3

Health and Healing

The wellness of our people, including their social, economic and spiritual well-being, crosses the boundaries of the separate terms of reference of the Royal Commission]. Wellness is a community issue, a national issue, a women's issue. It touches youth concerns, family considerations, even self-government and historical concerns. I firmly believe that no other [issue] so fundamentally relates to the survival of our people as that of health.

Tom Iron
Fourth Vice-Chief
Federation of Saskatchewan Indian Nations
Wahpeton, Saskatchewan, 26 May 1992[*]

CANADA IS WIDELY THOUGHT to be one of the best countries in which to live. In 1994, the United Nations Development Programme measured the quality of life around the world, using a variety of social and economic indicators. Canada placed first.[1]

Yet, within Canada's borders, there are two realities. Most Canadians enjoy adequate food and shelter, clean water, public safety, protection from abject poverty, access to responsive medical and social services, and the good health that results from these things. Aboriginal people are more likely to face inadequate nutrition, substandard housing and sanitation, unemployment and poverty, discrimination and racism, violence, inappropriate or absent services, and subsequent high rates of physical, social and emotional illness, injury, disability and premature death. The gap separating Aboriginal from non-Aboriginal people in terms of quality of life as defined by the World Health Organization remains stubbornly wide:

- Life expectancy at birth is about seven to eight years less for registered Indians than for Canadians generally.[2]

- Part of this difference in life expectancy is explained by high rates of infant mortality among registered Indians. For infants, the death rate is about twice as high as the national average.[3] There are also high rates of injury and accidental death among Aboriginal children and adolescents. Mortality in all age groups is higher for registered Indians than for Canadians generally.

- Infectious diseases of all kinds are more common among Aboriginal people than others.

- The incidence of life-threatening degenerative conditions such as cancer, heart, liver and lung disease — previously uncommon in the Aboriginal population — is rising.

- Overall rates of injury, violence and self-destructive behaviour are disturbingly high.

- Rates of overcrowding, educational failure, unemployment, welfare dependency, conflict with the law and incarceration all point to major imbalances in the social conditions that shape the well-being of Aboriginal people.

We believe that most Canadians are disturbed by these facts. Non-Aboriginal people are baffled and feel helpless. The stories they hear about ill health in Aboriginal communities do not sound like *their* Canada. They do not understand why so much ill health persists among people living in such a great country, or what should be done about it. Aboriginal people feel ashamed or angry. They see that some communities have made great strides toward the dynamic state of health and harmony to which all aspire, but they also see that many health and social problems go unchecked and that some are getting worse. They know they did not live with such high levels of illness and unhappiness in the past, and they do not understand why they must do so now. In this chapter, we hope to answer the questions posed by Aboriginal and non-Aboriginal people alike.

The mandate of the Commission directed our attention to social issues of concern to Aboriginal peoples in these words:

The Commission may study and make concrete recommendations to improve the quality of life for aboriginal peoples living on-reserve, in native settlements and communities, and in rural areas and cities. Issues of concern include, but are not limited to: poverty, unemployment and underemployment, access to health care and health concerns generally, alcohol and substance abuse, substandard housing, high suicide rates, child care, child welfare and family violence.

These and other indicators of continuing ill health in Aboriginal communities are a source of pain, suffering, anger and feelings of betrayal and despondency. We believe that one of the most significant contributions the Commission can make to Aboriginal life in Canada is to highlight reasons for these unacceptable conditions and to identify priorities for action that will, in Aboriginal terms, restore balance in the life support systems that promote mental, emotional, physical and spiritual well-being — in other words, health.

During our public hearings, Aboriginal people — particularly women — accorded enormous significance to the Commission's work on health and healing. Many named 'healing' as the first priority among the four 'touchstones for change' put forward in the Commission's discussion paper, *Focusing the Dialogue*.[4] Many more identified healing as a prerequisite for progress toward self-government and economic self-reliance.

The word 'healing' is familiar to non-Aboriginal people, of course, but the idea that Aboriginal people have in mind when they use it is likely not. Healing, in Aboriginal terms, refers to personal and societal recovery from the lasting effects of oppression and systemic racism experienced over generations. Many Aboriginal people are suffering not simply from specific diseases and social problems, but also from a depression of spirit resulting from 200 or more years of damage to their cultures, languages, identities and self-respect. The idea of healing suggests that to reach 'whole health', Aboriginal people must confront the crippling injuries of the past.[5] Yet, doing so is not their job alone. Only when the deep causes of Aboriginal ill health are remedied by Aboriginal and non-Aboriginal people working together will balance and harmony — or health and well-being — be restored.

At least in part, it is to achieve whole health that Aboriginal peoples so vigorously seek self-determination. The relationship between self-determination and health is a circle, however; thus, only when whole health is achieved will successful and mature self-determination be possible:

With the healing in place we can have self-government, but without that healing we will have dysfunctional self-government.

Jeanette Costello
Counsellor, Kitselas Drug and Alcohol Program
Terrace, British Columbia, 25 May 1993

Without healthy, socially developed youth, we have no leaders for the future. Without available, high-quality care for the elderly, we have no guidance or wisdom from the past. Without strong, committed people acting today to champion our rights and to further our nations' interests, we have no guarantees for anyone beyond today….If we are to survive as a vibrant culture, and as strong and independent nations, we must attend to the health of our people.

Tom Iron
Fourth Vice-Chief
Federation of Saskatchewan Indian Nations
Wahpeton, Saskatchewan, 26 May 1992

Health and social services are important because they enhance people's comfort and attachment to life. But whole health is not a product that can be delivered by external agents; it requires the full engagement of persons interacting with their environment to create and sustain life. Because health services touch people's lives so intimately, they can encourage action in the broader community where conditions essential to health are determined.

With these considerations in mind, the objectives we set for our work on health and healing are

- to further the work of restoring whole health to all Aboriginal people in Canada, both for its own sake and as a requisite for social, political and economic development;

- to place health and healing concerns in the context of history, culture and the imperatives for change in the relationship between Aboriginal people and Canadian institutions; and

- to change the way Aboriginal health is understood and promoted and, by extension, to transform the system of medical and social services delivery.

Statistics on indicators of physical ill health and social distress among Aboriginal people have been repeated so often in the media that they can easily be seen as old news. Still, we consider it necessary to re-examine the burden of ill health borne by Aboriginal people in physical, social, emotional and community terms. Our intention is not to shock, although it is shocking to realize that in a number of health-related areas we may be losing ground. Instead, we intend to demonstrate that in the face of continuing threats to well-being, effective action is possible — and already under way — by drawing on community strengths, traditional knowledge and creative use of professional services.

We have observed that Aboriginal people have well-articulated insights into their individual and collective poor health and that these insights converge with recent scientific research on determinants of health. We conclude that the convergence between Aboriginal perspectives and health sciences research provides a powerful argument for adopting a health strategy based on

- equitable access to health services and equitable outcomes in health status;

- holistic approaches to treatment and preventive services;

- Aboriginal control of services; and

- diversity of approaches that respond to cultural priorities and community needs.

Several fundamental changes are necessary to implement our proposed health and healing strategy. The first element — and the core of the strategy — is to develop a system of healing centres for front-line services and healing lodges for residential treatment. Healing centres and lodges would be accessible in urban, rural and reserve settings to First Nations and Métis people and to Inuit. They would operate under Aboriginal control to deliver integrated health and social services.

The second element is a human resource strategy, incorporating traditional knowledge and training of Aboriginal people to transform Aboriginal health and social services. We present detailed proposals on what should be done in health and social services to achieve the education goals described more generally in our chapters on education in this volume and on economic development in Volume 2.

The third element of the strategy is to adapt mainstream service systems to complement Aboriginal institutions. The fourth element of our proposed strategy, bringing housing and community infrastructure up to prevailing Canadian standards, is summarized here and discussed in detail in Chapter 4 in this volume.

Finally, we place our proposals in the context of the political and economic restructuring needed for Aboriginal communities to achieve whole health.

1. The Burden of Ill Health

1.1 From the Past to the Present

There is considerable evidence to show Aboriginal people enjoyed good health at the time of first contact with Europeans. Historical records and the findings of modern paleo-biology suggest that many of the illnesses common today were once rare, and that mental and physical vigour once prevailed among Aboriginal people:

> [Aboriginal people] were not subject to disease, and knew nothing of fevers….They were not subject to the gout, gravel, fevers or rheumatism. The general remedy was to make themselves sweat, which they did every month and even oftener.[6]

> Before the Indian began to use the white man's foods, he was perforce compelled to live on a comparatively simple diet. His choice was limited, his cooking simple. Yet he lived in perfect health and strength…and attained a vigour, a robustness, that puts to shame the strength and power of civilized man.[7]

> Skeletal remains of unquestionably precolumbian date…are, barring a few exceptions, remarkably free from disease. Whole important scourges [affecting Europeans during the colonial period] were wholly unknown….There was no plague, cholera, typhus, smallpox or measles. Cancer was rare, and even fractures were infrequent….There were, apparently, no nevi [skin tumours]. There were no troubles with the feet, such as fallen arches. And judging from later acquired knowledge, there was a much greater scarcity than in the white population of…most mental disorders, and of other serious conditions.[8]

Canadian historian Olive Dickason quotes from the Jesuit *New Relation of Gaspesia*, then adds her own commentary:

“Amerindians are all by nature physicians, apothecaries and doctors, by virtue of the knowledge and experience they have of certain herbs, which they use successfully to cure ills that seem to us incurable”….The process by which the Amerindians acquired their herbal lore is not clearly understood, but there is no doubt about the results. More than 500 drugs used in the medical pharmacopoeia today were originally used by Amerindians.[9]

Some analysts argue that disease agents themselves were rare in pre-contact America until the tall ships began to arrive with their invisible cargo of bacteria and viruses.[10] What is more likely is that Aboriginal people had adapted well to their home environments: they had developed effective resistance to the micro-organisms living alongside them and had knowledge of herbs and other therapies for treating injury and disease. Of course, some Aboriginal people died prematurely. But more stayed well, or recovered from illness, and thus lived to raise their children and continue the clans and the nations. Aboriginal populations fluctuated largely in relation to food supply.

It was the European explorers and settlers who were more likely to be weak and sick when they first met Aboriginal people.[11] Many arrived suffering from illnesses they brought with them or from the effects of conditions they endured on the voyage: crowded quarters with primitive sanitary facilities, limited and sometimes contaminated drinking water, and limited and sometimes diseased food. Those who accepted the herbal remedies and unfamiliar cures prescribed by Aboriginal healers — bathing, fasting and sweating among them — were the most likely to recover.

In his classic study of Native American health during the colonial period, Virgil Vogel shows how the tone of contemporary observations changed from admiration to disgust after Aboriginal people began to show the effects of contact with Europeans. Written accounts increasingly describe epidemic disease, violence and death in Aboriginal communities.[12] Many writers stated or implied, with blithe disregard for the facts, that Aboriginal people themselves were responsible for the misery they were enduring.

Hundreds of thousands sickened and died as a result of their encounters with Europeans. (For a full discussion of the population dynamics of Aboriginal peoples before and after European contact, see Volume 1, Chapter 2.[13]) Famine and warfare contributed, but infectious diseases were the great killer. Influenza, measles, polio, diphtheria, smallpox and other diseases were transported from the slums of Europe to the unprotected villages of the

Americas. The subsequent decline of the indigenous population is often described as genocide or a holocaust. Estimates of the Aboriginal population before contact in the area that was to become Canada range from 220,000 to two million, with a figure of 500,000 now being widely accepted. An 1871 census estimate of the Aboriginal population in Canada was 102,000 (see Volume 1, Chapter 2).

Aboriginal people were well aware of the link between the newcomers and the epidemics that raced through their camps and villages.[14] During the eighteenth and nineteenth centuries, their leaders sought agreements or treaties with representatives of the British Crown aimed at ensuring their survival in the face of spreading disease and impoverishment. In the expectation of fair compensation for the use of their lands and resources, and in mounting fear of the social and health effects of Euro-Canadian settlement, many Aboriginal nations, clans and families agreed to relocate to camps, farms, villages or reserves distant from sites of colonial settlement. Many did so in the belief that the Crown would guarantee their well-being for all time.[15] Given the gulf that separated Aboriginal and non-Aboriginal cultures, it is not surprising that the meaning of those oral and written agreements has been a matter of conflicting interpretation ever since.[16]

The transformation of Aboriginal people from the state of good health that had impressed travellers from Europe to one of ill health, for which Aboriginal people were (and still are) often held responsible, grew worse as sources of food and clothing from the land declined and traditional economies collapsed. It grew worse still as once-mobile peoples were confined to small plots of land where resources and opportunities for natural sanitation were limited. It worsened yet again as long-standing norms, values, social systems and spiritual practices were undermined or outlawed.

Traditional healing methods were decried as witchcraft and idolatry by Christian missionaries and ridiculed by most others. Ceremonial activity was banned in an effort to turn hunters and trappers into agricultural labourers with a commitment to wage work. Eventually, the *Indian Act* prohibited those ceremonies that had survived most defiantly, the potlatch and the sun dance.[17] Many elders and healers were prosecuted. In these ways, Aboriginal people were stripped of self-respect and respect for one another.

The low point for Aboriginal health and social conditions in Canada came in the early years of the twentieth century. Newspaper stories and official reports on the destitution and continuing epidemics of disease on reserves and in isolated

Inuit, First Nations and Métis settlements were a source of shame to many. The first person assigned a position of responsibility for improving Indian health was Dr. Peter Bryce, who was appointed general medical superintendent in the department of Indian affairs in 1904. Despite the lack of interest and sometimes outright racist attitudes of his colleagues toward his work, Dr. Bryce fought tirelessly (although not always successfully) to raise the standards of health and welfare among the Aboriginal population until leaving office in 1910.[18]

Many of his successors have done likewise.

From the end of the nineteenth century to the middle of the twentieth, health care was provided, first by an assortment of semi-trained RCMP agents, missionaries and officers, and later by a growing number of nurses and doctors in the full- or part-time employ of the federal government. In 1930, the first on-reserve nursing station was opened in Fisher River, Manitoba. By the 1950s, the department of national health and welfare was operating a network of 33 nursing stations, 65 health centres, and 18 small regional hospitals for registered Indians and Inuit.[19] This undertaking was motivated by the post-war spirit of humanitarianism that propelled the emerging Canadian welfare state and by fear of the threat posed to Canadians by sky-high rates of tuberculosis in Aboriginal communities.

The new health system operated on the assumption that Aboriginal people would welcome western-style health care services, and for the most part they did.[20] Where infectious diseases were still a major killer, the impact of medical treatment was immediate. In the longer term, infant mortality began to decline and life expectancy began to increase. But these benefits did not come without a price:

- Aboriginal people with serious illnesses were often sent, unaccompanied, to distant medical facilities for treatment in strange and sometimes hostile environments.

- In their own communities, Aboriginal people were offered health care services that had no foundation in local values, traditions or conditions. At worst, a few were forced (or convinced) to suffer invasive medical procedures, including sterilization.[21]

- Virtually all providers of health and social services were non-Aboriginal, many with little interest in the cultural practices or values of their Aboriginal clients.

Encounters were often clouded by suspicion, misunderstanding, resentment and racism.[22]

- Indigenous healing skills and knowledge of herbal medicines and other traditional treatments were devalued by medical personnel and hidden by those who still practised or even remembered them. Much knowledge was eventually lost.

- Aboriginal people learned that they were not in charge; non-Aboriginal people learned that they were. This legacy is difficult for both sides to put behind them.

Aboriginal health came to national attention again in 1978 when the federal government attempted to reduce its financial responsibility for First Nations and Inuit health care. The specific issue was the provision of non-insured health benefits (that is, benefits such as prescription drugs and eye glasses not universally available through medicare) to registered Indian people and Inuit. This action provoked a forceful protest from the major Aboriginal organizations, whose leaders claimed that services to which their members had a right were being cut off without negotiation. The ensuing debate gradually widened to include all aspects of federal policy on health care for Aboriginal people. Ultimately, it led to a new federal policy statement on Aboriginal health, commonly called the ‘three pillars’ policy.[23] The pillars of Aboriginal health it identified were community development (promoted as the key strategy for improving Aboriginal health), the continuing special responsibility of the federal government for the health and well-being of First Nations people and Inuit, and the essential contributions of all elements of the Canadian health system, whether federal, provincial, territorial or municipal, Aboriginal or non-Aboriginal, public or private.

Although not listed as a pillar, the federal government’s commitment to greater participation by Aboriginal people in planning and delivering their own health services was also stated in the new policy. This commitment was given greater weight and specifics by the 1980 *Report of the Advisory Commission on Indian and Inuit Health Consultation*, written by Justice Thomas Berger. The object of this report was to propose “methods of consultation that would ensure substantive participation by the Indian people and the Inuit people in decisions affecting the provision of health care to them”.[24] The language was conservative, but the report was radical, giving support to the concept of community control by Aboriginal people. Thus, it gave credence to the then-startling idea that Aboriginal people could manage their own affairs. In fact, Berger imagined a complete end to the institutional dependency long fostered by the Canadian state.

Community control was understood by those who supported the report as a means of empowerment, but it was interpreted in a much more restrictive way by most federal officials. They understood it as a transfer of administrative responsibility for certain existing health-related programs, starting with the National Native Alcohol and Drug Abuse Program and the Community Health Representative program in 1980-1981. (We discuss these important programs in more detail later in this chapter.) The idea of transfer of administrative authority for community health services more generally was to be tested in a five-year Community Health Demonstration Program, which got under way in 1982.[25]

Perhaps even more significant during this period was the case-by-case success of some Aboriginal nations and communities in gaining control over their health services. These successes were achieved not as a result of progressive federal policies, but independently of one another as a result of particular local struggles. Some involved non-status, urban, Métis, and Inuit communities to whom the federal transfer initiative did not even apply. We describe only a few here:[26]

- The Kateri Memorial Hospital Centre is the oldest such case. It came into being in 1955, when a local Mohawk woman broke new ground by securing joint funding from the Quebec government and the Mohawk Council of Kahnawake to keep open the local hospital, which had been in the community since 1905. Through 35 years of tumultuous relations with federal, provincial and university (McGill) agencies, the hospital now provides treatment and prevention services to residents of the Kahnawake reserve and to Aboriginal people from nearby Montreal.[27]

- Hailed by some as a model of self-government, the James Bay and Northern Quebec Agreement (JBNQA) of 1975 created the first independent Aboriginal health and social service boards in Canada. Debate continues regarding the strengths and weaknesses of JBNQA. Participating communities have continually charged that the control they were promised has never, in practice, been realized.[28] But within some significant limits, community control has been greatly extended.

