throughout the world despite the fact that "biomedicine has emerged the dominant or officially legitimized health care system" (Gagnon, 1989:175). There are now two major streams of medicine in the West: biomedical (or allopathic) and alternative (or complementary). For Aboriginal peoples, traditional medicine, where available, constitutes a third, distinct system. The availability of these varied treatment options serves to empower patients through providing choice in treatment and acknowledgement of their individual beliefs.

While many Native individuals do not have access to traditional healers (and perhaps lack awareness of traditional medicine), others visit traditional healers with or without the 'blessing' of their local hospital or family doctor. Generally, Indigenous persons move easily between the allopathic/biomedical and traditional medicine systems, being quite comfortable seeking out the services of both a doctor and traditional healer to address the origin and effect of a specific illness. Such a "pathway through medical options should not be viewed as naïve, speculative, or irrational, but as a pragmatic search from symptom relief in a milieu in which he maintains control" (Kennedy, 1984:28). Additionally, some conditions may be viewed as exclusively 'white' or exclusively 'Native,' requiring treatment from the appropriate system.

"It is generally agreed that the demands of Canada's Indian population are not being met by Western medicine" (Kennedy, 1984:30). Certain key shortcomings in biomedicine become apparent when dealing with Aboriginal peoples; primary among these is an ethnocentric view of medicine - the majority of healthcare workers are of Anglo descent, and harbour "a strong belief that modern medicine is the most successful and perhaps the only means of curing illness" (Good, 1996:63). Other weaknesses stem from fundamental differences in each group's explanatory model, giving rise to miscommunication, lowered compliance and poor outcomes that have profound effects on the quality of life of individual patients. "The Western model of analytical segregation of communities for the purpose of health education and health promotion can hardly gain support from Indigenous peoples as they feel that this approach may result in 'blaming-the-victim' models of community organization" (Colomeda and Wenzel, 2000:252). These failures "are thought to reflect unrealistic expectations for behaviour

change, by the abstraction of behaviour from its social context, and some degree of paternalism and discrimination within the health care system” (Daniel et al., 1999:816). The onus for strengthening weak points in the biomedical system is with its practitioners, some of whom have begun to comment and act upon problem areas, recognizing that “[t]here may be much more that we can do from the non-Aboriginal side to change our attitudes and practices, and improve communications, than we currently suspect” (Weeramanthri, 1997:1014).

### **Barriers to Formalization and Collaboration**

*What we saw as their passivity frustrated us. What we didn't know was that there was another system, another way of dealing with living and dying, suffering and healing, that we knew nothing of* (Hammerschlag, 1989:4).

Colomeda and Wenzel describe the defining characteristic of Western medicine today as its ‘pre-eminence,’ adding that “Western medicine assumes its pre-eminence because it believes in scientific rationality of the European kind, claiming that its paradigm of scientific conduct is the only one that merits acknowledgement [...]” (Colomeda and Wenzel, 2000:247). The philosophy of Western science and medicine does not accept the very principles on which traditional medicine is founded; marking a profound barrier to effective collaboration. Arguments constructed in favour of Aboriginal healing systems, based on tradition and belief, are scientifically unsound in the absence of empirical evidence. Legitimizing traditional healing is problematic, since research into traditional Native medicine is confounded by the importance of culture in Indigenous healing modalities. Stripped of cultural context, traditional medicine can be lacking in clinical evidence, left on par with such practices as bloodletting and leaching. Unfortunately, researchers who have attempted to operationalize culture have had less than uniform success (Wilson et al., 2002). Because they are lacking in scientific credibility, it is potentially unethical to promote Aboriginal therapies. Allopathic practitioners are therefore generally disinclined to formally collaborate with traditional healers, if on purely philosophical grounds.