- In Labrador, where communities were dependent on the International Grenfell Association for health care, Inuit created the Labrador Independent Health

Commission (LIHC) in 1979. LIHC concentrates primarily on health education and promotion and public health needs.[29]

- The Alberta Indian Health Commission (AIHCC) was established in 1981 to address First Nations' concerns about health in the province. In addition to consulting and being a liaison with Aboriginal and provincial agencies, AIHCC provides urban community health representatives in Edmonton and Calgary.[30]

- Anishnawbe Health Toronto was first funded by the provincial government in 1988 as a multi-service urban community health centre. It is grounded in the principles of the Medicine Wheel and has a mandate to provide services to off-reserve, non-status, and Métis people living in Toronto.[31]

By 1986, the federal government's Community Health Demonstration Program (CHDP) for First Nations communities had funded 31 projects and attracted a volley of criticism. Only seven of the projects funded actually focused on transfer-related issues, yet other initiatives toward greater Aboriginal control of health and social services had been put on hold in favour of CHDP. Many First Nations objected to the very idea of demonstration projects, arguing that they should not have to prove to the federal government's medical services branch (MSB) or any other authority that they could manage their own affairs. Some objected to the MSB policy of working only with individual bands, which discouraged the development of regional and nation institutions. Few were aware that MSB intended (at first) to restrict the health transfer program to First Nations communities participating in CHDP.[32]

By 1987, the demonstration phase, with all its faults, was over. Health transfer itself had begun. Some of the shortcomings of CHDP had been corrected, but transfer remained (and remains) controversial. The Assembly of First Nations, along with several communities and tribal councils, continued to argue that self-determination in health should be part of comprehensive self-government and that the federal government had a hidden agenda of divesting itself of responsibility for Aboriginal health and welfare long before Aboriginal people had achieved good health. Certainly there were yawning gaps in the scope of transfer. For example, major components of care, notably the services covered under the non-insured health benefits program, were excluded from transfer agreements, except in the case of Inuit in Labrador.[33] Budgets transferred to First Nations' control took no account of members living off-reserve, many of whom come home for health care or need culturally appropriate programs wherever they are. It also appeared that transferred funds were to be frozen at pre-transfer levels, thus preventing the development of new programs except at the expense of old ones.[34]

Yet the offer of increased responsibility was irresistible to many First Nations communities. Band and tribal councils weighed the pros and cons of the transfer program and made their decision. By 1989, 58 pre-transfer initiatives involving 212 First Nations communities were under way.[35] Those that chose to participate did so with the full understanding that they were co-operating in a less than perfect process, as one leader of the Swampy Cree Tribal Council made clear a few years later:

> This policy direction had been criticized as an attempt to abrogate treaty rights and have Indian people administer their own misery. Nevertheless, we entered the transfer process — but with our eyes wide open. We saw transfer as a way to achieve some of our objectives, and we felt we could look after ourselves in dealing with government.[36]

By March 1996, 141 First Nations communities had assumed administrative responsibility for health care services, either individually or collectively through multi-community agencies or tribal associations; 237 First Nations communities were involved in the pre-transfer process.[37] As the program has evolved (and as clever negotiators have pushed back the edges), the benefits of transfer have been significant. Gains include flexibility in the use of program funds, more freedom to adapt services to local needs and priorities, reduced paperwork in accounting to MSB, and a greater sense of community ownership of services.[38] But there are significant disadvantages, too, as we heard in public testimony. The drawbacks remain much as they were when the program began: the restricted nature of the programs and services that can be transferred, the brief time available for planning and community education for program responsibility, the cap on funds regardless of need, and the possible failure of the federal government to live up to its fiduciary obligations to Aboriginal people.[39]

> When we talk about health planning [for transfer] in First Nations, the first thing the government does immediately is to slot your concerns into 15 budget line items. They are asking us to do the health plan based on only these 15 items, and by no means does that help us to build a comprehensive health system. All they are interested in is their budget items and "how does your planning fit into our planning?"….We can do all the planning in the world, but Medical Services Branch has no money for enrichment of services. So no matter what kind of

health plan we come up with, if we don't put it within the 15 budget line items, then it's up to us to come up with our own resources, or to handle those as best we can.

Gloria Thomas
Six Nations Community Health Review
Brantford, Ontario, 13 May 1993

The "no enrichment" policy of transfer creates the question: is this a set-up for failure? Is the consequence to this policy that we have administrative responsibility for an already underfunded system? Can we really deliver [creative new] programs under transfer? Can we expand and develop new facilities and additional services in response to new health needs and challenges? Would the transfer of funding to our control be a true [instance of Aboriginal control] since the multi-tiered structure of Medical Services Branch makes it difficult to determine an individual community's share of programs and services?

Claire Campbell
Community Health Nurse, Nipissing First Nation
North Bay, Ontario, 11 May 1993

[Even after transfer], there remain a number of issues which are barriers to providing comprehensive health care services for the Tribal Council membership. Some of these are that we have inadequate community-based mental health programs; we lack adult care; we lack services for the disabled; we have poor, inadequate emergency medical transportation services. Transportation is a non-insured health benefit, and we protest that those benefits are not on the table for transfer of control.

Glen Ross
Cree Nation Tribal Health Centre
The Pas, Manitoba, 20 May 1992

The federal government must not interpret Aboriginal participation in its Federal Health Transfer Program as an abrogation of its fiduciary responsibility to provide health care to Aboriginal peoples on Indian reserves. The federal transfer of health should not be limited to nurses, community health representatives, NNADAP [alcohol and drug addiction] and janitors. Services must be expanded beyond para-professional services, and beyond the ad hoc mentality. Transfer does not mean that Aboriginal people automatically become provincial responsibility. Federal responsibility must remain intact and must be identified as a responsibility within the Canada Assistance Plan as a cost sharing arrangement….

The federal transfer of health must now move into a self-government model….Local control and local development must be encouraged, not discouraged with a narrow interpretation of federal and provincial responsibilities. Federal transfer of federal finances to First Nations, such as the Nisg_a'a, should be viewed by Canada as assistance to a developing nation with sovereignty and dignity remaining as an ideal sought by both partners.

Peter Squires
Chairman, Nisg_a'a Valley Health Board
Terrace, British Columbia, 25 May 1993

Governments are quick to point out that since their first, reluctant acceptance of a major role in ensuring the health and well-being of Aboriginal people, improvements in Aboriginal health status have been dramatic. The greatest strides have been in controlling once-rampant infectious diseases and in reducing infant and child mortality rates that rivalled those of developing countries. Commissioners do not dispute these achievements. However, we believe that their contemporary significance can be — and often is — overstated.[40]

We are deeply troubled by the evidence of continuing physical, mental and emotional ill health and social breakdown among Aboriginal people. Trends in the data on health and social conditions lead us to a stark conclusion: despite the extension of medical and social services (in some form) to every Aboriginal community, and despite the large sums spent by Canadian governments to provide these services, Aboriginal people still suffer from unacceptable rates of illness and distress.[41] The term 'crisis' is not an exaggeration here.

The statistical data in this chapter present only a snapshot of the crisis; our tables and figures are key indicators of health and social well-being — or, in this case, of ill health and social malaise. Although the life expectancy of Aboriginal people throughout North America as measured from birth is significantly lower than for non-Aboriginal people, it has improved since the Second World War. In the United States, Native American males have gained about 15 years of life expectancy, females, more than 20 years.[42] In Canada, comparable figures are difficult to come by, but the trend is the same: life expectancy for registered Indians rose by about four to five years between

1976 and 1986.[43] Life expectancy for Inuit in the Northwest Territories more than doubled between 1940 and 1980,44 although it has remained well below that of other Aboriginal peoples.[45] Registered Indians have made smaller gains since 1978, as illustrated in Table 3.1.[46]

TABLE 3.1

Life Expectancy at Birth, Age 30 and Age 60, Registered Indian and Total Populations, 1978-1981, 1982-85, and 1990

Years	**At Birth**		**At Age 30**		**At Age 60**	
	Registered Indians	**Total Population[1]**	**Registered Indians**	**Total Population[1]**	**Registered Indians**	**Total Population[1]**
Male						
1978-1981	61.6	71.0	39.5	43.4	18.4	17.5
1982-85	64.0	72.4	40.8	44.4	17.9	18.0
1990	66.9	73.9	41.1	45.7	16.9	19.0
Female						
1978-1981	69.0	79.2	44.1	50.7	21.4	23.4
1982-85	72.8	80.1	46.8	51.4	22.5	23.8
1990	74.0	80.5	46.7	51.6	20.5	23.7

Notes:

1. Total population is the total population of Canada, including Aboriginal persons.

2. Life expectancies at age 30 and 60 for registered Indians in 1990 are the average life expectancies for ages 30-34 and 60-64 respectively.

Source: Health and Welfare Canada, "Health Indicators Derived from Vital Statistics for Status Indian and Canadian Populations, 1978-1986"

(September 1988); DIAND, "Life Tables for Registered Indians, 1985 and 1990", Information Quality and Research Division, unpublished tables (May 1995); Statistics Canada, *Report on the Demographic Situation in Canada*, catalogue no. 91-209E (Ottawa: 1993).

Table 3.1 also shows that the gap in life expectancy between Aboriginal and non-Aboriginal people is narrowing. Yet Indian women born in 1990 can expect to die 6.5 years earlier than other women in Canada, and Indian men seven years before other men. The greatest discrepancies occur among the young. By age 30 the difference in life expectancy has been halved; by age 60 it has declined by half again.

TABLE 3.2
Estimated Life Expectancy at Birth, Total and Aboriginal Populations, 1991

Years	**Male**	**Female**
Total population	74.6	80.9
Total Aboriginal population	67.9	75.0
Total, North American Indians*	68.0	74.9
Registered North American Indians	66.9	74.0
On-reserve	62.0	69.6
Non-reserve, rural	68.5	75.0
Non-reserve, urban	72.5	79.0
Non-Registered North American Indians	71.4	77.9
Rural	69.0	75.5
Urban	72.5	79.0
Métis	70.4	76.9
Rural	68.5	75.0
Urban	71.5	78.0
Inuit	57.6	68.8

Note: * North American Indians includes all who self-identified as North American Indian on the 1991 Aboriginal Peoples Survey, whether or not they are registered under the *Indian Act*.

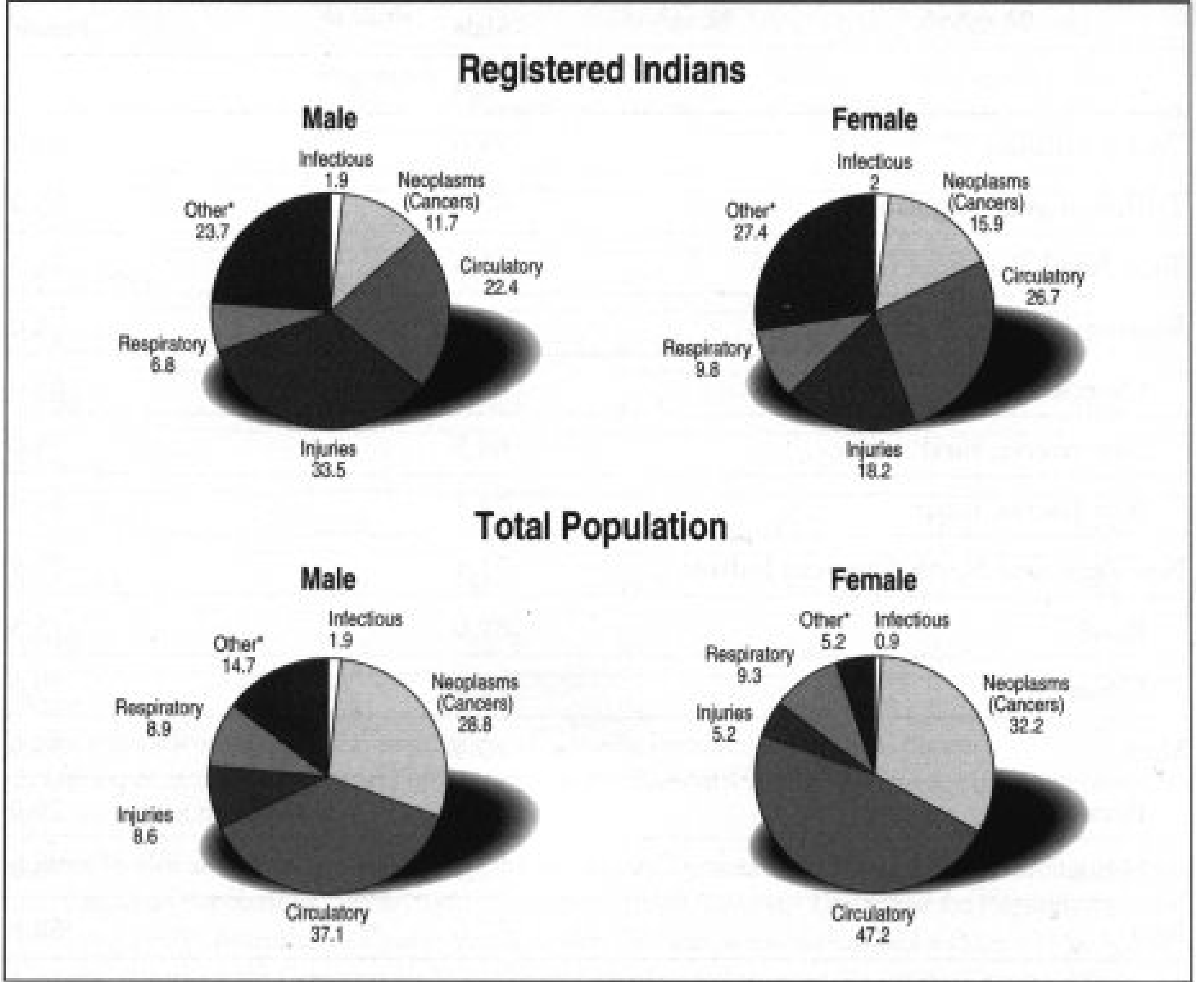
Source: Health and Welfare Canada, "Health Indicators Derived from Vital Statistics for Status Indian and Canadian Populations, 1978-1986" (September 1988); DIAND, "Life Tables for Registered Indians, 1985 and 1990", Information Quality and Research Division, unpublished tables (May 1995); Statistics Canada, Report on the Demographic Situation in Canada, catalogue no. 91-209E (Ottawa: 1993).

Inuit continue to have the lowest life expectancy of all Aboriginal people, among both women and men, followed by Indian people living on-reserve (see Table 3.2).[47] Indian people in urban settings, whether registered or not, have the highest life expectancy of Aboriginal people, exceeding that of urban Métis people by about one year for both women and men.

Figure 3.1 shows that the pattern of illness and injury leading to death was quite different for registered Indian people than for other Canadians in 1992. The two leading causes of death in the general population were circulatory diseases and neoplasms (cancers). Among registered Indian males, injuries, including accidents, suicides and homicides, are the leading cause of death. While injuries play a lesser role among registered Indian women, they still account for three times the proportion of deaths among women in the general population.

FIGURE 3.1

Selected Causes of Death as a Percentage of all Deaths, 1992



Note: * Includes endocrine/metabolic/immunity disorders, blood/blood-forming organs, mental disorders, nervous system and sense organs, digestive system, genito-urinary system, complications of pregnancy/childbirth, skin and subcutaneous tissues, musculoskeletal system, congenital anomalies, conditions from perinatal period, symptoms/signs and ill-defined conditions, and others.

Source: Health Canada, Medical Services Branch, unpublished tables, May 1995.

Table 3.3 shows rates of hospital admission and reasons for admission in Manitoba in 1990-91. At least in Manitoba, Aboriginal people continue to be adversely affected by many causes of illness and death that are better controlled in the non-Aboriginal population. Table 3.4 shows that, in one province, Aboriginal people in all age groups (except 65 and older) used two to three times more hospital days than a comparable number of people in the general population, indicating their lower general health and the severity of their illnesses upon admission.

TABLE 3.3

Hospital Utilization Rates by Diagnostic Category, Registered Indian and Provincial Populations, Manitoba, 1990-91

	Registered Indians[1]	**Provincial Population[2]**
	In-patient cases per 1,000 population	
Infectious/parasites	33	18
Neoplasms (cancers)	24	133
Endocrine/nutritional/metabolic	59	31
Blood and blood-forming organs	15	8
Mental disorders	80	176
Nervous system and sense organs	42	81
Circulator	98	228
Respiratory	221	110
Digestive	134	103
Genito-urinar	71	53
Pregnancy/childbirth	220	75
Skin and subcutaneous tissue	54	19
Musculoskeletal	48	64
Congenital anomalies	17	6
Perinatal	8	3
Symptoms/signs ill-defined	63	50
Injury/poisoning	181	142
Other	88	156

Notes:

1. On- and off-reserve population.

2. All Manitoba residents.

Source: MHSC Hospital, Table 25, 1989-90, in Postl et. al, 1992.

TABLE 3.4
Hospital Utilization Rates by Age, Registered Indian and Provincial Populations, Manitoba, 1990-91

	Registered Indians[1]	**Manitoba**[2]
	days per 1,000 population	
under 10 years	1105	338
10-17	622	272
18-34	1318	600
35-64	1983	941
65+	7200	7022

Notes:
1. On- and off-reserve population.

2. All Manitoba residents.

Source: MHSC Hospital, Table 25, 1989-90, in Postl et al., 1992.

Table 3.5 and Figure 3.2 provide some indicators of the social conditions prevalent among Aboriginal people in Canada. Table 3.5 shows that Aboriginal people derive a greater portion of their income from government transfers than do members of the general population. Figure 3.2 provides data on registered Indian children ‘in care’ (children under the supervision of child welfare authorities) over time. It shows a high rate of child apprehensions among registered Indian people, a rate that has fallen rapidly since 1980 but that continues to be problematic. (The complexities of child welfare are discussed in Chapter 2.)

TABLE 3.5

Percentage Distribution of Income by Source, Aboriginal Identity and Non-Aboriginal Populations, 1991

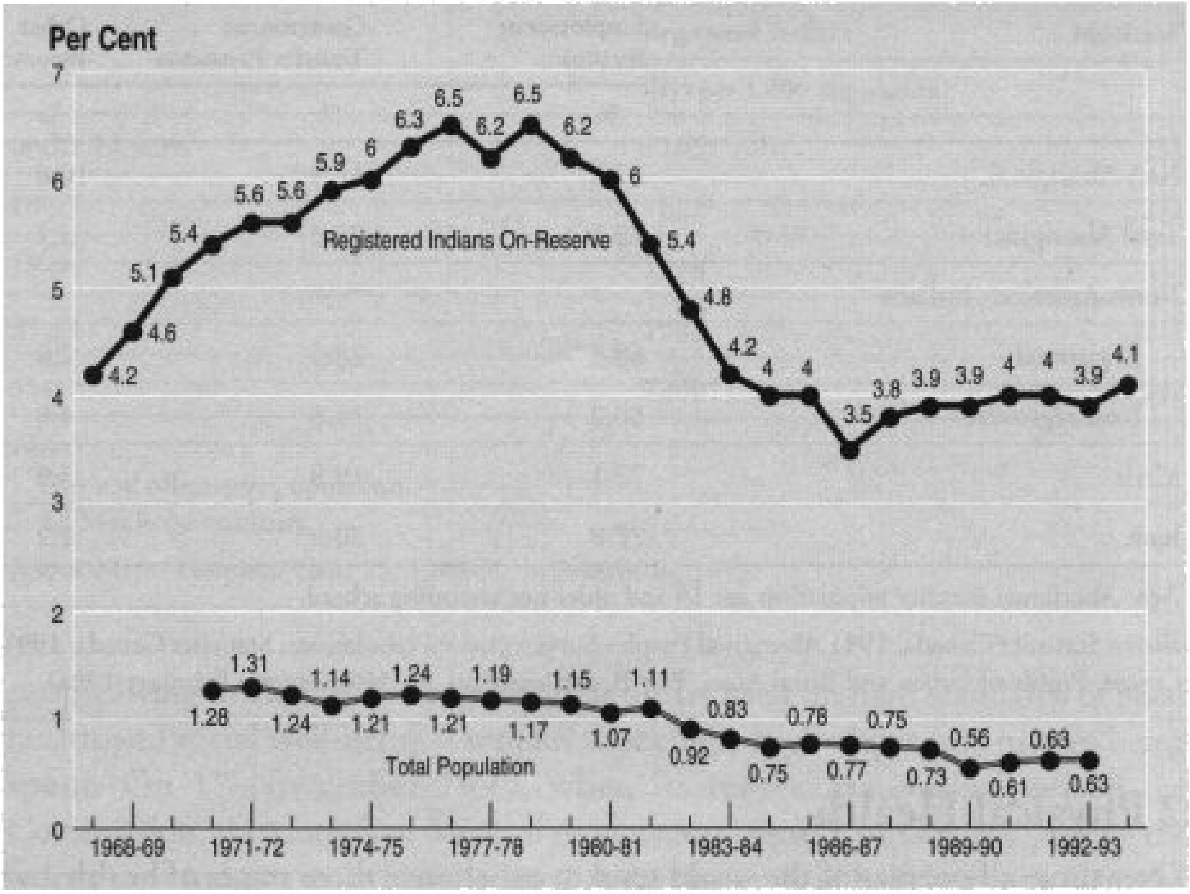
	Employment Income	Government Transfer Payments	Other Income
	%	%	%
Non-Aboriginal	77.8	11.4	10.8
Total Aboriginal	73.5	23.3	3.1
North American Indians			
Registered	68.5	28.5	2.8
Non-registered	80.2	14.8	4.8
Métis	77.1	19.8	3.0
Inuit	77.8	20.9	1.2

Note: Aboriginal identity population age 15 and older not attending school.

Source: Statistics Canada, 1991 Aboriginal Peoples Survey, custom tabulations; Statistics Canada, 1991 Census, Profile of Urban and Rural Areas, Part B, catalogue no. 93-340 (Ottawa: February 1994).

FIGURE 3.2

Children in Care as a Percentage of Registered Indian (On-Reserve) and Total Populations



Notes:

1. Programs, definitions and reporting systems vary considerably between provinces and within a given province over time. As a result, data are not comparable and should be used as estimates only.
2. Before March 1983, Quebec data include all child welfare services as well as children in care. Data from March 1983 to March 1990 include the number of interventions made on behalf of children in foster homes, institutions, protection cases and children with disabilities. Therefore, the data are not comparable over time. Quebec data from March 1990 on are not available.
3. Yukon data for 1975-76 to 1977-78 are included in Northwest Territories data.
4. March 1987 data for Ontario and Alberta are estimates.
5. From 1987 to 1988, Ontario data are for June or December, depending on the availability of the data.
6. Recent data are subject to revision.

Source: DIAND, Basic Departmental Data, 1994, Information Quality and Research Directorate (Ottawa: January 1995); Human Resources Development Canada, Cost-Shared Programs Branch, Social Development and Education, Table 421 (March 1994); and Statistics Canada, Population Estimates Division, Population Estimates for Canada and Selected Provinces and Territories, 1971-93.

Many studies have attempted to measure or estimate rates of social dysfunction among Aboriginal people. Because these conditions are difficult to define, let alone measure, the conclusions of such studies are often disputed.[48] The majority of studies, however, point to disproportionate rates of social and community ill health among Aboriginal people. Moreover, we are convinced that the social problems facing Aboriginal people today are proving more resistant to change than are their physical health problems.

Table 3.6 shows expenditures on health and social services delivered to Aboriginal people by federal, provincial and territorial governments, comparing them with the amounts spent on services delivered to Canadians generally. The difference in per capita expenditures is not what concerns us here. What concerns us is that rates of ill health and social dysfunction among Aboriginal people living in Canada — a country that prides itself on high standards of good health and social well-being — remain shockingly high *despite* the money being spent. On 17 November 1993, when its representatives addressed the Commission, the Canadian Medical Association issued a press release urging the federal government to "acknowledge that the degree of ill health among Canada's Aboriginal population is unacceptable and take immediate and specific measures to improve it".[49]

It could be that the amounts being spent, however great, are still too small to solve outstanding problems. Certainly, for some health problems and for some Aboriginal people, we will argue that this is the case and that greater investment is required. But Commissioners believe that the main impediment to restoring good health to Aboriginal people is not the amount of money spent but *how* it is spent. As we will show in this chapter, the causes and dynamics of ill health among Aboriginal people are not the same as among non-Aboriginal people — and because illness is not the same, prevention, cure and care cannot be the same either.

TABLE 3.6

Selected Government Expenditures on Aboriginal and Total Populations, 1992-93

Federal expenditures on	**Health**	**Social Development**	**Housing**
Aboriginal population ($ millions)	798	1,450	410
Provincial/territorial expenditures on Aboriginal population ($ millions)	1,215	1,313	133
Total expenditures on Aboriginal population ($ millions)	2,013	2,763	542
Expenditures per person, Aboriginal identity population ($)	2,720	3,733	732
Expenditures per person,			
total population ($)	1,652	2,946	130
Ratio of Aboriginal to total per capita expenditures	1.6	1.3	5.5

Notes: Expenditures include those on programs intended specifically for Aboriginal people as well as a share of expenditures on general programs. The relevant shares were calculated by program area based on the Aboriginal share of the client population and information about the rate of use by Aboriginal people. Thus, for example, health care expenditures include a share of provincial hospital, preventive and other health care expenditures. Social development expenditures include a share of old age security, employment insurance and workers compensation as well as social assistance and transfer payments to Indian bands, Inuit settlements and agencies delivering services. The amounts pertain to all Aboriginal peoples, including First Nations, Métis and Inuit.

Source: RCAP estimates. See Volume 5, Chapter 3.

In the next few pages we examine the causes and dynamics of ill health among Aboriginal people. Our purpose is threefold:

- to show the extent and seriousness of the conditions summarized by the statistics presented in our research;

- to examine representative illnesses to discover themes and commonalities regarding ill health in Aboriginal communities; and

- to lay the groundwork for a strategy to transform the health conditions of Aboriginal people.

1.2 Physical Health

Over time, all peoples of the world tend to experience three stages of health and illness patterns as they become more urbanized and industrialized.[50] The first stage is marked by famine, high rates of infectious disease and high death rates, especially among infants and children. The second is marked by declining rates of infectious disease and rapid population growth. The final stage is marked by the rise of chronic and degenerative diseases.

Aboriginal peoples in North America appear to be in transition from the second to the third stage. The birth rate is high. Infectious diseases, although far from controlled, are declining from the peak of devastation reached in the nineteenth century. Degenerative conditions such as heart disease, cancer and diabetes are on the rise.[51] Social pathologies — particularly alcohol and drug abuse — continue to cause widespread concern, while interpersonal violence and suicide contribute to high rates of injury and death.

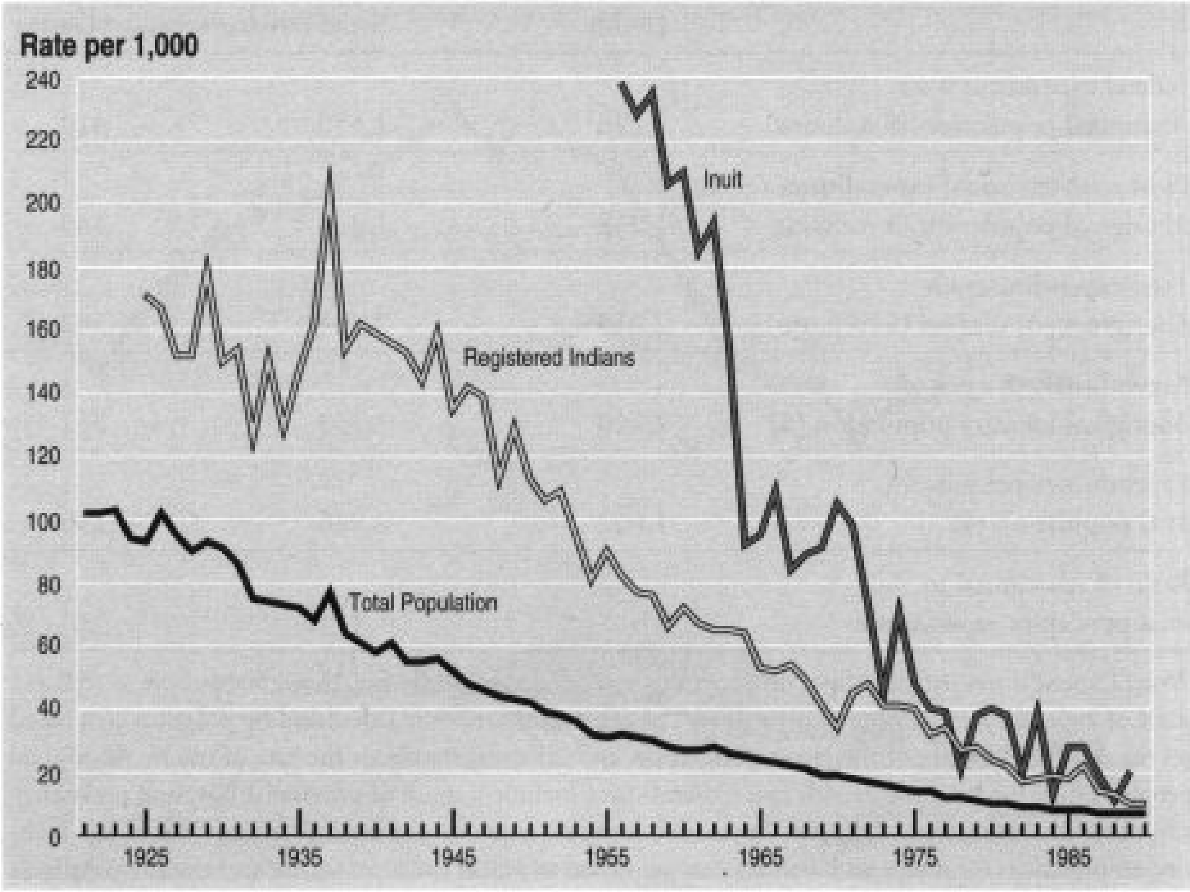
The issues of physical ill health facing Aboriginal people demonstrate intractable problems in four major categories: infant and child health, infectious disease, chronic disease, and disability.

Infant, child and maternal health

Infant mortality (death among children in the first year of their lives) is an important measure of population health the world over. Although the infant mortality rate (IMR) among Aboriginal people in Canada has declined steeply, a significant difference in the rates for Aboriginal and non-Aboriginal people remains (see Figure 3.3). From a high of more than 200 deaths per 1,000 live births in the 1920s and 1930s, the IMR among Aboriginal people has fallen to about 14 among registered Indian people and about 20 among Inuit.[52] The IMR for Canadians generally, however, is about seven per 1,000 live births. Thus, the ratio of Aboriginal to non-Aboriginal infant deaths is just about the same today as it has been for 100 years — about twice as high for Indian people and three times as high for Inuit in the Northwest Territories as for other Canadians. These ratios hold true for stillbirths (deaths of fetuses of less than 28 weeks' gestation) and perinatal mortality (deaths of fetuses after 28 weeks' gestation and of infants until the end of the first week of life).[53] The stillbirth and perinatal death rates among Indians are about double the Canadian average. Among Inuit living in the Northwest Territories, they are about two and a half times the Canadian average.

FIGURE 3.3

Infant Mortality Rates, Registered Indian, Inuit and Total Populations



Source: Kue Young, "Measuring the Health Status of Canada's Aboriginal Population: a statistical review and methodological commentary", research study prepared for RCAP (1994).

Beyond the risk of premature mortality, long-term human health is influenced by what happens in the womb and in the first months and years of life. Health researchers are only beginning to understand how subtle and far-reaching the effects of pre- and postnatal health can be. It is now well established that fetal and perinatal distress can impair the full physical and mental development of children. Research on programs similar to Head Start suggests that early stimulation can lead to gains in health status as well as educational achievement.[54] One leading health analyst writes:

> The search for causes of Western diseases has concentrated on the adult environment. The importance of the childhood environment in determining responses in later life [appears to] have been underestimated.[55]

Neonatal and infant health is largely the result of the living conditions and health care choices of pregnant women and new mothers. The Commission looked at three key factors in infant and child health: abnormal birth weight, the use of alcohol during pregnancy, and childbirth practices and policies.

Abnormal birth weight, particularly low birth weight, is a known risk factor for ill health in childhood and later life. It contributes to many of the common problems of infancy, from the stresses of prematurity generally and colic specifically, which interfere with family bonding, to the risk of death itself. The Canadian Institute of Child Health has cited low birth weight as being a major health concern in Canada.[56]

Alcohol consumption during pregnancy is another leading cause of ill health in infancy. Fetal alcohol syndrome and fetal alcohol effect (FAS and FAE) are matters of extreme concern in Aboriginal communities where there is or has been alcohol abuse.

Childbirth practices and policies have been the subject of extensive debate in recent years, and they are seen increasingly as an issue by Aboriginal people. Many have argued that normal birth, where health and safety are not threatened, should once again become a non-medical, family and community event.[57]

Abnormal birth weight

The birth weight of infants is defined as low when it is below 2.5 kilograms (5.5 pounds). In 1990, almost 22,000 low birth weight (LBw) babies were born in Canada, most often to teenage girls or women over 40. About 15 per cent died in the first month of life. At present, Aboriginal women appear to run about the same or a slightly lower risk of giving birth to an LBw baby as non-Aboriginal women (see Table 3.7). Aboriginal women have a higher than average risk of giving birth to a high birth weight (overweight) baby, a condition that also carries ill health effects, although these are not so well understood.

Low birth weight increases the chance of death in infancy and of life-long health and social problems. LBw babies are likely to have underdeveloped respiratory and other systems. They are also likely to have weakened immune systems. On both counts, they are at risk for serious and/or chronic ill health. LBw babies are also likely to be 'difficult' babies — often because they are in pain. They may fuss and cry more than other babies, which increases their risk of parental neglect and abuse. Their care and nurture is costly (ranging from $500 to $1,000 per day in Canada), both to families and to the publicly funded health system.[58]

The factors that put a woman at risk of delivering an LBw baby are complex. Those that are considered preventable include

- inadequate nutrition during pregnancy;
- smoking and drinking during pregnancy;
- poverty and stress;
- pregnancy during adolescence;
- physical inactivity during pregnancy; and
- general self-neglect by pregnant women.[59]

The co-ordinator of the Healthiest Babies Possible Pregnancy Outreach Program of the Native Friendship Centre in Prince George, British Columbia, gave Commissioners some insights into the sources and dynamics of the risks faced by Aboriginal women:

> Many Aboriginal women are isolated, impoverished and suffering from low self-esteem and sometimes emotional pain. Frequent barriers these women encounter in accessing health care [include] lack of medical coverage. Often women are transient and come here from other provinces, and there's a lapse in their care. Sometimes [such a lapse] occurs when teens are away from their families [when pregnant] and don't have communication with them and they don't have their [health] card numbers, and it takes us days and days to get them to a physician….

Transportation is an issue. [Many of our clients have] no bus fare….Lack of child care is also an issue. Respite care is needed for many of these women to attend their appointments. And often this ties into transportation, juggling around strollers and babies who are ill, to get them to the doctor.

Shortages of food [are an issue]. The pregnancy outreach programs across B.C. are currently lobbying for an increased natal allowance from social services. The $25 a month has not been increased for many, many years….

Lack of appropriate and affordable housing leads to frequent changes of address and the stresses of finding housing. Low literacy often leads to the inability to seek appropriate [help]. They are unable to read bus schedules, posters, et cetera.

Low self-esteem and loss of identity [is an issue]. Many are grieving individual and/or collective Aboriginal spiritual and cultural losses and, therefore, feel powerless [to help themselves].

Marlene Thio-Watts, RN
Co-ordinator, Healthiest Babies Possible
Pregnancy Outreach Program
Executive Director, Northern Family Health Society
Prince George, British Columbia, 1 June 1993

TABLE 3.7

Percentage of Low and High Birthweight Babies, Registered Indian and Total Populations, 1979-1992

	Low Birth Weight1		High Birth Weight2	
	Total Population	Registered Indians	Total Population	Registered Indians
1979	6	5	10	—
1980	6	5	10	—
1981	6	5	10	—
1982	6	5	11	—
1983	6	4	11	—
1984	6	4	11	—
1985	6	4	11	—
1986	6	4	11	—
1987	5	4	12	—
1988	6	3	12	—
1989	5	4	12	14
1990	5	3	12	14
1991	6	5	12	9
1992	5	4	13	16

Notes:
1. Less than 2.5 kilograms.

2. More than 4 kilograms. — = data not available.

Figures have been rounded to the nearest per cent.

Source: For registered Indian population, Health Canada, Medical Services Branch, unpublished data; for total population, Statistics Canada, catalogue nos. 84-204 and 84-210.

Thio-Watts told Commissioners that she and the caregivers working with her are attempting to help pregnant women and new mothers with needs that go well beyond the mandate (and funding capacity) of her program. The problems they dealt with include, for example,

- providing support and counselling for the victims of rape, assault and abandonment;

- investigating child neglect and abuse allegations;

- providing child welfare and family strengthening services (for example, parenting education); and

- providing addictions counselling and support for children with fetal alcohol syndrome or effect (discussed in more detail later).

Clearly, many of the risk factors for abnormal birth weight are social and economic and do not fall within the scope of medical services. Aboriginal health authorities cannot address the full range of risk factors unless they are treated as ‘health’ issues and become priority targets for health program funds. The Child Development Initiative (formerly Brighter Futures) of Health Canada’s medical services branch has taken a significant step in this direction with its community-controlled ‘healthy babies’ program. Yet its reach is limited, because its funding is modest and because only reserve communities are eligible.

Thio-Watts recommended a storefront-style health centre with ‘one-stop shopping’ services to meet the needs of Aboriginal women who are pregnant or already struggling with infants and young children. Under the current care system, however, only a minority of Aboriginal communities have that possibility open to them: on-reserve communities where authority transferred from the federal government enables them to set their own priorities, and off-reserve communities fortunate enough to have access to relevant provincial or territorial programs. Thus, the way forward for pregnant Aboriginal women is stymied by both program and jurisdiction rigidities.[60]

Fetal alcohol syndrome and effect

Fetal alcohol syndrome (FAS) is the term used to describe a continuum of disabling effects on a child brought about by a mother’s heavy drinking during pregnancy (two or more drinks per day). FAS

and its milder form, FAE (fetal alcohol effect), can cause low birth weight, growth retardation and small body size, facial anomalies (such as close placement of the nose to the lips and of the eyes to one another), skeletal abnormalities, and cardio-vascular problems. Equally problematic and more difficult to diagnose are the effects of FAS and FAE on the brain and nervous system. These range from difficulty understanding cause-and-effect relationships, impulsiveness and impaired judgement, to severe mental disability. Researchers now recognize that prenatal alcohol exposure may cause subtle deficits in judgement and reasoning in people with apparently normal intelligence.[61] The degree of brain and neural damage varies with the amount of alcohol consumed and perhaps with the timing and concentration of consumption.

No one knows how many people are affected by FAS or FAE, as the syndrome was identified only about 20 years ago and reliable studies are few.[62] Studies of FAS among Aboriginal people are fewer still, but some conducted in Canada have indicated an alarmingly high prevalence.[63] The experience of local health and social service workers supports the idea that FAS is a serious problem in at least a few Aboriginal communities where alcohol abuse has been a long-standing health problem, and a lesser but still troubling problem in others.[64] FAS causes particularly acute pain among Aboriginal people — the pain of accepting responsibility for having caused harm. This is the dilemma facing a woman whose drinking has damaged her children and the community that allowed it to happen. FAS and FAE are entirely preventable, but there is no known way to cure their effects, which are permanent. The estimated cost of meeting the needs of someone who is severely affected by FAS over a lifetime is $1 to $1.5 million.[65] The social and emotional cost to families and communities is also great, as Commissioners heard in testimony:

Children with FAS or FAE are often difficult babies, especially if they are withdrawing from the alcohol that surrounded them in the [womb]. If the mothers are still actively abusing alcohol, these children often are subject to attachment breaks, abuse, and/or neglect, and they often become involved with the child welfare system as foster or adopted children.

Betsy Jackson
Alcohol-Related Birth Defects Committee
Whitehorse, Yukon, 18 November 1992

They are hard to care for, their disability is not understood, there are many peer and social pressures, no skills to fall back on….Currently we believe many adults [who were born] with FAS/FAE are either on the street or in jail.

Lorraine Stick
Alcohol-Related Birth Defects Committee
Whitehorse, Yukon, 18 November 1992

FAS in its extreme forms is a severely disabling condition. In its milder forms, it is a probable cause of the behavioural problems of many children, both Aboriginal and non-Aboriginal. Support for its victims and public education for the prevention of new cases are needed.

Prevention depends on just one thing: the reduction of alcohol consumption during pregnancy. Aboriginal women who are pregnant need clear and accessible information about the potential effects of alcohol. The desire for a healthy child gives all pregnant women a powerful motivation to stop using alcohol and drugs. Indeed, they are likely to be more open to reducing their drinking during pregnancy than at any other time in their lives. This suggests to us that priority be given to alcohol and drug programs for pregnant Aboriginal women. Yet we have been told that treatment services are unprepared to deal with pregnant women, or with women who already have children.[66] As well, Aboriginal women who are pregnant need culture-based prenatal outreach and support programs, designed to address their particular situation and vulnerabilities, such as the Healthiest Babies Possible program in Prince George, described earlier.

Support issues are more complex:

- Family caregivers in Aboriginal communities are often forced, by lack of private means or public programs suitable for their children as they grow up, to place their children in provincial care facilities.

- Schools may treat FAS and FAE children as having incorrigible behaviour problems without recognizing their capacity for skills development by means of a hands-on learning style. Some FAS and FAE children have super-abundant physical energy, which could be directed to athletics. Some have an active fantasy life, which could be channelled into artistic activities.

- Many FAS and FAE children have social and emotional problems related to their condition and can be at increased risk of suicide in adolescence.

- Some with FAS and FAE are seriously disabled and need extensive supervision. Others need a sensitive assessment of their limits and strengths and assistance in reaching their potential.