A second barrier to collaboration is reticence to forfeit control of what amounts to a professional monopoly. Actions taken to protect this monopoly include insistence that ‘alternative’ methodologies not interfere with allopathic medicine. “[C]oncern with Indian patients’ psychosocial needs [...] has not been forthcoming from the larger body of general medical practitioners. Indeed [it] has been criticized as being anti-Western, pro-nativist and anti-positivist,” setting up a false dichotomy and antagonistic relationship (Kennedy, 1984:31). This sentiment is further entrenched when physicians are living outside of the community they service, and are consequently removed from the concerns of their patients – as is the case for most doctors serving Aboriginal communities. This problem is amplified when the patients belong to a minority group.<sup>7</sup> An undercurrent of hostility to collaboration has been noted in academic literature, where it has been observed that “most Western respect for Aboriginal beliefs [is] merely ‘lip service,’ since most [do] not believe that Aboriginal explanations [are] of equivalent explanatory value to Western explanations” (Weeramanthri, 1997:1009).

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<sup>7</sup> This is one of the reasons that nurses have been more active in the acceptance and promotion of traditional medicine (Waldram et al., 2000:216).

The fear of cultural appropriation for profit, exacerbated by the modern commodification of culture and a predilection for 'New Age therapies,' has resulted in a disinclination to transfer Native healing knowledge outside of the Indigenous community. Humility, cultural taboos and fear stemming from a long history of persecution also act to impede open sharing or welcoming of Western investigation into traditional medicinal practices.

If Aboriginal medical practices are recognized as medicine in the conventional sense, it opens up the complex question of whether or not traditional healers are practicing medicine without a license. There are issues of criminal and civil liability when it comes to the provision of health care, since the Canadian courts have ruled that an individual's personal beliefs may not interfere with the provision of recognized medical care. A lack of regulatory bodies, professional and licensing associations, and insurance providers within the field of traditional medicine make an obligation to protect Canadian citizens from medical fraud difficult. Even though healers are validated and regulated by the community, consensus on a healer's abilities is lacking even at a limited level, making formal recognition impossible. 'Charlatanism' is prevalent enough that North American Native organizations have passed resolutions warning of the dangers posed by fraudulent or insufficiently knowledgeable practitioners (Waldram et al., 1995). Even where the capabilities of Indigenous healers are not in doubt, treatments from the allopathic and traditional spheres can be contraindicated. The burden of responsibility, should any medical crisis occur during collaboration between these spheres, is very poorly defined, while the risk of prosecution is very real.

Collaboration between the dominant and traditional medical systems is, at present, largely informal, despite numerous examples of positive interactions (Gregory, 1989). Not surprisingly, medical personnel with the most experience working in Indigenous communities, or with Indigenous patients, are the most amenable to future alliances between the two medical systems. This speaks to the "need for more systematic training and practice exposure to Native healers and healing practices in both undergraduate and continuing medical education" (Gagnon, 1989:185). If a formal referral system were implemented, most physicians have indicated they would utilize traditional healers in the course of caring for their Aboriginal patients (Gagnon, 1989).

Ultimately, investigation into collaborative models has produced no consensus from within or beyond the Native community – indeed, there is even doubt as to whether such a marriage of cultural practices should be undertaken. Many healers, on both sides of the system, believe that while collaboration is necessary, the two medical systems must operate independently (Gagnon, 1989).

### **Aboriginal Initiatives**

*North American Indians have at their disposal a rich heritage of communal healing techniques (Brady, 1995:1487).*

Aboriginal, community-driven initiatives in health care, while having been accepted and even lauded within the discipline of mental health, have been largely ignored by mainstream biomedicine. Great advances have been made in healing directed at individuals recovering from physical, mental or substance abuse, and those suffering the effects of institutionalization within residential school or correctional systems. Culturally restorative processes have proven the most successful in treating dependencies

on alcohol and narcotics in Indigenous communities. Recovering alcoholics who have moved through this process credit a “focus on the ways that [...] they have been able to live the life they have long seen as proper,” and a restoration to wholeness where “their integrity not just as people, but as Indian people” (Spicer, 2001: 237-238).