- Once FAS and FAE children become adults, their needs change. Although some can be capable of independent living, others need access to supervised shelter operated by people who understand the nature of their impairment.

In 1992, the government of Canada rejected the recommendations of a House of Commons standing committee for “aggressive public information campaigns” among Aboriginal people and “more effective and appropriate community-based ways of dealing with learning disabilities, of which FAS is the major portion of demand” in Aboriginal communities.[67] According to the minister of health at the time, current health programs provide ample opportunity for Aboriginal communities to undertake prevention and support for families coping with FAS and FAE.[68] The minister argued as well that no group in Canadian society is at greater risk of FAS or FAE than any other and that programs targeted to Aboriginal people would have the effect of stigmatizing them.

The Commission takes a different view. The extent of FAS and FAE in Aboriginal communities is unknown. Aboriginal communities with high rates of alcohol abuse in the past may have a high incidence of FAS and FAE effects today. Until the facts are established, no one can say whether special provisions are needed. Ministerial pronouncements of this sort simply underline the powerlessness of Aboriginal nations and their communities to determine their own health and social service needs and set their own priorities.

Control over Aboriginal health research and over special health education campaigns is still denied to Aboriginal people. Within the limits of what is now possible, a number of proposals to prevent FAS and FAE and to support its victims were made to the Commission.[69]

Family-centred birthing

At our hearings in the provincial and territorial north, Aboriginal women raised an issue of special concern in the north: the mandatory transportation of birthing women to distant hospitals, regardless of their medical risk. Since the early 1960s, medical services branch and almost every health jurisdiction in Canada has had a policy of transporting all Aboriginal women who are pregnant to secondary or tertiary care hospitals for childbirth.[70] No doubt lives have been saved by this policy. However, for women with no apparent risk of medical complication, enforced transportation has meant an end to family-centred birth, community-based care and the possibility of culture-based choice. Aboriginal people have objected to the interruptions and strains this causes to family life, the isolation and stress for mother and infant, and the fact that it interferes with indigenous birthing knowledge, local midwifery skills and traditional family-centred ceremonies.[71]

In a minority of pregnancies, where there are risks to the health of the pregnant woman or the newborn, transporting the woman to hospital is appropriate. But for healthy Aboriginal women, enforced evacuation has profoundly negative consequences. A woman must leave her family behind and live in a hostel for a two-week waiting period, then enter a hospital for delivery. She may find that no one speaks her language or understands her background. She may give birth attended by strangers. What was traditionally a joyous, even sacred event can be frightening and alienating. Her family and community are denied the life-affirming experience of sharing in the miracle of new life. The father, siblings, grandparents and other relatives are excluded from the birth and from the all-important first days or weeks of the infant's life when the bonds of love and responsibility are forged. In the Innuulisivik (Povungnituk) case study, some informants speculated that excluding fathers (and others) from pregnancy and birth contributes to the abuse of women and the neglect of children by distancing family members from the newborn.[72]

In addition, when the birth occurs away from the community, traditional rituals to name and welcome the child are delayed or abandoned. The vital contributions of the traditional Aboriginal midwife to health promotion and family solidarity are lost as well.

The idea that midwives can provide safe, supportive and cost-effective care for pregnant women in low-risk childbirth situations has become more widely accepted in Canada in the last 10 to 15 years. Ontario passed legislation to recognize and regulate the practice of midwifery in 1991. Most other provinces are moving in a similar direction. In the Northwest Territories, where traditional midwifery has survived the longest, all pregnant women are the object of transportation policies, and authorities have so far expressed little interest in change. A pilot project is under way in Rankin Inlet to explore possibilities for birthing in facilities close to the pregnant woman's community.

Most expert evidence suggests that when the pregnancy is normal, midwifery services decrease the risks of complications in childbirth — or at the very least, do nothing to increase complications.[73] (No kind of care can guarantee problem-free birth.) As Martha Greig of Pauktuutit argued, the barriers to creating community-based maternity services staffed primarily by Aboriginal midwives are political, the result of ignorance of Aboriginal ways:

> [Inuit women] would like to find alternatives to the present system of removing pregnant women from their families at the time of birth. We seek alternatives which benefit the entire family and which do not expose women and newborn infants to unnecessary risk; alternatives which allow us to feel pride and respect in ourselves and our culture. To us, healthy children are born into their family and their community; they are not born thousands of miles from home to an unhappy, frightened mother.
>
> Unfortunately, the debate we often find ourselves engaged in is premised on a disrespect for our history and for the knowledge and skills which many of our elders still possess. We often find ourselves on the defensive, endlessly declaring that, of course, we too are concerned about maternal and infant mortality rates. We have not been allowed to engage in this debate as equals. Recognition of our traditional skills, knowledge, values and approaches to life is necessary, not just around issues of childbirth but in all spheres.
>
> Martha Greig
> Vice-President, Pauktuutit
> Ottawa, Ontario, 2 November 1993

The example often mentioned to us of a new midwifery service that has returned control of the birth experience to Aboriginal women and their families, in a safe and meaningful form, was the Innuulisivik Maternity Centre in Povungnituk, northern Quebec. There, planning for a small, regional hospital built in the early 1980s provided the occasion for Inuit women to ask for an end to the policy of routine travel to Moose Factory or Montreal for childbirth. Following community consultation, the planning committee undertook to develop a regional maternity service, staffed primarily by midwives and Aboriginal birth attendants in training to become midwives, with support from other hospital personnel.

‘The Maternity’, as it is known in the region, has been a great success. Since opening in September 1986, it has responded to the birthing preferences of Inuit women in a socially and culturally appropriate manner, and its record in maintaining or improving the health outcomes of its clientele has been confirmed by independent evaluation.[74] In its first two years, staff managed 84 per cent of the births (a total of 350) in the eight Hudson Bay communities it serves and achieved perinatal mortality rates comparable to or lower than the rates for Quebec as a whole.[75] Staff were able to help new mothers with post-natal care and advise on crucial issues such as infant nutrition. The positive psycho-social and cultural effects are less quantifiable, but were often cited by residents of northern communities.[76]

The pressure for community-based, culturally sensitive birthing services in the north demonstrates the problems that have accumulated over the past 50 years as a result of imposing 'illness care' protocols on Aboriginal communities. Such protocols are not necessarily the best approach, are not necessarily wanted, and often interfere with creative, culture-based solutions. This is not to suggest that modern medical care is devalued by Aboriginal people — far from it. Rather, the wholesale replacement of traditional health and healing systems with western systems has had negative and positive results. In the case of childbirth, many Aboriginal women (in the south as well as in the north) are arguing for a combination of traditional and modern practices. To us, this approach makes sense — not only with respect to birthing but for other health objectives as well.

The persistence of infectious disease

The decline of infectious diseases in developed societies since the late nineteenth century is often thought to be the result of modern medical care. In fact, it is largely the result of improved standards of living, higher real wages, higher quality housing and sanitation, and access to more and better food.[77] To the extent that Aboriginal people have shared in Canada's rising standard of living, their health has improved as well. To the extent that they have continued to experience lower incomes, inferior housing conditions and more contaminated water, they continue to suffer from infectious diseases in like measure.

Epidemics of smallpox, diphtheria, polio, measles, mumps and rubella wreaked havoc among Aboriginal peoples in the past. Infectious diseases killed or disabled infants, children and elders, as well as adults in the prime of their lives, the people who hunted and trapped for food, cooked the meals and cared for the children, led the councils of government and communicated with the spirit world. It is difficult for us to imagine the misery and chaos; entire clans all but disappeared, leaving only a few orphans to tell the stories of what once was.

The far-reaching effects of infectious diseases on the social stability of First

Peoples is illustrated by a story told by Chief Frank Beardy at our public hearings in Big Trout Lake:

> I would like to take you back in time. I would like to take you back to the days and years before 1929 [when the adhesion to Treaty 9 was signed]….What happened in the 1800s and early 1900s, I am told by the elders, is that certain diseases swept across our lands and the lands of the Big Trout Lake people. Smallpox, chicken pox, tuberculosis, mumps, measles. Diseases that [our healers] didn't know how to heal or how to counter with their herbal medicines. [These diseases] totally decimated our villages. [They] totally decimated the clan structure that we knew, the clan system that governed our lives.
>
> What also happened was that, at the same time as these diseases were sweeping across the north…Ontario's conservation officers…were already implementing game laws that were made up in the halls of Queen's Park and on Parliament Hill….[T]hese conservation officers were confiscating fish nets, they were confiscating guns, they were confiscating the animals that were [used] by our people for food, because they were saying that the Indian people were breaking their conservation laws….
>
> My grandfather, who was a headman in Bearskin Lake at that time, heard about the treaties that had happened in Northern Manitoba in the Island Lake area. Through the missionaries or the Hudson Bay managers that were already in the area, he wrote a letter to the Queen, requesting that they be allowed to sign treaty with the Queen of England or the King of England. It was only because of these illnesses that plagued our people, and because the conservation officers were really hard on our people and confiscated their livelihood, that…my grandfather was, in a way, forced to request for the treaty to be signed in Big Trout Lake.
>
> Chief Frank Beardy
> Muskrat Dam First Nation community
> Big Trout Lake, Ontario, 3 December 1992

Epidemics were not confined to the distant past. Aboriginal people in the Yukon were stricken many times during the construction of the Alaska Highway in the 1940s.[78] In 1952, Inuit on Baffin Island and the Ungava peninsula of Quebec suffered an epidemic of measles that infected nearly everyone and killed between two and seven per cent of the population.[79]

We have chosen to discuss tuberculosis as an example of the persistence of infectious diseases among Aboriginal people. We have also examined the preliminary evidence on the rise of HIV/AIDS, a new threat. If unattended, HIV/AIDS could devastate Aboriginal people as much as other infectious diseases have in the past.

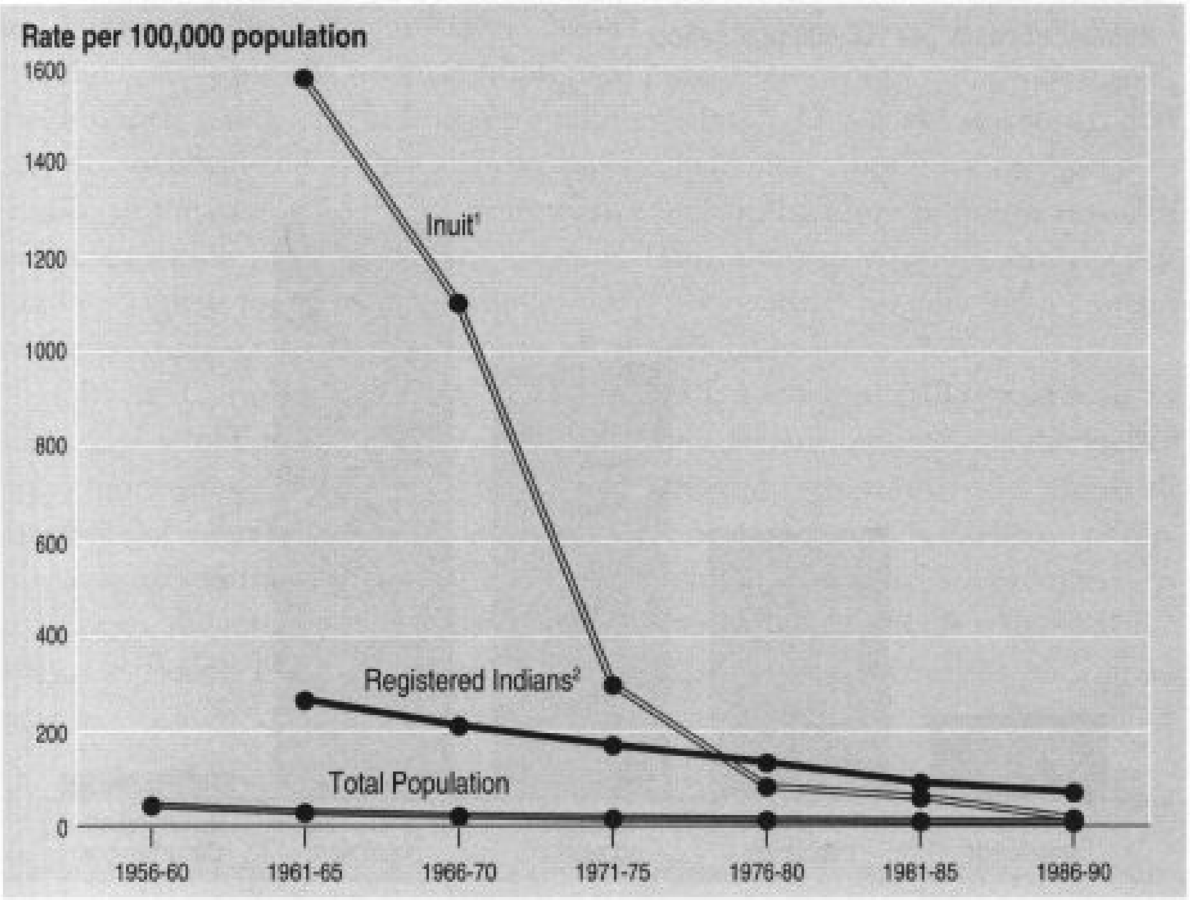
Tuberculosis

Tuberculosis was one of the first epidemic diseases noted in Jesuit accounts of Aboriginal life in the new world. It spread steadily and disastrously until, by the early 1900s, some observers thought TB might completely eliminate the indigenous nations of Canada.[80]

The spread of TB was exacerbated by the crowded and often unsanitary conditions created by reserve and settlement living — and by gathering Aboriginal children into boarding schools. Many arrived at school in good health, only to test positive for TB within two years.[81] Many TB survivors carried the disease back home.[82]

After denying responsibility for several decades, the federal government began aggressive control measures in the mid-1930s. In 1936, the budget for TB treatment was already $50,000, ballooning to $4 million by 1946. From 1950 to 1952, nearly 14,000 Aboriginal people were hospitalized. Most were sent to facilities far from home, cut off from family and culture, sometimes lost to both forever. It took 20 more years for TB infection rates to fall below crisis levels. The data on rates of infection available to the Commission begin in 1956-1960 (see Figure 3.4).

FIGURE 3.4
Incidence of Active Tuberculosis, Registered Indian, Inuit and Total Populations, 1956-1990



Notes:
1. Inuit living in the Northwest Territories.
2. Data on registered Indians for the years 1965, 1970, and 1975 are single-year figures; all other rates shown based on five-year averages.

Source: Kue Young, "Measuring the Health Status of Canada's Aboriginal Population: a statistical review and methodological commentary", research study prepared for RCAP (1994).

Part of the reason for a decline in TB infection was that Aboriginal people were at last developing their own immunity. Given sufficient time, natural selection (by which some individuals in an epidemic survive and gain immunity, or are naturally immune and pass their immunity on to their children) enables any people to acquire increased immunity to a new bacillus. This is an aspect of the natural history of infections, independent of medical intervention.

The decline of TB now appears to have stalled. It is still more common among Aboriginal families and communities than among other Canadians. Based on 1992 figures, rates of infection are 43 times higher among registered Indians than among non-Aboriginal Canadians born in this country. The rate is about the same for Aboriginal people living in Canada as for people living in Africa[83] (see Figure 3.5). In Sioux Lookout, we were told Tuberculosis has become, once again, a significant health concern in the First Nations of our area. We have about 100 cases per 100,000 compared to 8 cases per 100,000, which is the national average. The federal government has initially responded to the TB epidemic by providing personnel to contain the outbreak in a few identified communities, and is now in the process of considering the possibility of a much needed long-term commitment to delivering a preventative TB program.

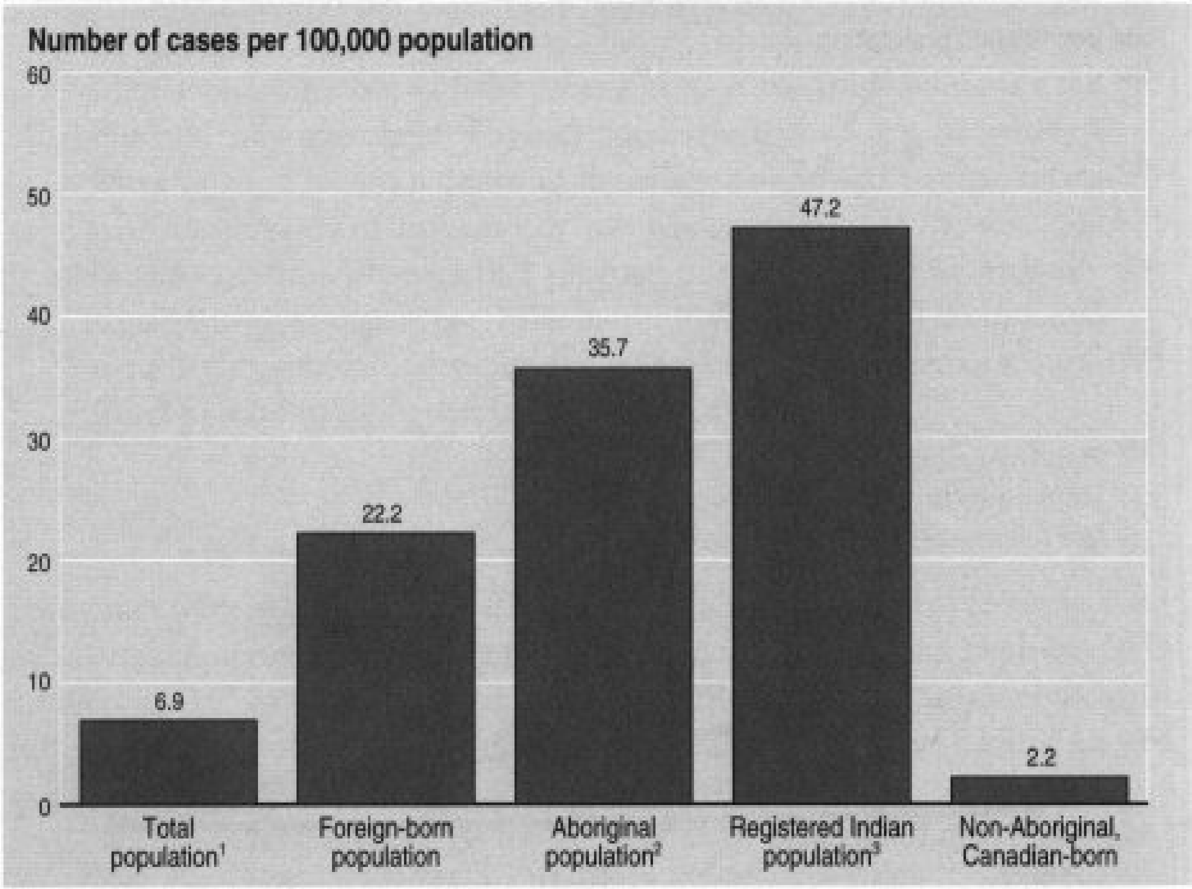
Nellie Beardy
Executive Director,
Sioux Lookout First Nations Health Authority
Sioux Lookout, Ontario, 1 December 1992

Controlling TB requires two approaches: improvements in housing, sanitation and nutrition; and case identification of those now infected, followed by medically supervised, self-administered antibiotic treatment. The health implications of housing, water quality and nutrition are discussed later in this chapter. (Housing is discussed further in Chapter 4 of this volume.) Self-administered treatment is a problem because Aboriginal people show poor compliance with medical instructions, including drug-taking orders.[84] This means, in short, that they do not always do as they are told, especially by non-Aboriginal medical personnel. In the case of active TB, compliance is critical: failure to follow through with medication means failure of the cure. Thus, preventive public health education designed for and by Aboriginal people is essential for successful control of this continuing obstacle to improved Aboriginal health.

In the Commission's view, control of TB is an urgent priority, at least in some regions of Canada; it is, however, only one of many contagious diseases to occur more often in Aboriginal than non-Aboriginal communities. In almost all categories of infectious disease identified by the international classification of diseases, registered Indians run a greater risk of illness than other Canadians.[85] In some cases, the ratio of Aboriginal to total Canadian disadvantage is four to one. We are especially concerned that HIV/AIDS poses a growing threat to Aboriginal people.