Native-driven projects avoid a pitfall that is common in dominant approaches: a restrictive definition and application of ‘culture’ in treatment:

A narrow definition of ‘culture’ runs the danger of losing the human element of choice, for people make selections from a wide range of adaptive possibilities according to their wants and needs. Rather than being viewed as the dynamic past and future of peoples (and not just their past), culture has become a ‘thing’ that you either have or you have lost [...] (Brady, 1995:1490).

The interweaving of traditional, Western and contemporary approaches provides, “a promising approach for health promotion in populations that have traditionally been viewed as “hard to reach” (Cook Gotay, 2000:535). Rituals and ceremonies like healing circles and sweat lodges (for mental, spiritual and physical health issues) are being reintroduced and revitalized, sometimes through the influence of elders from a separate community or culture. Aboriginal health directives stress that educational and preventive functions of care operate alongside treatment. Community involvement is fostered through widespread health promotion – in newsletters, clean-up efforts, health fairs, workshops and activities for different age groups (Garro et al., 1986:282). Whenever possible, conventional therapies “are made culturally more appropriate, and traditional approaches to healing are brought in to augment, but not necessarily replace, biomedical approaches” (Waldram et al., 1995:256). The result is the creation of a “syncretic system offering more culturally relevant health care to Indian people” (Kennedy, 1984:30). Indigenous programs tend to be holistic and intensive, oriented around the community, centred on preventative as well as interventive treatments and stressing individual responsibility without the spectre of blame. Treatment is invariably accompanied by cultural education and ceremony, and elders (not all of whom are healers) have significant input into the programming (Waldram et al., 1995:255).

Native initiatives are not entirely free of weaknesses, however. A strong impediment to the use of traditional medical services is language, as individuals who speak an Aboriginal language are more likely to seek out traditional healers and invest significant belief in the equality (or superiority) of these treatments for certain conditions; while Anglo- or Francophone Indigenous individuals may not share this affinity (Waldram et al., 1995). Additionally, although data is limited, all indications point to a critical lack of qualified traditional healers and a deficit of youth interested in learning Native healing techniques. Aboriginal communities are chronically under-served medically, presenting considerable stress for medical staff, while funding is invariably in short supply. Payment, too, presents a problem: traditionally a healer does not levy a fee for services, and full-time dedication to a healing practice which does not include the means to earn a sufficient living is untenable.

Movements toward Native control of health services are plagued by the same problems experienced in other areas of struggles for sovereignty – primarily the inability to reach agreement on the definition of ‘self-determination.’ Besides obvious differences in viewpoints between Indigenous and government representatives, there are

disagreements among various Aboriginal groups, between the provincial and federal levels of government, and among all of these groups and the general population. That being said, not all Native communities desire complete assumption of the planning, budgeting and delivery of health programs: “many are not currently prepared to do so, and others do not feel this would be in their best interest” (Garro et al., 1986:284).

Despite consistent underestimation and undermining from Western political and scientific institutions, Indigenous communities and organizations have demonstrated tremendous ingenuity and political will in assessing their own wellness and implementing their own healing strategies. In addition, they have increased awareness of health care issues at the community and national levels, and have had unprecedented success in motivating community-wide action in support of positive change in patterns of behaviour (Rowe, 1997). “Despite the health challenges facing aboriginal communities in Canada over the past several decades, aboriginal people have demonstrated incredible strength, determination and resiliency to survive, thrive and prosper” (IAPH, 2002:2).

### **Future Directions**

*Nothing functions by itself [...]. Everything is interrelated – body, mind, and spirit. Family, community, country. Job, education, heritage, home. History, culture, religious beliefs, principles* (Hammerschlag, 1989:12).

Improvement of health status will be negligible, if not impossible, without improvement in the socio-economic status and political environment of Aboriginal peoples in Canada. Programs that promote economic development, deal directly with unemployment and improve persistence in education need to be simultaneously implemented. Further, movement in this direction, in order to gain momentum, must receive support from within both the Native community and the broader national arena. “That this needs to be a bilateral process goes without saying” (Garro et al., 1986:284).