FIGURE 3.5

Tuberculosis Rates, Aboriginal and Total Populations, 1993



Notes:

1. Includes new and reactivated cases.
2. Includes registered and non-registered Indian persons, Métis persons and Inuit.
3. Calculated using population counts from DIAND registry.

Source: Statistics Canada, Health Statistics Division, unpublished tabulations.

HIV/AIDS

There are no adequate national data on the incidence of sexually transmitted diseases among Aboriginal people.[86] With regard to AIDS (acquired immune deficiency syndrome), 97 of the 9,511 Canadians diagnosed (and surviving) as of April 1994 were Aboriginal, based on self-definition or physicians' records. Although the number of diagnosed AIDS cases (97) is relatively small, it is four times the number given in the first report of the Joint National Committee on

Aboriginal AIDS Education and Prevention just four years earlier. Figures on the rate of HIV infection among Aboriginal people are even more difficult to come by. In Canada as a whole, the ratio of persons infected with HIV to those with AIDS is thought to be about four to one.[87]

Risk factors identified among Aboriginal people suggest that a serious AIDS problem may be in the making:[88]

- The overall health of Aboriginal people is poorer than that of non-Aboriginal people in Canada, suggesting that Aboriginal people may have weaker immune systems in general.

- Aboriginal people have higher rates of several illnesses associated with HIV/AIDS.[89]

- Anecdotal evidence and some limited survey data would seem to indicate that unprotected sexual activity is the norm among Aboriginal people.[90]

- Excessive use of alcohol, which increases the chance of unprotected sexual activity, is also a risk factor in some communities.

- Groups in which the rate of HIV/AIDS is already high — such as street youth, prostitutes and the prison population — include a significant number of Aboriginal people.

Even more troubling is that many Aboriginal people apparently do not think of AIDS as a disease that affects Aboriginal people. We were told that some think of it as a gay disease, imagining that homosexuality is rare among Aboriginal people; as a city disease, imagining that it will not follow them into small or isolated communities; or as a white man's disease, imagining that it can somehow be restricted to non-Aboriginal people.[91]

These are false hopes. Although the Commission has no data on the incidence of homosexuality and bisexuality, we have no reason to believe it is less common among Aboriginal people than among non-Aboriginal people.[92] The fact that many — and perhaps most — Aboriginal people who are gay choose to hide their sexuality increases their risk.[93] Further, the tendency of Aboriginal people to migrate freely between their home communities and urban centres makes it inevitable that transmission of the virus from city to country will occur. As for cultural or group distinctions, HIV/AIDS spares no one. In other words, Aboriginal people are vulnerable — all the more so if they do not think they are and therefore take no precautions. Aboriginal youth are at particular risk.[94]

At present, there is no continuing mechanism through which information on HIV/AIDS can be exchanged by Aboriginal people, no monitoring being done on HIV/AIDS in Aboriginal communities, no research being undertaken on the risks to Aboriginal people, and no Aboriginal-specific policy being developed.[95] Given the lessons history has taught about the impacts of infectious diseases on unprotected peoples, this seems to us an irresponsible omission by health and social service agencies, both Aboriginal and non-Aboriginal.

We are also disturbed to hear that some Aboriginal communities are rejecting their own members who are HIV-positive or who have AIDS:

> People are dying in cities and in rural communities. They are our brothers, sisters, aunties, mothers, fathers, nieces and nephews. They are human beings. But often they are not treated like human beings, and die alone because nobody wants them in their own communities. Why? Because of fear and ignorance based on lack of education about the transmission of HIV….
>
> One of [our] concerns is the lack of education on the virus and the lack of support, care and treatment for those individuals who are living with AIDS. Often entire families are shunned, rejected, and even attacked in communities when other members learn a family has AIDS. At a time when the individual and their families most need support and compassion, the individual cannot even return home to receive proper care and treatment. This is also often due to a combination of a lack of resources, both financial and medical, or because they are not wanted or welcome in their own communities. Fear based on ignorance has meant that people who are living with AIDS are denied the right to live and die with dignity in their own communities.
>
> Linda Day
> Executive Director, Healing Our Spirit
> B.C. First Nations AIDS Society
> Vancouver, British Columbia, 2 June 1993

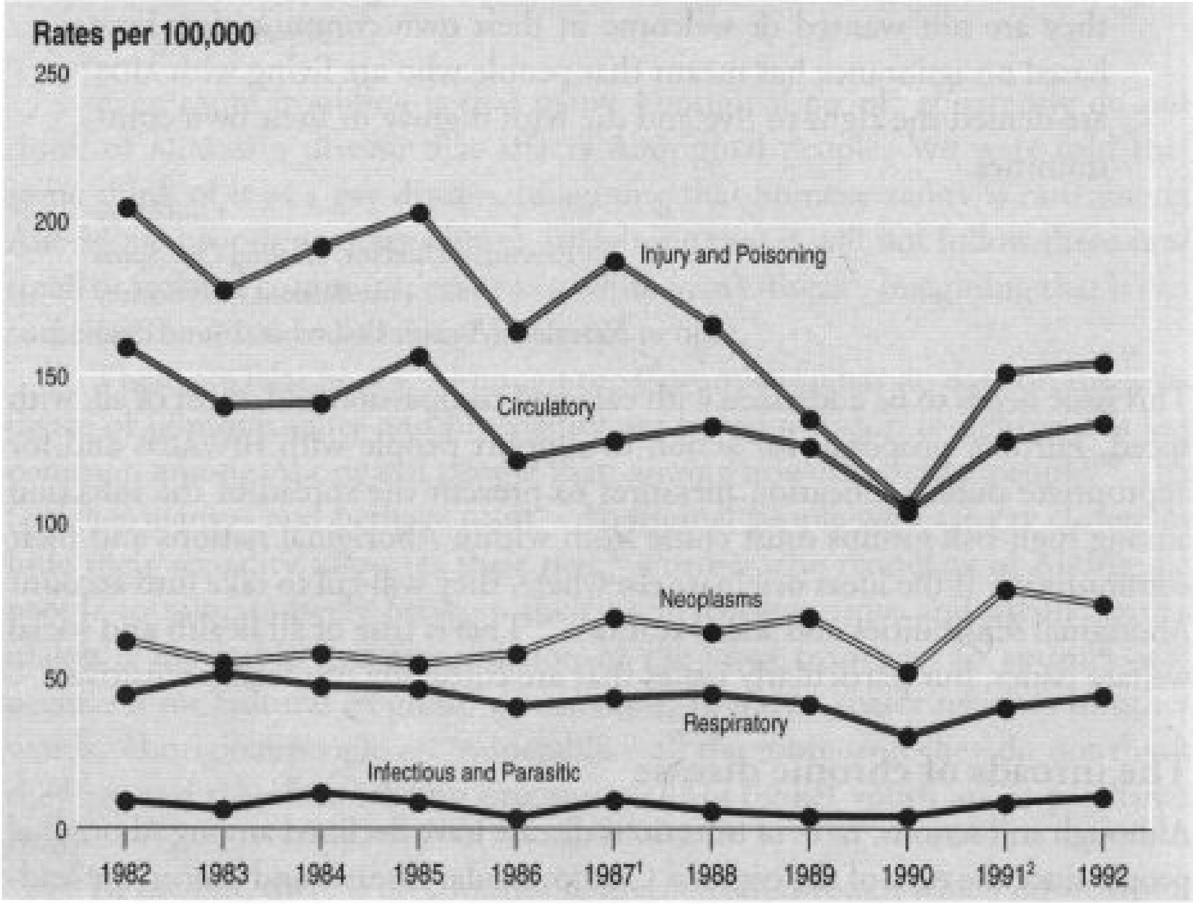
This issue needs to be addressed with care and compassion and, most of all, with speed. Further, proposals for action to support people with HIV/AIDS and for appropriate public education measures to prevent the spread of the infection among high-risk groups must come from within Aboriginal nations and their communities. If the ideas originate elsewhere, they will fail to take into account Aboriginal sensibilities and social realities.[96] This is true of all health and social welfare issues, but particularly issues that are culturally or socially sensitive.

The inroads of chronic disease

Although still serious, rates of infectious disease have declined among Aboriginal people since the turn of the century. Cardiovascular diseases and cancer, the leading killers of Canadians generally, are found at lower rates in the Aboriginal population, though they remain significant causes of death. Metabolic disorders, particularly diabetes, and respiratory and digestive disorders are also significant factors in Aboriginal illness and death, as shown in Figures 3.1 and 3.6. Chronic conditions are sometimes called the diseases of modernization, or western diseases because they attend the lifestyles typical of western industrial nations: reduced physical exercse; diets overloaded with fat and sugar; high levels of stress; and increased exposure to a wide range of pollutants in the air, water and food supply. These risk factors set the stage for a wide range of diseases, including cancer, heart disease, obesity, gall bladder disease and diabetes.

FIGURE 3.6

Mortality Rates by Selected Causes, Registered Indian Population, 1982-1992



Notes:

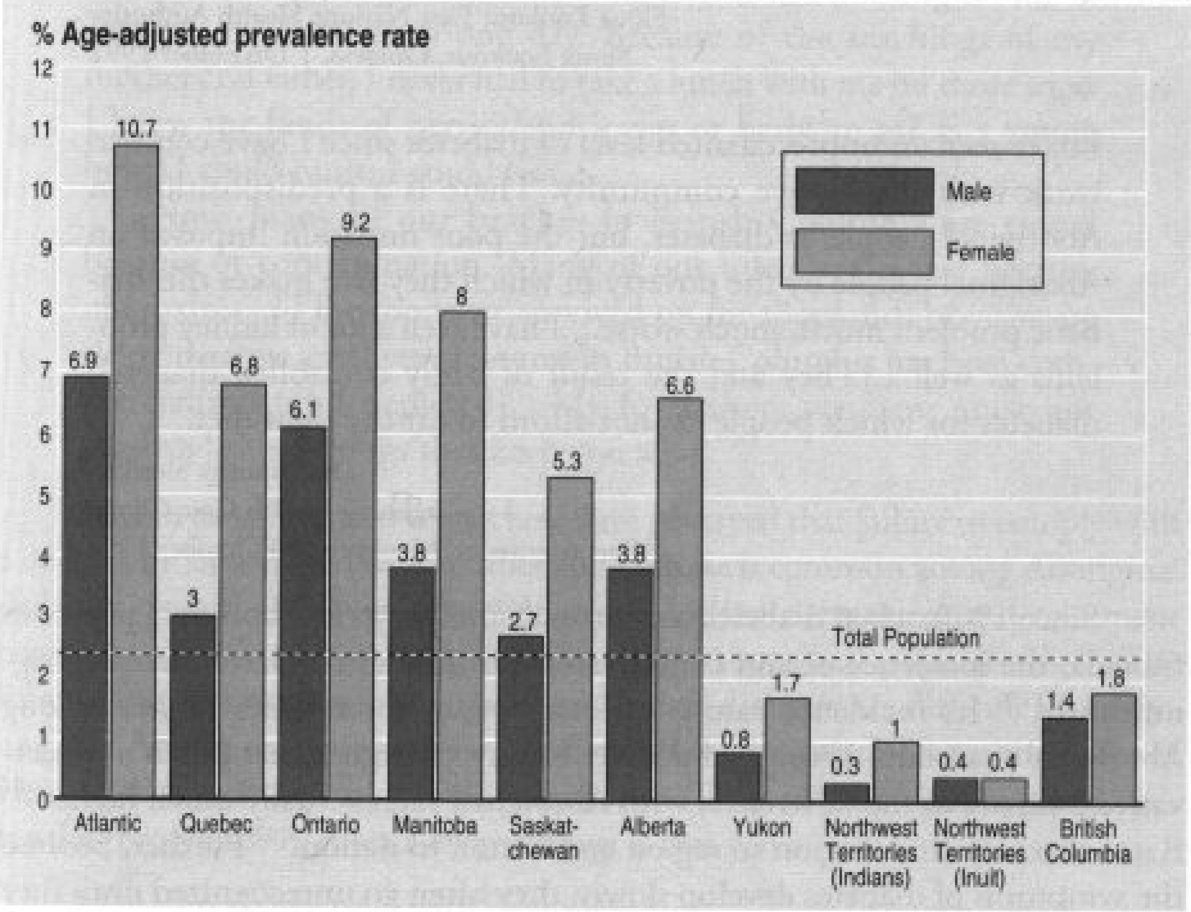
1. Rates since 1987 no longer include Indian persons in the Northwest Territories because of the transfer of health services to the government of the Northwest Territories.
2. British Columbia data were not included in counts and rates for 1985 to 1990, but are included beginning in 1991.

Source: DIAND, Information Quality and Research Directorate, *Basic Departmental Data, 1994* (Ottawa: January 1995).

The Commission has chosen to discuss diabetes as an example of a serious chronic disease with specific dynamics of cause and effect among Aboriginal people. Diabetes affects Aboriginal people disproportionately (see Figure 3.7), and the cost of that prevalence is great. As well as leading to premature death, diabetes causes medical complications and disability, including kidney disease, heart and circulatory disease, blindness, amputations, nervous system disease, and birth defects among infants born to diabetic mothers. In Canada, diabetes is the cause of 30 per cent of new cases of kidney disease and is the leading cause of new cases of adult blindness. It causes 50 per cent of all non-traumatic amputations and doubles the rate of heart disease (for women, it multiplies this rate by five). It triples the rate of birth defects and increases the risk of neonatal complications requiring intensive medical intervention by a factor of five.[97]

FIGURE 3.7

Prevalence of Diagnosed Diabetes, Registered Indian, Inuit and Total Populations, 1987



Source: T.K. Young, E.J.E. Szathmary, S. Evers and B. Wheatly, "Geographical distribution of diabetes among the Native population of Canada: A national survey", *Social Science and Medicine* 31 (1990), pp. 129-139.

Dialysis for kidney disease costs about $40,000 per patient per year in Canada.

The total cost to Canadians of all treatment (for both direct and indirect ill health effects of diabetes) in 1994-95 has been estimated at $4 billion.[98]

In our public hearings, several community health caregivers told us they are alarmed about the growing number of people with diabetes in Aboriginal populations.[99]

Our health status report gives a representative view of the health status of Inuit people. We know the bleak statistics with regard to Aboriginal health status [elsewhere] in Canada, and our health status assessment shows no differing results here in this region. Diabetes, hypertension, overweight, poor nutritional status are epidemic amongst Native people in Canada today.

Bette Palfrey
Keewatin Regional Health Board
Rankin Inlet, Northwest Territories, 19 November 1992

Over the last decade…diabetes mellitus has been recognized as a major disease among Aboriginal communities across North America. In the Sioux Lookout zone [population approximately 15,000], approximately 1,095 people of the population over 25 years of age…are known to be diabetic. It is significant that 50 per cent of the cases have been diagnosed within the last five to ten years.

Nellie Beardy
Executive Director,
Sioux Lookout First Nations Health Authority
Sioux Lookout, Ontario, 1 December 1992

I have seen an unprecedented level of diabetes since I have come to work with the Native community. There is a predisposition in Aboriginal people to diabetes, but the poor nutrition imposed on Aboriginal people by the poverty in which they live makes this diabetic problem much, much worse….I have seen a lot of kidney problems as well….[They are] the result of badly controlled diabetes, diabetes for which people cannot afford to eat the right diet.

Dr. Timothy Sheehan
Sagkeeng Health Care Centre
Fort Alexander, Manitoba, 30 October 1992

Since 1940, when diabetes was virtually unknown in Aboriginal people in Canada, the incidence of and complications from diabetes have increased significantly.[100] Its incidence rate is at least two to three times higher among Aboriginal than non-Aboriginal people. Kewayosh argues that this is a conservative estimate of the difference, with Aboriginal rates actually much higher.[101] Rates also vary from region to region and nation to nation.[102] Further, because the symptoms of diabetes develop slowly, they often go unrecognized until they are well advanced. Thus it has been said that for every known case of diabetes, at least one goes undiagnosed.[103]

There appears to be an inherited tendency among Aboriginal people to diabetes;[104] nevertheless, the disease was rare in pre-contact times. What, then, has changed in Aboriginal lives to stimulate its occurrence? The main risk factors for diabetes are obesity, poor eating habits and physical inactivity. Obesity is thought to be a growing problem in Aboriginal communities.[105] Physical activity has decreased, as a result of the historical confinement of some Aboriginal people to reserves and settlements and the adoption of a sedentary lifestyle by urban migrants. Another factor is the consumption of alcohol. Perhaps most serious of all has been a change in diet from high quality country foods to processed foods with high levels of fat and sugar. We discuss the nutritional value of country food (fish, game and vegetables available directly from surrounding lands) in more detail later in this chapter and in Volume 4, Chapter 6.

At a recent international conference on diabetes and Aboriginal people, Elder Simon Lucas of the Hesquiaht First Nation community at Tofino, British Columbia (himself a diabetic) described the changes in his people’s lifestyle and diet:

> The traditions of our forefathers were amazing. Our people were so busy they didn’t have time to be sick. My father built his last canoe when I was 8 years old, and [thinking about] this has made me remember how busy I was as a young boy. It was nothing for me to row 10 to 15 miles in one day. Because of the teachings of my mother and father, I never had to take a lunch with me on those trips. I knew the kinds of berries and leaves or herbs to eat as a young boy….I could hunt, I could fish….
>
> Now, many of our beaches in British Columbia are closed because of contamination. Many of our inlets are closed because of…toxins….[T]he foods we survived on for thousands of years are sicker than we are. Every resource in British Columbia has been commercialized [and depleted]….My forefathers say…you must not [destroy] those things that keep you alive.[106]

Health caregivers and researchers have observed that failure to comply with a doctor's orders on medications, diet and exercise is common among Aboriginal diabetics. It has also been observed that standard prevention and treatment programs are "simply not successful" among Aboriginal populations.[107] The lifestyle changes necessary to prevent or control diabetes are difficult for everyone, but Aboriginal people approach diet and weight control from the point of view of their culture, values and experience. They require culture-based prevention programs. Alethea Kewayosh put it this way:

Low compliance rates with treatment protocols can in part be attributed to non-culturally relevant educational and prevention materials. This is best illustrated by the problems of dietary compliance. Native people with diabetes often fail to comply with [prescribed] dietary changes due to: (a) their perception of the role of food; (b) strong cultural beliefs that equate health and prosperity with being overweight; (c) the lack of familiarity with many of the food items recommended on the diet, and (d) the high cost of many of the recommended dietary items that are not only difficult to obtain, but may require special preparation.[108]

Dr. Jennie Joe, director of the Native American Research and Training Center in Tucson, Arizona, has also concluded that non-compliance stems from the use of health programs and materials developed for use in non-Aboriginal cultures. For greater success in Aboriginal communities, she recommends such strategies as

- showing (with slides, videos and other visual aids) what can happen as a result of diabetes, instead of describing it in writing;

- involving families in treatment and whole communities in prevention;

- recognizing the cultural significance of food among peoples for whom it was often scarce, even in recent memory; and

- acknowledging that chronic disease is a new concept for Aboriginal people and that they may have difficulty accepting that preventive measures to forestall or control diabetes must last a lifetime.[109]

The Commission is aware of a number of promising initiatives to develop culture-based diabetes prevention programs for Aboriginal people in Canada. One of them is the Diabetic Outreach Program in the High Prairie region of northern Alberta. Another is the Walking in Balance Program developed at the

Anishnabe Spiritual Centre on Manitoulin Island.[110] The most comprehensive is the four-part initiative undertaken at the Kateri Memorial Hospital Centre at Kahnawake, Quebec. Commissioners believe that the Kateri Centre could, and should, serve as a base for training caregivers from other Aboriginal communities in preventing and managing diabetes.[111]

The stresses of disability

Disability among Aboriginal people was raised in a number of presentations to the Commission, pointing out the long-time neglect of people with disabilities.[112]

According to Statistics Canada's 1991 Aboriginal peoples survey (APS), 31 per cent of Aboriginal people have some form of disability — more than twice the national average. For young adults, the rate is almost three times as high.[113] Disabilities affecting mobility and agility are most common, but hearing and visual disabilities affect a large portion of the Aboriginal population. About one in three of the APS sample reported a hearing impediment, compared with one in four in the general population. About one in four reported a problem with sight, compared with one in 10 in the general population. Problems with sight are most common among Indian people on-reserve; problems with hearing are most common among Inuit (see Table 3.8).

The disparity between Aboriginal and non-Aboriginal rates of disability corresponds to disparities in rates of injury, accident, violence, self-destructive or suicidal behaviour, and illnesses (such as diabetes) that can result in permanent impairment. But why do Aboriginal people suffer disability more often than others? A special committee of the House of Commons summed up the answer this way:

Native communities, and Native people living in non-Native communities, suffer on a daily basis from living conditions which other Canadians experience only rarely. These adversities — economic, political, social and cultural in nature — greatly increase the probability of being disabled at some time in a person's lifetime.[114]

TABLE 3.8

Persons with Physical Disabilities, Total and Aboriginal Populations, 1991

			North American			
	Total Population	**Total Aboriginal**	**On-Reserve**	**Non-Reserve**	**Métis**	**Inuit**
Mobility disability	45	45	47	45	44	36
Hearing disability	23	35	39	33	34	44
Seeing disability	9	24	32	21	22	24
Agility	44	35	34	36	38	26
Speaking disability	10	13	14	13	13	10
Other disability	37	36	37	37	35	36

Notes: Population is those 15 years of age and older.

Source: Statistics Canada, "The Daily", 25 March 1994, catalogue no. 11-001E.

Reversing these adversities is the objective of primary prevention, which involves programs to improve health and safety conditions in Aboriginal homes and communities so that injury and accident are reduced, efforts to improve social and economic conditions so that violence and self-destruction are reduced, and programs in health promotion and disease prevention so that illness-based disability is reduced. However, the testimony before Commissioners was aimed almost exclusively at providing support for Aboriginal people who already have disabilities:

[After my accident] I was in the hospital for 14 months. Ever since I ended up in this wheelchair, I had no place to go….Right now I am living in [name of institution]. I don’t call that home. What I call home is my own house….I was wondering if disabled [Aboriginal] people could get their own places, and if they could…pay somebody to help take care of a disabled person in his own house….I am not just talking for myself; I am talking for other disabled Native people.

Victor Cody
Native Disabled Group
Saskatoon, Saskatchewan, 27 October 1992

The kinds of disabilities I am working with are quadraplegics, paraplegics, heart and stroke victims, vision (partially and totally impaired), hearing (partially and totally impaired), head and brain injuries, and also people on dialysis. Each one of these people has a very unique type of disability, and it takes a lot time dealing with each and every one of them because of the individual problems they have….

Also, there is a lot of racism in institutions such as private home care institutions, larger institutions too. It makes it more difficult for Native people who are disabled living in these institutions. I strongly believe that an all-Native home should be provided….

There is a lot of abuse taking place also with Native disabled people….And without somebody like me who can go out there and investigate this [a resource which most disabled Aboriginal people certainly do not have], there is nothing that can be done for those people to get help.

Isabelle Smith
Disability Counsellor
Saskatoon Indian and Metis Friendship Centre
Saskatoon, Saskatchewan, 27 October 1992

Aboriginal people with disabilities who live on reserves and in rural settlements face such problems as inaccessible buildings, including band offices, schools, churches and homes; inaccessible places of community activity, including community centres, arenas and meeting halls; lack of appropriate recreation opportunities; the difficult choice between staying on under-serviced reserves and settlements or leaving home to seek services away from relatives, friends and familiar surroundings.[115]

The Commission has selected the example of hearing impairment to illustrate some of the origins and consequences of disability specific to Aboriginal people. Most premature hearing loss results from excessive noise or from otitis media (OM). OM is an acute or chronic inflammation of the middle ear, to which children are highly susceptible. It occurs when an infection of the nose or throat — including an infection caused by a cold or flu — blocks the passageway connecting the back of the throat to the middle ear (the eustachian tube). Some children have recurrent attacks, sometimes every few weeks over a period of years, especially in the winter.[116] Children who are otitis-prone are likely to have temporary or permanent hearing problems that interfere with language learning, school success and social development generally.[117] Most of this hearing loss is preventable.[118]

As with all infectious diseases, inadequate housing conditions — overcrowding and less than ideal sanitation facilities — are major risk factors. For OM in particular, anything that increases the child's exposure to colds and flu or weakens the immune system adds to the risk. Bottle feeding increases risk, especially if the child is fed while lying flat. (This position allows milk to pool in the pharynx and puts pressure on the ear. Breast feeding offers protection through better positioning of the child and through the transfer of antibodies from mother to child.)[119] Exposure to second-hand cigarette smoke is also a risk factor.

Inuit children have especially high rates of OM. As many as 80 per cent show evidence of current infection or scarring from past episodes.[120] In one community, research showed found that one child in 10 had suffered permanent hearing loss as a result of past infections.[121] In another, one child in five was found to be at least partly deaf.[122]

Dr. James Baxter, an expert in this field, has indicated that OM went from a rarity among Inuit to a serious health problem in only a few years, starting in the 1950s.[123] Lifestyle changes were responsible. Once-migratory Inuit began to live in close quarters year-round; colds and flus were thus in greater circulation. Inuit moved into government-built houses that were often inadequate for the climate, and their immune systems were compromised by inferior store-bought food, alcohol consumption and cigarette smoke. Bottle-feeding replaced breast-feeding in many households. All the conditions needed to promote OM at high rates were in place, and indeed the condition was epidemic until very recently. Improvements are primarily the result of outreach to parents, aggressive case finding by medical and school personnel, and treatment by specialized personnel from southern hospitals and university medical faculties.[124]

Such strategies can be applied to other Aboriginal health and social services. Outreach and case finding are feasible for most Inuit and reserve communities now. Access to specialized personnel is notoriously difficult to come by, however, especially in northern and isolated communities.[125] Yet, as Commissioners heard many times in testimony, fly-out patient programs are expensive and disruptive to patients and their families, and they work only when accurate local diagnosis can be depended on. Fly-in expertise is irregular, unreliable, and sometimes insensitive to local cultures and conditions. The magnitude of the issue of access to trained personnel suggests the need for a comprehensive human resources strategy. We return to this matter later in the chapter.

The problems of Aboriginal disability raise a broader issue: the difficulty of providing equitable programs and services for all Aboriginal people when responsibility is divided between federal and provincial/territorial governments. In 1981, a special committee of the House of Commons urged all governments to develop programs for Aboriginal people with disabilities.[126] Little was done for a decade. Then, in September 1991, the federal government announced a national strategy for the integration of persons with disabilities. The program has been funded to a maximum of $158 million over five years and has a long list of commendable objectives, including some that apply to Indian people on-reserve and to Inuit in the Northwest Territories. As part of the national strategy, the department of Indian affairs is spending $5 million to improve co-ordination and accessibility and to promote sensitive design and delivery of existing programs and services to people with disabilities living on-reserve. Health Canada has conducted a major consultation on key issues regarding the care of elderly people and persons with disabilities on-reserve, with the promise of action to come. Medical services branch has allocated $2 million over five years to retrofitting existing health facilities. (It estimates that retrofitting all the health facilities it operates in Aboriginal communities would cost $7.5 million.) Even so, these initiatives leave untouched the major problem areas identified in 1981: housing, employment and economic security, education, emotional support and service delivery.

In March 1993, however, a House of Commons committee released another report on Aboriginal people with disabilities.[127] It pointed out that no comprehensive plan of action covering all Aboriginal people with disabilities exists even now, and that no single agency is charged with developing one. It identified fragmented efforts within the federal government and jurisdictional murkiness between federal and provincial/territorial governments as the two main barriers to relieving unacceptable human suffering.

The problem of inequities in services and community self-development is rooted in the distinctions of responsibility of different levels of government. It is a pervasive problem that requires complex solutions. Our proposals for reorganizing the delivery of health and social services are designed to overcome problems of unequal access to culturally appropriate services. A complementary action to fill the policy vacuum affecting urban, Métis and other Aboriginal people is discussed in Volume 4, Chapter 7.

1.3 Social and Emotional Health

Commissioners agree with health analysts all over the world and with scores of Aboriginal people who addressed us during our public hearings that health involves much more than the physical. In the imagery common to many Aboriginal cultures, good health is a state of balance and harmony involving body, mind, emotions and spirit. It links each person to family, community and the earth in a circle of dependence and interdependence, described by some in the language of the Medicine Wheel.[128] In non-Aboriginal terms, health has been seen primarily as an outcome of medical care. But we are quickly learning that any care system that reduces its definition of health to the absence of disease and disability is deeply flawed.

Testimony and research show that many Aboriginal people suffer from social and emotional ill health. The Commission heard accounts of the years lost by Aboriginal people in jails and prisons, in struggles with alcohol and drugs, and in violence and suicide, and of the breakdown in community and family order that underlies these social and emotional ills. Social disorder contributes to accidents, injuries and lack of self-care. Further, social ills undermine the collective self-esteem of Aboriginal people; many are ashamed and afraid of the self-destructive and antisocial behaviour they see around them. As well, the images of social and emotional distress in circulation in the wider population carry a distorted message to Aboriginal and non-Aboriginal people alike about what it means to be Aboriginal.

We have discussed some of these matters in other publications and in other parts of this report.[129] To illustrate the complexity of the problems and possible solutions, we examine three additional aspects of social and emotional ill health: injury and accidents, alcohol abuse and child protection.

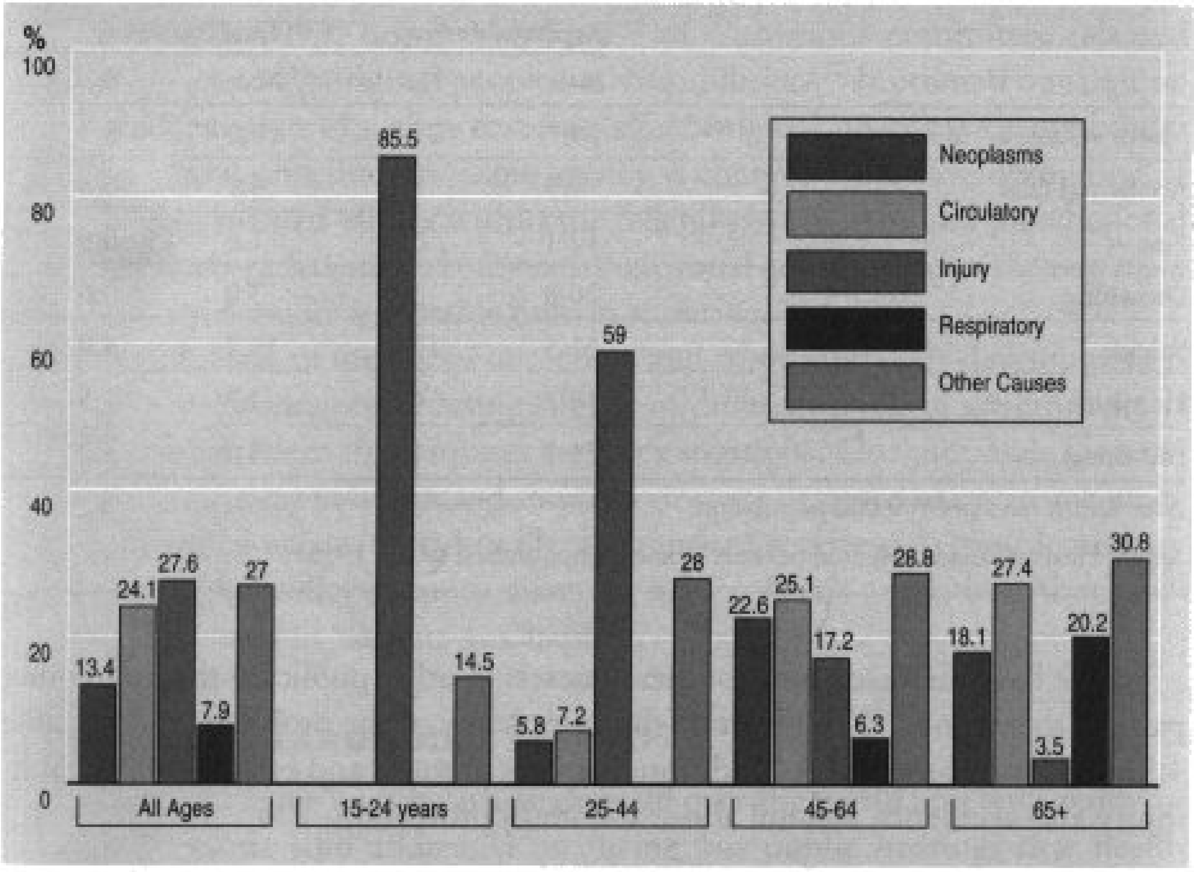
Injury and accidents

In 1992, fatal injuries were the leading cause of death among registered Indian males and the second most frequent cause of death among registered Indian females in regions for which Health Canada collects data (see Figure 3.1, Figure 3.6, Table 3.9 and Figure 3.8). ‘Injury’ includes all forms of accidental death (unintentional injury) and homicide and suicide (intentional injury). For young people aged 15 to 24, fully 85.5 per cent of all deaths were the result of injury.[130] Even among those aged 25 to 44, 59 per cent of all deaths resulted from injury. We discussed suicide and violence among Aboriginal people in *Choosing Life*; here we are concerned primarily with accidental death and wounding.

The majority of Aboriginal deaths from injury are the result of motor vehicle accidents (with alcohol as a major contributing factor), drownings, house fires and gunshot wounds.[131] Such injuries are considered preventable in about nine cases out of 10.

The rate of death by injury among Aboriginal people has decreased substantially in the last 20 years. However, it is still almost twice as common among Aboriginal people as among Canadians generally. In some age groups, it is more than four times as common. Furthermore, injury is responsible for a large number of non-lethal ill health effects among Aboriginal people (temporary wounds and long-term disabilities that require hospitalization and other treatment). Thus, in terms of human suffering and days of life and labour lost to Aboriginal nations and their communities and to the country as a whole — plus the cost to the health care system — injury among Aboriginal people is an extremely serious social health problem.

FIGURE 3.8
Selected Major Causes of Death, Registered Indian Population, 1992



Note: If a cause of death is not a major one for a given age group, it is counted in the 'other causes' category for that age group. For example, neoplasms (cancers) and circulatory and respiratory diseases are grouped in the 'other' category for the age group 15-24 years.
Source: Health Canada, Medical Services Branch, unpublished data, 1992.

High rates of injury when war is not a factor arise primarily from adverse psycho-social and economic factors. In the case of Indigenous people in Canada, the cultural and material losses they have suffered and their place of relative powerlessness in Canadian society have contributed to anger that has no harmless outlet, grief that does not ease, damaged self-esteem, and a profound sense of hopelessness about the future of Aboriginal people in general and themselves in particular. These contribute in many subtle and not so subtle ways to the incidence of injury:

- Reckless and potentially self-destructive behaviour, such as operating a motor vehicle (car, truck, snowmobile or boat) while under the influence of alcohol, may be caused or triggered by the powerful emotions of grief, anger and hopelessness. Other forms of violent and self-destructive behaviour, including homicide and suicide, can be triggered in the same way.

- The correlates of poverty, especially substandard housing and community infrastructure, increase the incidence of fires and other household accidents.

- In a somewhat different vein, the casual storage and occasional misuse of firearms (which are a necessary part of everyday life in hunting cultures) may also contribute to high rates of lethal or wounding injury.

Until recently, accident and injury have received little attention in government-sponsored health promotion programs for Aboriginal people. High rates of injury, to some degree, result from injustices to Aboriginal people in Canada and will not be reduced simply through education and prevention measures. Nevertheless, such approaches must be tried and assessed.

Mainstream public health offers models for successful prevention and control of injuries. Some of these have been considered — but apparently not tested — in Aboriginal communities.[132] By and large, culturally appropriate prevention strategies for Aboriginal people are underdeveloped, and we believe they are very much needed.

Brighter Futures, a child health initiative of Health Canada, now includes a component aimed at preventing injury among First Nations children. It has been funded for five years, from fiscal year 1992-93 to fiscal year 1996-97. About 80 per cent of the program budget is available for community-based programming. The remainder is reserved for national projects in support of local activity. These include materials development, training and the development of a culturally appropriate data collection system. Medical services branch data suggest that few First Nations have made use of the injury prevention component of the program so far.[133]

Strategies should be directed to the three phases of prevention. The pre-event phase could include developing programs to encourage the safe use of wood stoves and fires, the safe storage of guns and other lethal weapons, the safe use and storage of poisonous household products, and so on. The event phase could include forming a volunteer fire brigade or an after-hours safety patrol, providing training in cardio-pulmonary resuscitation and other first aid techniques, developing a well-advertised electronic link with an urban poison control centre for isolated communities, and training crisis intervention specialists. The post-event phase could include developing advanced first aid skills among community members, and implementing special emergency response education for community health representatives and other community caregivers for such common injuries as burns, poisonings and overdoses. For example, the Indian Health Service in the United States conducts an injury control fellowship program to assist junior-level health workers in upgrading their knowledge of injuries, including their prevention.

TABLE 3.9

Rates of Death for Selected Types of Injury, Registered Indian and Total Populations, 1989-1992

	Registered Indians		**Total Population**	
	Male	**Female**	**Male**	**Female**
Motor vehicle accidents	59.7	24.7	20.0	8.3
Accidental falls	9.9	7.1	6.1	6.3
Fire	12.1	6.6	1.6	0.8
Drowning	20.8	3.1	3.0	0.6
Suicide	51.5	15.1	19.2	4.9
Homicide	18.2	6.8	2.7	1.5
Poisoning	21.1	11.7	3.0	1.2

Note: Death rates per 100,000 population.

Source: Health Canada, Medical Services Branch, unpublished tables, 1995.

It is clear from the social nature of the causes of injury among Aboriginal people, however, that prevention cannot be limited to education and behaviour modification. Long-term strategies must address community norms for safe and careful activity and, more important, the broad social conditions that provoke recklessness and lack of self-care. They must also address the possibility of dangerous products and hazards in the environment, which may require modification or regulation.

The Canada Safety Council has offered its expertise to Aboriginal people to increase preventive education about the leading causes of accidental death. In particular, representatives discussed with us the possibility of adapting its courses on driver safety awareness to suit Aboriginal audiences. (In the Commission's view, this program must extend to snowmobile and all-terrain vehicle safety, as well as the more common car and truck driver education.) We have also discussed the possibility of assessing the potential of the Council's new aggression control workshop program for use by Aboriginal communities and of working in partnership to develop culturally appropriate awareness programs about the other causes of death by injury that are at issue in Aboriginal communities: the misuse of firearms, drowning, fire, and drug overdose. We encourage Aboriginal health authorities to take the Council up on its offer. We will have more to say about such offers of positive support from non-Aboriginal health organizations later in this chapter.

As an example of co-operation already under way, we note that St. John Ambulance, a nation-wide voluntary organization that focuses on first aid and general health promotion, has entered into a partnership with the Meadow Lake Tribal Council (MLTC) of northern Saskatchewan to address the problem of injuries in the MLTC region. Members of St. John Ambulance are working with the tribal council's health and social development unit on three initiatives:

- adapting general training programs, such as the Northern Wilderness First Aid course, to Meadow Lake's needs;

- modifying special training programs on child care, babysitting and elder care to reflect Aboriginal norms and values; and

- assisting MLTC in developing other strategies for injury prevention.

We received few presentations in testimony on the problems of injury. We urge those in leadership positions to place greater priority on the prevention of injury among Aboriginal people of all ages and, where it cannot be prevented, on harm reduction. 'Harm reduction' is a phrase commonly used in the addictions field to describe a treatment goal of reducing the intake of alcohol or drugs to reduce harmful consequences; it is an alternative to total abstinence. In the field of accident and injury, if outright prevention is impossible or unlikely, harm reduction may be feasible. For example, since wood stoves cannot realistically be eliminated in Aboriginal communities, those who use them can be informed about safe use and emergency procedures in case of fire. More important, strategies can be developed to reduce alcohol abuse and encourage adult supervision of children in households with wood stoves.

The general approaches sketched here must be made specific to the patterns of injury experienced by particular Aboriginal cultures, communities and age groups. This requires a serious initiative to gather and interpret information. Medical services branch has promoted such an initiative (for First Nations only) with its ‘injury surveillance project’.[134] Some other jurisdictions have small projects under way, but these lack co-ordination. Aboriginal nations and their communities across the country would benefit with help from an intergovernmental and inter-agency planning mechanism to facilitate the sharing of ideas, materials and resources.