In 1996, the Royal Commission on Aboriginal Peoples (RCAP) recommended that Indigenous peoples be empowered to create and administer an Aboriginal health care system (RCAP, 1993); the National Aboriginal Health Organization (NAHO) grew out of that recommendation (NAHO, 2002). Formed by the Assembly of First Nations, Congress of Aboriginal Peoples, Inuit Tapirisat of Canada, Métis National Council and the Native Women’s Association of Canada, the organization’s specific objectives address the challenges faced by Native communities in matters of health – challenges delineated by the 1997 Auditor-General Report, First Nations/Inuit Regional Health Surveys, Canadian Human Rights Commission, RCAP, and most recently by the Romanow Commission. A second important effort to coalesce in recent years is the Aboriginal Healing and Wellness Strategy (AHWS), the “single largest Aboriginal initiative undertaken by a province in Canada [...] designed, delivered, and managed by Aboriginal communities, for Aboriginal people” (AHWS, 2000:1).

Another overwhelmingly positive change is the confident manner in which Indigenous groups are beginning to address Western research interests. Some communities now screen teams and proposals, demanding that accessible language be used to explain projects, that all benefits be clearly delineated, that researchers obtain licenses before beginning fieldwork and that results be shared with the community (IAPH, 2002). Additionally, research has begun to emanate from within Native communities, becoming “more closely oriented towards [Aboriginal] social, spiritual,

economic, and political needs” (Waldram et al., 1995:262). There has also been optimistic and focused work in the field of collaborative research from the Western side of the discourse, with a growing number of teams announcing that “despite inevitable constraints, it is possible to implement rigorous research methods in an appropriate and acceptable way to collect useful Aboriginal health data” (Holmes et al., 2002:1277). The Canadian Institute of Health Research has explicitly listed, among its core values in its 2002-2007 Five-Year Strategic Plan, inclusiveness of Indigenous organizations and transparency in all undertakings (CIHR, 2002). Both of these characteristics are critical to the success of future collaborative research concerning Aboriginal health in Canada - both have been lacking in past efforts.

There is obviously no guarantee that health status will improve if Native peoples gain control of health care delivery in their communities:

Communities know that taking control over health services and providing quality health care is not simple, and that no single recipe will fit all communities, but given adequate resources, flexibility, time, training, and information about alternative structures and models, communities can assume responsibility for the control and operation of health care services (Garro et al., 1986:284)

From a national perspective, models already exist for the simultaneous federal support of Western and traditional medicine, “by allowing them to operate as “parallel and equal systems” (Gagnon, 1989:175). Currently, governments in both China and India fully support both Indigenous and Western medical systems (C. Leslie, cited in Gagnon). The World Health Organization (WHO), considered a scientifically conservative body, published a position paper calling on nations to support the role of traditional medicine in today’s globalizing world (WHO, 1996). The federal government of Canada, if sufficiently dedicated to the task, could act upon this call by utilizing existing precedents to develop a new, bicultural medical system in collaboration with Aboriginal peoples. In the process, however, “[i]t will not be enough to listen to the voices of those who have been marginalized, and to understand the historical processes of oppression. There needs to be the collective willingness to deal with systemic discrimination which structures life opportunities. These are health and health care issues [...]” (Anderson, 1996:704).

Indigenous peoples continue to experience disproportionate levels of premature and excess mortality and morbidity in the face of relatively widespread government health programs and the existence of long-term socialized medicine in this country. As Joan Anderson has pointed out, “Achieving health is not just a matter of enabling people to take more responsibility for their health; it is also about naming injustice, and taking action to address social and economic inequity. This will be the challenge for the 21<sup>st</sup> century” (1996:704). The gap between the health of Native and non-Native persons is not a budgetary issue; it is not a ‘cultural’ issue; it is not an issue of personal compliance. From an ethical standpoint, the health status of Aboriginal peoples in Canada can no longer be painted as anything other than what it is: a political issue. As Native individuals continue to bear a disproportionate amount of premature morbidity and mortality, this issue demands a level of attention – of political will – commensurate with its urgency.

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