Alcohol abuse

Alcohol was introduced to Aboriginal people in the course of trade and social interaction with European explorers, fur traders and merchants.[135] It became a part of business and a part of pleasure. The effects were somewhat similar to those of introducing smallpox and other infectious diseases: Aboriginal people had no ‘immunity’ to alcohol, in the sense that social norms and personal experience can ‘protect’ against over-consumption. Stereotypes of drunkenness among Aboriginal people have been greatly exaggerated, but there can be no doubt that the problem of abuse was — and is — real.

Excessive consumption of alcohol has serious physical health consequences; it increases the risk of heart disease, cirrhosis and liver disease, gastritis and gastro-intestinal cancers, hepatitis and fetal alcohol syndrome. Its social and emotional correlates include accidents, suicides, family violence and breakdown, unemployment, criminal behaviour and, to apply a concept from pediatrics, ‘failure to thrive’.[136] Commissioners heard contradictory evidence regarding the current extent of alcohol abuse. Many Aboriginal people told us, often in graphic terms, that the effects of alcohol abuse still run wide and deep:

> Twenty-three years ago, I woke up one morning and knew I was going to die unless I quit drinking, so I quit….Of the men of my generation who were my working and drinking companions, most are dead in violence, in accidents or from alcohol-related diseases.
>
> Winston McKay
> Métis Addictions Corporation of Saskatchewan
> La Ronge, Saskatchewan, 28 May 1992

In Canada they say there’s about 80 per cent of the Native people that are directly or indirectly affected by the alcohol and drug abuse. Let me explain that. What I mean by ‘directly or indirectly’, it doesn’t mean that 80 per cent of Native people are addicted and should be in a treatment centre, but that somebody in their family is addicted, and that one causes [many other problems].

Robin Dupuis
Executive Director,
Labrador Inuit Alcohol and Drug Abuse Program
Happy Valley-Goose Bay, Newfoundland and Labrador
16 June 1992

I became a drinker as well, and it was to hide the pain and the hurt I suffered [from abuse] in my childhood. And because I married a violent person as well, I continued drinking to mask all that fear and hurt….I didn’t become aware of that cycle of violence until I was much older. I had raised my children already, and they in turn [had become] its victims.

Edith Young
Swampy Cree Tribal Council
Thompson, Manitoba, 31 May 1993

The chain reaction of addiction hurts many people….It can cripple individuals, families in our society, and even make [a whole] region dysfunctional….Myself, I am a sober alcoholic and drug addict. My sister perished when she was drunk. My nephew killed himself and his own father and mother while they were drunk. My older brother shot himself when he was drunk.

Henoch Obed
Addictions Counsellor
Labrador Inuit Alcohol and Drug Abuse Program
Nain, Newfoundland and Labrador, 30 November 1992

We also heard testimony suggesting that for many individuals and communities the curtain is beginning to lift:

I am sure you hear a lot of bad news in your Commission. I am here to bring you good news. Things are moving ahead [in relation to addictions]….Seventy-six per cent of the [former drinkers] that we have surveyed had two to 10 years of sobriety….The Native Addictions programs, the Health and Welfare program, they are working. Things are changing….I believe that in the area of substance abuse, we are finally making progress. I believe that we have assumed responsibility [for our own recovery].

Maggie Hodgson
Nechi Institute on Alcohol and Drug Education
Edmonton, Alberta, 11 June 1992

As a collective, [the National Native Association of Treatment Directors has] identified our successes as deriving from: [doing our own] program development and delivery; cultural programming to increase awareness and self-esteem; the use of Native counsellors as role models; introducing or strengthening traditional spirituality; and helping our clients learn to help themselves.

We cannot say that 40, 60, 70 or 80 per cent of the 7,500 people we treat annually have remained sober or drug-free, because we do not have access to tracking. We do know, however, that every client who completes our treatment programs…[has] begun the healing journey.

Patrick Shirt
President, National Native Association of Treatment Directors
Calgary, Alberta, 27 May 1993

The evidence put forward by researchers in the field is contradictory. The Canadian Centre on Substance Abuse reported in their presentation to the Commission that one in five hospital admissions for alcohol-related illness in Canada is an Aboriginal admission, that alcohol psychosis occurs among Aboriginal people at four times the national average rate, and that the rate of liver disease among Aboriginal people is three-and-a-half times the national average.[137]

However, survey data from a number of sources indicate that alcohol consumption rates among Aboriginal people are in fact lower in some measurement categories than among non-Aboriginal people. The primary source of national data is the Aboriginal peoples survey (APS). The picture it presents is based on self-reports, and as such must be regarded with some caution, though it is regarded as reasonably reliable by experts in the field.[138] The APS found that a lower proportion of Aboriginal people than Canadians generally drink daily or weekly. Abstinence is almost twice as common among Aboriginal people (see Table 3.10). Additional findings of the APS are that of those in the Aboriginal population who do use alcohol, consumption rates are higher among those with the most education and income, higher among men than women, and lowest among those aged 55 and over.

TABLE 3.10

Percentage of Persons Who Reported Drinking Alcohol in the Past Year, Total and Aboriginal Identity Populations, 1991

	North American Indians						
	On-Resrve	**Non-reserve**	**Total**	**Métis**	**Inuit**	**Total Aboriginal**	**Total Population**
Never	22	13	16	11	22	15	8
None	18	14	15	14	11	15	11
Some	60	73	69	75	67	70	81
Frequency of drinking among drinkers (%)							
Daily	1	2	2	2	1	2	7
Weekly	31	37	35	34	30	35	46
Monthly	38	31	33	32	32	33	24
Less than once a month	30	30	30	32	37	31	24

Use of alcohol in the past year (%)

Notes:

Population aged 15 and over.
Never = persons reporting lifetime abstention.
None = persons reporting drinking no alcohol in the past year.

Source: Statistics Canada, Language, Health, Lifestyle and Social Issues: 1991 Aboriginal Peoples Survey, catalogue no. 89-533 (June 1993); Thomas Stephens and Dawn Fowler Graham, eds., Canada's Health Promotion Survey 1990: Technical Report, catalogue no. H39-263/2-1990E (Ottawa: 1993).

The findings of the APS are supported by those of the *Yukon Alcohol and Drug Survey*, also based on self-reports.[139] The Yukon survey found that abstinence is about twice as common among Aboriginal people as among other Canadians. It also found that, of those who do report drinking, more Aboriginal people are heavy drinkers, both in the frequent ('regular') and infrequent ('binge') patterns. A third survey, conducted in nine Cree communities in northern Quebec, found a similar pattern of self-reported drinking behaviour in which both abstinence and heavy drinking are more common than moderate consumption.[140]

The explanation for these discrepancies is a matter of conjecture. The most optimistic interpretation is that Aboriginal people are now beginning to achieve higher levels of sobriety, thus breaking patterns recorded by earlier studies that continue to be reflected in mortality and morbidity data. This possibility is given weight by the follow-up study by Kinzie and colleagues in 1988 of mental health issues in a northwest coast village previously studied by Shore and colleagues in 1969. Alcohol use and abuse rates in 1988 were still high, but were lower than those reported in 1969. The success of drug education and treatment programs were thought to offer one possible explanation for the change.[141]

A less encouraging possibility is that Aboriginal people may under-report alcohol consumption, despite assurances of anonymity and confidentiality. Or, it could be that the small number of heavy drinkers in the Aboriginal population skews the social and medical effects data toward an unrepresentative extreme. In any case, the widely held belief that most Aboriginal people consume excessive amounts of alcohol on a regular basis appears to be incorrect.

Canadian governments have been slow to expand their services to include social and emotional ill health, or what is sometimes gathered together under the term 'mental health'.[142] Yet, fully 20 years ago, the federal government funded a demonstration program, the National Native Alcohol and Drug Abuse Program (NNADAP), to find ways to reduce the incidence and effects of alcohol use in Aboriginal communities.[143] Today, NNADAP provides funds for about 400 community-based prevention and treatment programs, 51 regional residential treatment centres, and basic training to prepare Aboriginal staff to deliver most of these services.[144] Budget estimates for 1994-95 show about $59 million allocated to NNADAP. Thus, alcohol and drug addiction is the only one of the inter-linked social and emotional problems facing Aboriginal people to have received long-term funding from government for services that are designed and delivered by Aboriginal people.

NNADAP has both supporters and critics. Both sides have argued the need for a full program review. The Commission believes this would be a useful way to identify the strengths and weaknesses of the many approaches to treatment funded by the program. We believe there are many worthwhile insights to be built upon.[145] Indeed, we would like to see the insights of Aboriginal addictions workers applied to social and emotional health problems more broadly.

In our view, the failure to do so reflects the half-hearted approach taken by Canadian governments to Aboriginal mental health issues generally. Alcohol addiction is seen by most health authorities — and by many of those who work in the treatment field — as a stand-alone problem with treatable causes. Some see it as a disease. Moreover, it is funded as a stand-alone problem with treatable causes. The most successful alcohol treatment programs developed by and for Aboriginal people have gone far beyond this restricted understanding of addictions; they have tackled related problems of physical and sexual abuse, loss of self-esteem and cultural identity, lack of personal opportunity and exclusion from mainstream Canadian society. Counsellors have found that Aboriginal addictions are part of a circle of oppression, despair, violence and self-destructive behaviour that must be addressed as a whole. For most of their clients, tackling addictions is like grabbing the tail of the tiger — family violence, suicide, self-injury, accidental injuries and deaths all being stripes on the same animal:

> In a Native-run [alcohol and drug] treatment centre, we get clients that come in, and they have multiple problems. We have only a limited three weeks to work with clients, and they have so many problems. It is really overwhelming what to do with these people that come in. For example, I myself have had to deal with an individual who had five family members die in one year, and she was contemplating suicide. I had to try to deal with her prescription drug problem and also her grieving. It was really overwhelming….We need workers that can practise a generalist approach, where they would be able to deal with all problems, with the many issues of the clients.
>
> Harold Fontaine
> Social Worker, Sagkeeng Al-Care Centre
> Fort Alexander, Manitoba, 30 October 1992

Staff at treatment centres have sometimes broadened the scope of their programs hesitantly, fearing that they were being diverted from the ‘real’ issue of alcohol abuse by the multi-dimensional social and emotional needs of their clients.[146] But, as they moved toward a model of holistic treatment, most have come to see such treatment as the most powerful tool at their disposal. They have found that truly effective treatment involves

- not just the mind and body of the addicted person, but his or her emotions, spirit, relationships and identity;

- not just the individual, but his or her family, friends and community; and

- not just change in the use of addictive substances, but change in fundamental patterns of living.

For Aboriginal youth who are abusing alcohol and drugs, programs such as Rediscovery (which teaches traditional skills and values and pride in Aboriginal culture) and sustained pursuit of challenging sports and recreational activities might provide the change of focus that is needed. (See Volume 4, Chapter 4 for a more detailed discussion of the role of sports and recreation in a balanced life.)

A number of people who spoke before us proposed the establishment of comprehensive mental health services encompassing the full range of psycho-social distress presented by the clients of addictions services, with flexible funding to match. It is an important proposal, and one that we will address in the discussion of services reorganization later in this chapter.

> One recommendation I would suggest is [holistic] Native treatment centres that not only cover alcohol treatment but the other issues we face, such as being ACOA [adult children of alcoholics], co-dependency, the [impacts of the] mission schools, the sexual abuse and all that. I went to a treatment centre…in 1990. I dealt with my alcoholism, but when I came back [to my community] I had a lot of other issues to face, because everything else [surfaced] for me. It was quite a struggle. We badly need treatment centres to deal with these other issues, not just alcohol. You are not better just because you deal with your alcohol abuse.
>
> Ann Bayne
> Watson Lake, Yukon
> 28 May 1992

> One thing we [object to] in government funding, both federal and provincial, is this: the government funds programs on an individual basis. They break everything up. For instance, drugs and alcohol is one funding. Sexual abuse is another category. Family violence [is another]. And what we are saying is we

want…to be funded for a holistic approach.

The holistic approach tells us [that] we cannot separate the issues in our community. If somebody comes to our drug and alcohol counsellors for counselling in the area of alcohol, and the root cause of that person's drinking in the end we find is sexual abuse, what do we do? In treatment programs, we have seen also a pattern why people drink. Some of the main reasons they give, a lot of the root cause we are finding is deeper, and the ones that are being treated for drugs [need to be treated] not for just sexual abuse but also for the loss of culture, loss of identity. The shame they feel is another area they have identified….

We are talking about one global treatment centre, dealing with all the different areas people need.

Lynda Prince
Northern Native Family Services
Carrier Sekani Tribal Council
Stoney Creek, British Columbia, 18 June 1992

We have found support for the idea of approaching social and emotional ill health from a holistic perspective in research and health policy analysis. In a major literature review prepared for the Commission, Laurence Kirmayer and colleagues concluded that

The fragmentation of mental health programs into substance abuse, violence, psychiatric disorders and suicide prevention…does not reflect the reality of great overlap among the affected individuals, the professional expertise needed…and the appropriate interventions. In many cases, it is not helpful to single out a specific problem as…a focus…because focusing attention exclusively on the problem without attending to its larger social context can do more harm than good. A comprehensive approach to mental health and illness should therefore be integrated within larger programs….[147]

The government of Canada has made the same case. In 1991, the Agenda for First Nations and Inuit Mental Health demonstrated that there was a critical lack of mental health services in Aboriginal communities and put forward a detailed plan for developing them.[148] It offered the following definition of mental health:

Among the First Nations and Inuit communities, the term mental health is used in a broad sense, describing behaviours which make for a harmonious and cohesive community and the relative absence of multiple problem behaviours in the community, such as family violence, substance abuse, juvenile delinquency and self-destructive behaviour. It is more than the absence of illness, disease or dysfunction — it is the presence of a holistic, psychological wellness which is part of the full circle of mind, body, emotions and spirit, with respect for tradition, culture and language. This gives rise to creativity, imagination and growth, and enhances the capacity of the community, family group or individual to interact harmoniously and respond to illness and adversity in healing ways.[149]

In many cases, the concept of mental illness is foreign to Aboriginal understandings of health. Physical, emotional, spiritual and environmental health are all essential aspects of well-being. When they are in balance, health and wellness prevail. When they are out of balance, ill health and social discord predominate. There is no expression for mental health in Inuktitut as spoken in northern Quebec. When local caregivers decided to get together to address psycho-social problems in the community, they called their group the Peace of Mind Committee.[150]

The Agenda for First Nations and Inuit Mental Health proposed ‘healing’ as the overriding goal of Aboriginal mental health services, and recommended that training needs be met, and intergovernmental jurisdiction and mandate issues be sorted out, to permit culturally appropriate and community-controlled and -delivered services to become a reality. The decisive action proposed in the agenda has still not been taken. As a kind of compromise, the multi-purpose Brighter Futures program has joined the National Native Alcohol and Drug Abuse Program, the Family Violence and Child Sexual Abuse Program, and the Non-Insured Health Benefits Program (which pays for some private psychiatric and counselling services) to make up the family of federally funded programs to promote social and emotional health among the minority of Aboriginal people to whom federal services apply. Programs are loosely co-ordinated through an administrative unit of the medical services branch called Addictions and Community Funded Programs. The situation is a far cry, however, from the Aboriginal-designed and comprehensive services envisaged by the consultative process of the Steering Committee on Native Mental Health in 1991, whose agenda we heartily endorse.

As well, we are aware of evidence to suggest that the government has adopted a stance of offloading responsibility for ‘social problems’ in Aboriginal communities without ensuring that communities are able to pick up the load. As an example, in the spring of 1993, the community of Povungnituk, in northern

Quebec, revealed to the media and its own citizens that two community members (one non-Aboriginal, one Inuk) had sexually assaulted more than 80 of the community's children. The government's initial response when asked for help was that, although some aid would be forthcoming, solutions must come from within.151 Such encouragement to take charge is attractive to people who have long been treated as if they are incapable of running their own affairs. In our view, however, such encouragement amounts to abandonment in the guise of empowerment unless it is accompanied by the institution building and human resource development needed to equip Aboriginal people to do the job. We discuss the need to build such capacity later in the chapter.

Child protection

One aspect of social and emotional distress in Aboriginal societies that causes most concern to Aboriginal people and service providers is the evidence of widespread family dysfunction and the resulting neglect and abuse of children. The evidence derives from high rates of children requiring placement in alternative care, the frequency of violence against women and children, and the phenomenon of homeless and vulnerable Aboriginal children on the streets of Canadian cities. Institutions for young offenders, provincial correctional institutions and federal prisons house scores of Aboriginal youth and young adults, a very large proportion of them casualties of dysfunctional families and failed efforts by child welfare agencies to protect them.

In Chapter 2 of this volume and in our special report on justice, we examined family and justice issues in detail and presented proposals for new approaches to support family life and deal with antisocial behaviour. In Chapter 5 we propose that all Aboriginal children have access to early childhood education services that reflect the priorities and complement the strengths of Aboriginal families. Here we wish to underline that issues of family, children and justice must be addressed in concert with the other symptoms of malaise that plague Aboriginal people.

1.4 Community Health

It is a cherished belief of Aboriginal cultures that human beings are profoundly interdependent and have their greatest potential to live in health, happiness and prosperity when they congregate and co-operate in communities, large or small. (See Volume 1, Chapter 15 for a discussion of Aboriginal cultures and their norms, values and beliefs.) 'Community' is an old and honoured notion in western cultures as well, although it generally takes second place to 'individual' as a core value.

According to Aboriginal tradition, the health and well-being of individuals depend in part on community health and social dynamics. Much of the most convincing recent health policy literature agrees. Both sources provide evidence that some aspects of ill health cannot be understood except in terms of social behaviour, and they cannot be alleviated except through collective action. Examples range from the transmission of infectious diseases to the norms that tolerate family violence.

We have identified three dimensions of community health as particularly important to the health status and well-being of Aboriginal people:

- poverty and social assistance;

- adequacy of the built environment, primarily in reference to shelter, water and sanitation facilities, but extending to community infrastructure more broadly; and

- environmental conditions, including all forms of pollution and land and habitat degradation.

Poverty and social assistance

The research literature that asks "What makes people healthy?" consistently concludes that economic status — personal income and the general prosperity of communities and nations — is of great significance.[152] For example, in every industrial nation where the relationship between income and life expectancy has been evaluated, people with higher incomes are found to live longer.[153] In one classic Canadian study, men whose income placed them in the top 20 per cent of earners were found to live about six years longer than those in the bottom 20 per cent. They were also free of major illness and disability for 14 years longer than the most disadvantaged group. The comparable figures for women are three years more life expectancy and eight years longer without major illness or disability for those in the top quintile.[154] A recent annual report of the provincial health officer of British Columbia shows that in Vancouver and Victoria there are twice as many infant deaths in the poorest neighbourhoods as in the richest.[155] In Winnipeg, premature death (defined as death before age 65) occurs at an increasing rate the lower the income level of the neighbourhood.[156]

The ill health effects of poverty on children are well documented and particularly disturbing. Poor mothers are more likely to have low birth weight babies. Poor children are more likely to have chronic health problems and to be admitted to health care facilities. Poor children are more likely to die of injuries. Poor children are more likely to have psychiatric and emotional disorders. Poor children are more likely to do badly in school and drop out.[157] It has been estimated that 50 per cent of Aboriginal children, whether living on- or off-reserve, are living in poverty.[158]

Part of the explanation for the link between poverty and ill health is that people who are poor experience the major risk factors for illness with greatest frequency: low birth weight, inferior nutrition (especially in childhood), exposure to various pathogens and toxins, unsafe houses and neighbourhoods, dangerous jobs (or alternatively, no job, which also constitutes a health risk[159]), stress, smoking and drinking behaviour, lack of familiarity with the concepts of health education, and so on. Further, the knowledge, resources, confidence and mobility to obtain superior treatment and remediation services are less common among the poor.

The Canadian Institute for Advanced Research has emphasized the significant improvements in public health that could be achieved by measures directed to improving the social and physical environment, for example, reductions in poverty and unemployment and support of mothers and children.[160]

Aboriginal people are among the poorest in Canada (see Volume 2, Chapter 5). Based on the evidence we have reviewed, we are in little doubt that the stark economic facts of Aboriginal life are causally related to the stark facts on ill health. We are deeply concerned, therefore, about the standard of living that can be achieved by Aboriginal people — not just for its own sake, but also *as a health issue.*

Poverty among Aboriginal people is, for some, the result of low-paying or part-time work. For others, it is the result of continued participation in the hunting and trapping sector of the economy. (In Volume 4, Chapter 6 we discuss the need to give additional support to this sector.) For most, however, the principal cause is unemployment.

In our cash-based economy, those without wages are forced to look elsewhere for money to live. In our individualistic society, they have learned to turn, not to the extended family or local community, but to the collection of government programs known as the social safety net. The safety net was designed to protect people from extreme poverty through a mix of income security, social insurance and social adjustment services. Its main mechanisms are

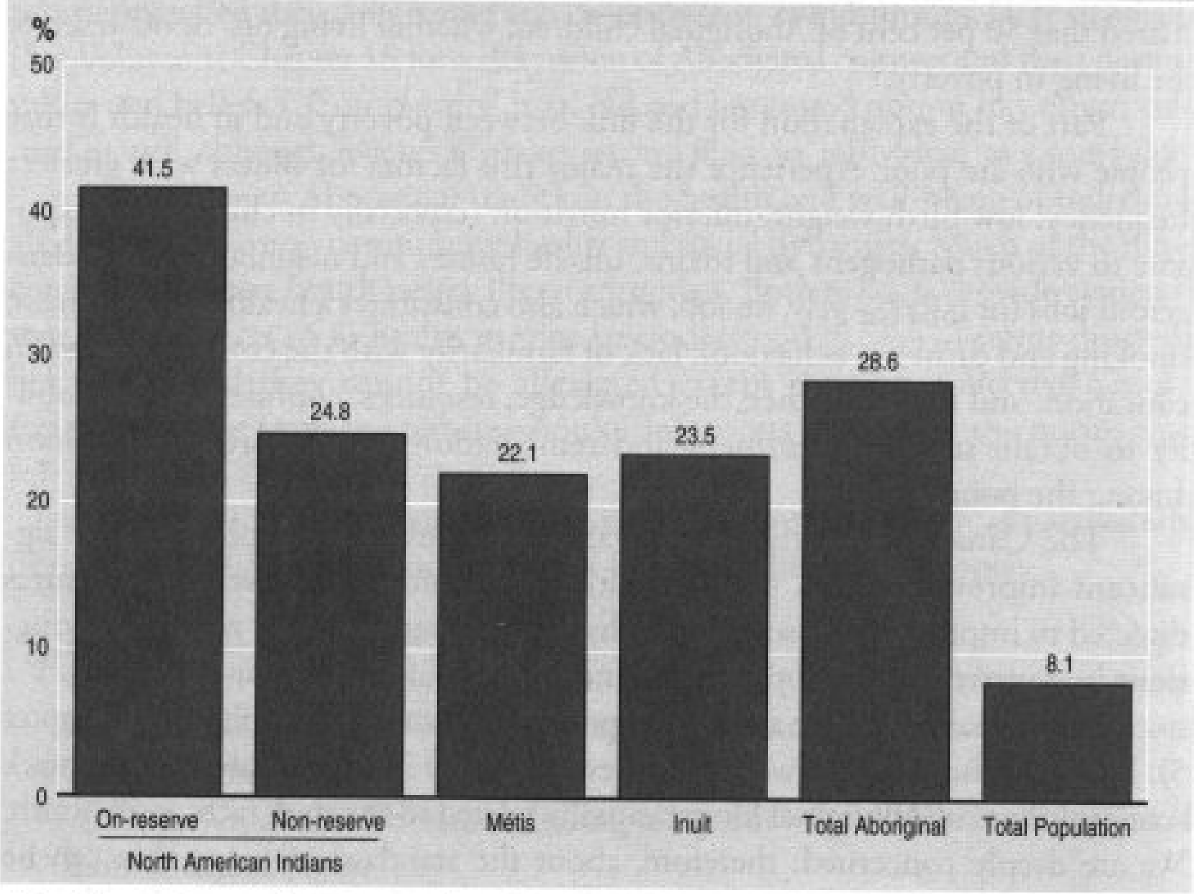
- provincial and municipal social assistance (welfare);[161]
- unemployment insurance (now termed employment insurance);
- the Canada and Quebec pension plans;
- Old Age Security and the guaranteed annual income supplement for low-income seniors; and
- other, lesser (and sometimes temporary) mechanisms such as education and training subsidies, disability allowances and tax adjustments.

For Aboriginal people, by far the most important of these is social assistance — welfare. (See Volume 2, Chapter 5 for a detailed discussion of income support and alternatives to the present system.) As shown in Figure 3.9, based on data from the Aboriginal peoples survey, the percentage of all Aboriginal people over the age of 15 years who relied on social assistance for at least part of the year in 1990 was 28.6, compared to 8.1 per cent of the general Canadian population. Indian people on-reserve had the highest rates of dependence at 41.5 per cent, while the rates were 24.8 per cent for Indian people off-reserve, 22.1 per cent for Métis people and 23.5 per cent for Inuit.

According to DIAND information using other data sources, dependence on welfare by Indian people living on-reserve remained fairly constant at around 38 per cent through the 1980s, then increased to 43 per cent by 1992. The rate for the non-Aboriginal population shows a similar pattern of change during this period, increasing from 5.7 to 9.7 per cent, but still at much lower levels than for Aboriginal people.[162]

The cost of dependency is reflected in government spending on ‘social development’, which includes other social services as well but is driven largely by social assistance expenditures. Federal government expenditures on social development grew from $221 million in fiscal year 1981-82 to $731 million in 1991-92, somewhat faster than the threefold growth rate of most government programs. (See Volume 5, Chapter 2 for an analysis of federal government spending on Aboriginal people. The figures quoted here are not adjusted for inflation.) Allocations for social development in federal estimates for 1995-96, at $1,108 million, show a continuation of this trend. When provincial government expenditures on Aboriginal social development are added to federal expenditures and calculated for 1992-93, the total is more than $2.2 billion per year.

FIGURE 3.9
Percentage Receiving Social Assistance, Aboriginal Identity and Total Populations, 1991



Note: The question on the 1991 APS about the receipt of social assistance was asked of persons age 15 and older. This figure is not intended to imply that eligibility for social assistance begins at age 15.

Source: Statistics Canada, Aboriginal Peoples Survey, catalogue no. 89-534 (1993); Statistics Canada, "Quarterly Demographic Statistics", catalogue no. 91-002; Social Program Information and Analysis Directorate, Strategic Policy Group, Human Resources Development Canada.

Labour market data for Aboriginal people over the decade 1981-1991 show a similar disturbing trend. As shown in Table 3.11, using 1981 census and 1991 APS data, the unemployment rate (that is, the percentage of the total Aboriginal population that was available and looking for work) increased from 15.8 per cent in 1981 to 24.6 per cent in 1991. During the same period the Canadian unemployment rate rose from 7.2 to 9.9 per cent.

TABLE 3.11

Participation and Unemployment Rates, Aboriginal and Non-Aboriginal Populations, 1981 and 1991

	Participation Rate1		**Unemployment Rate**	
	%	**%**	**%**	**%**
	1981	**1991[2]**	**1981**	**1991[2]**
Non-Aboriginal	65.0	68.1	7.2	9.9
Total Aboriginal	51.8	57.0	15.8	24.6
North American Indians				
Registered[3]				
On-reserve	37.4	45.3	19.3	30.1
Non-reserve	55.9	56	15.6	29.4
Non-registered	62.7	67.5	14.3	21.1
Métis	57	63.7	14.5	21.3
Inuit	48.2	57.2	15.2	24.1

Notes:

1. Participation rate is the percentage of all persons aged 15 and older who are employed and unemployed, i.e., active in the labour force.

2. For comparison purposes, the Aboriginal rates for 1981 exclude reserves that were enumerated incompletely in the Aboriginal peoples survey.

3. Data for registered North American Indians in 1991 exclude persons who regained Indian status after 1985 as a result of Bill C-31, which amended the Indian Act with regard to eligibility for Indian status. Such persons were added to the 1991 North American Indian non-

registered population for purposes of comparing 1991 and 1981 data.

Source: D. Kerr, A. Siggner and J.P. Bourdeau, "Canada's Aboriginal Population, 1981-1991", research study prepared for RCAP (1995).

The increase in the unemployment rate reflects not only workers falling out of work; it also reflects new workers joining the labour force but not being able to find steady work. The number of Aboriginal people over the age of 15 is growing rapidly as a result of high birth rates and decreasing rates of mortality. In addition, a larger percentage of Aboriginal adults is in the labour market, as reflected in the rise in the participation rate shown in Table 3.11. In 1981, 51.8 per cent of Aboriginal people over the age of 15 participated in the labour market; in 1991, 57 per cent of them were employed or looking for work. These figures compare to 65 per cent and 68.1 per cent of non-Aboriginal people participating in the labour force in 1981 and 1991 respectively. The indications are that even when some progress in employment development is being made on an absolute basis, the gains are overtaken by population growth, which adds to the Aboriginal labour pool and drives up the unemployment rate.

The sum of our analysis is that unemployment and dependency on welfare are high and likely to get higher and that rising investment in social assistance, while necessary to provide a minimal income flow, is not an adequate response to the situation.

We now turn to our hearings for Aboriginal perspectives on poverty and to research on its health effects. In public testimony and research studies, many Aboriginal people say they detest and feel diminished by the atmosphere of passivity that has settled upon some of their communities as a result of the welfare economy and that they are anxious to replace dependency with productivity:

> Social financial assistance is the single most destructive force on our heritage. Our people do not want to be part of a welfare state that looks after them from cradle to grave. If the social financial assistance can be transferred to First Nations, we can begin to develop our people, or at least provide employment which will make each individual feel like they are a productive member of the community.
>
> Elizabeth Hansen
> Councillor, Inuvik Native Band
> Inuvik, Northwest Territories, 5 May 1992

Welfare is a number one problem of [Inuit] society today, although it might be seen as a solution to the need of those that are unemployable….My father-in-law, when he first heard that welfare was to be introduced in the North, he shuddered that this solution will not create a long-term solution that is acceptable, but it will create a great dependency where no one will get out of it. He has been right ever since. Social programs that work are good, but these social programs should not be used to create dependency.

Charlie Evalik
Economic Development Facilitator
Cambridge Bay, Northwest Territories, 17 November 1992

In our community, a significant number of residents contribute economically through trapping, fishing and hunting. All these economic activities are potentially productive and renewable but only if the ecology is not disrupted and is properly managed. The damming and flooding required by hydroelectric projects in Saskatchewan has caused severe impacts on the ecology. In fact, as time passes, these harsh effects have intensified to the point where 90 per cent of the main income earners in our First Nation communities have lost their employment, and are required to rely on social assistance.

Peter Sinclair
Mathias Colomb First Nation
Thompson, Manitoba, 1 June 1993

There are many Indian people who get up in the morning and look for jobs. The first stop is usually at the Band Office, but there are no jobs, or limited jobs. The next stop is at the local employment office. Once there, they are reminded that they do not have the training or education to apply for these jobs. The last stop will be at the social assistance office. Without much hope for becoming financially independent, they become part of the forgotten Indian people. They are lost in the process.

Linda Chipesia
Whitehorse, Yukon
18 November 1992

Aboriginal people living in urban centres fare somewhat better than reserve residents in gaining employment, but their unemployment rate is still two and a half times the unemployment rate of non-Aboriginal people, and their total annual income from all sources lags behind by 33 per cent. The situation varies by region. On the basis of 1991 census data on household incomes, more than

60 per cent of Aboriginal households in Winnipeg, Regina and Saskatoon were below the low-income cut-off or poverty line established by Statistics Canada. The situation was even more disastrous for female single-parent households in these cities, where 80 to 90 per cent were below the poverty line, many of them undoubtedly maintained at this level by social assistance.

The effects on physical health and morale of living in hopeless poverty are a concern to health advocates as well as to Aboriginal people. Yet social assistance itself is a legislated form of poverty. No jurisdiction provides a level of income support through social assistance that comes close to the low-income cut-off established by Statistics Canada. In most cases, the level of support is 30 to 50 per cent below the poverty line.[163]

Moreover, there is no indication that levels of assistance are becoming more adequate with the passage of time. On the contrary, increases in benefit levels in the past decade have not kept pace with increases in the cost of living.[164] Real rates of social assistance declined between 1986 and 1993 for most categories of recipients in nine of the 12 jurisdictions surveyed by the National Council of Welfare in 1993, and only one jurisdiction provides automatic adjustment of entitlements to take into account increases in the cost of living. (In Quebec, benefits are indexed to the cost of living for those served by the Financial Support Program.) As a result of these trends, poverty has been increasing in Canada generally. There are half a million more children living in poor families today than there were 10 years ago.[165]

The low levels of income support available through social assistance programs have negative health and social effects on all recipients. The National Council of Welfare has said:

Many thousands of children from welfare families go to school hungry. Many thousands of people with disabilities face disproportionately larger problems because of the additional expenses related to their disability. Many thousands of single people and families live in substandard housing. The only “choice” many people on welfare have is deciding how to cut back on food as the end of the month approaches and the money starts to run out.[166]

The Canadian Institute of Child Health has said:

[Not having enough money] means not having enough food to eat. It means living in houses in ill-repair. It means not having warm clothes in the winter. It means not having the kinds of play and recreation facilities that children need to grow and develop. It means being less likely to finish high school and even less likely to go to college or university, which means being less likely to find a job.[167]

In testimony to Commissioners, Aboriginal people also expressed their concerns about the inadequacy of welfare:

A man came to me one time when I was a Deputy Grand Chief and he said, you know, Lindy, I had a trap line out here, and for 30 years I provided for my family. I raised my family. He said, I still have a couple of kids at home. I have eight children and, he said, now I have nothing. How am I going to provide for my children? He said, I have no bush left on my reserve. There is no marten, there is no beaver, there is nothing there. He said, welfare doesn’t cover what I used to make with the trapline and they have no other trap line to give me….He said, all I get now is social assistance.

I want to tell you, social assistance in this country does not meet the needs of the Native people….For example, Attawapiskat. You get $50 per person, but little do [authorities] know that we have to pay $5 for a pound of butter. Here [in Timmins] you pay $3, but over there [in Attawapiskat] you have to pay $5 because you have to pay the air freight. That is not compensated. [In Attawapiskat] you can’t buy a file unless you pay $10 for a file to sharpen your axe to go and catch a rabbit. They need to trap in order to fill in for the welfare that is not provided….[They] only get so much a head, and it is not enough to fill the grocery basket.

Lindberg Louttit
Wabun Tribal Council
Timmins, Ontario, 5 November 1992

The single, unemployed person [with no children] can only get assistance for two months. If they have not successfully gained employment, then they have nothing to live on. It is either stealing to feed themselves again, or go back home to the senior parents….The senior parents are not the welfare office. Some of them can barely make ends meet. They get debt-ridden because they have to support their grown children.

The single parent with one child has to work. Yes, they put their child in a subsidized daycare home and the parent pays a certain amount and the government pays a certain amount. In the long run, this is causing more problems, wasted money, and the child suffers. It rarely sees its parent, and when it does see its parent, the parent is usually too tired [to] fulfil the role of a loving, caring parent. What have we caused here? A possible child neglect and/or abuse [case], and the child may become a behaviour problem later on.

Frances Ebersbach
Lac La Biche, Alberta
9 June 1992

Two per cent [of the local social assistance budget] is designated [by the federal government] for preventative social services, family violence, community-based programs and family support. We are only given enough money to become dependent on the government. We are not given enough to develop the programs and the services that are really needed, such as life skills counselling services, job readiness, healing centres, daycare centres, group homes, youth treatment programs, et cetera — all of which is readily available to non-Natives and other groups that do not reside on reserves.

Linda Hill George
Social Development Officer
Gitksan and Wet’suwet’en First Nations
Kispiox, British Columbia, 16 June 1992

The adequacy of social assistance benefits is of particular concern to the Commission because of the ill effects of poverty on the health of children. The move in several jurisdictions to reduce welfare rates across the board, without regard to the long-term effects on children, seems particularly short-sighted. Tying Aboriginal welfare rates to provincial rates despite radically different community circumstances compounds the problem.

In seeking to replace welfare with productive work, Aboriginal people face a forbidding set of circumstances in relation to economic opportunity. They report that the greatest barrier to gaining employment is the absence of jobs. They lack a land and resource base as a foundation for local economic development. When they migrate to urban centres, their education and skills often prove insufficient to compete successfully in the job market. They encounter discrimination in the labour market. The restructuring of national and international economies is substituting technology for human labour, reducing demand and raising the skill levels required for employment.[168]

The solution to the problem of economic dependency ultimately lies in

- recognizing Aboriginal rights, honouring historical treaties and concluding new ones to establish an adequate land and resource base for Aboriginal nations;

- revitalizing Aboriginal economies by extending Aboriginal jurisdiction over economic development, improving access to capital and business development, and encouraging a mix of harvesting and wage-based activities on traditional lands;

- implementing more effective education and training so that Aboriginal people are equipped to lead the renewal of their own economies and participate equitably in the Canadian market and wage economy; and
- removing the barriers that operate to exclude or disadvantage Aboriginal workers in the labour market.

The steps necessary to effect fundamental change in Aboriginal economic life are set out in Volume 2, Chapters 4 and 5. In addition, the substantial resources now directed to social assistance can be applied more effectively.

In Volume 2, Chapter 5 we propose that social assistance policy should conform to three criteria. Social assistance should

- actively support individuals' social and economic development, including acquisition of life skills, education and employment;

- contribute to integrated social and economic development in the community, involving employment, health, housing, social services, education, training, recreation and infrastructure, as well as income support; and

- be directed by Aboriginal people so that adaptations to the cultures and conditions of the people served can be made.

As part of our economic development strategy we developed two models of social assistance reform. One retains current characteristics of individual entitlement to assistance, modified to support employment and economic development initiatives and to strengthen traditional mixed economies. The other introduces the concept of community entitlement to a budget roughly equivalent to current social assistance allocations, for initiatives that advance the community's social and economic objectives. In both cases, flexibility to opt for different models at different times and measures to ensure accountability to the people whose current entitlements would be re-directed are built into the models. In addition, the interests of those who are unable or unwilling to participate in personal or community development projects are protected in the proposed models.

We conclude that poverty among Aboriginal people is a serious health issue. Its negative health effects will persist if social assistance is maintained at its present levels and in its present form. They will increase if social assistance is reduced without realistic alternatives.

Living conditions

The issues discussed here are part of a broader concern, namely community infrastructure. 'Infrastructure' in the broadest sense refers to a wide range of facilities and services, including power and energy, communications, roads and transportation, public services and recreation, fire and emergency services, services to business and industry, and so on. Here, we are concerned with the aspects of infrastructure tied most closely to health and well-being — water, sanitation and housing. Further discussion of Aboriginal housing conditions and supply, and the Commission's recommendations for increasing the supply and for upgrading infrastructure generally, are in Chapter 4 of this volume.

The health effects of water quality, sanitation and housing conditions have been acknowledged at least since the era of the early Greeks and the writers of the Old Testament. More recently, in the nineteenth century, the leaders of the public health movement in Europe fought long and hard for their belief that the deplorable living and working conditions of their times were largely responsible for the epidemics of infectious disease that were killing thousands in the new and rapidly growing cities.

After years of resistance, governments in the industrial countries began to address conditions that were beyond the control of individual citizens: overcrowded and unsafe housing, unclean food and water, open sewers, inhumane and unsafe conditions in the workplace. The impact on population health status was dramatic. In France, for example, life expectancy in major cities increased from 32 years in 1850 to 45 years in 1900 as the supply of clean water and waste water disposal facilities grew.[169] Similarly, in North America, water-borne infectious diseases (a leading cause of death in the nineteenth and early twentieth centuries) declined as public water supplies and sewage systems expanded.[170] Even so, because infectious diseases have remained a threat to health in so much of the world, the United Nations proclaimed the 1980s the International Drinking Water Supply and Sanitation Decade.[171]

Access to potable water, adequate sanitation and waste disposal services has been routine for so long in this country that most Canadians take them for granted. The same access is not guaranteed for Aboriginal people, however, and their health suffers as a result. Inadequate housing is a problem for Canadian society generally, but it is a greater problem for Aboriginal people (see Table 3.12).

TABLE 3.12

Selected Housing Indicators, Aboriginal and Total Populations, 1981 and 1991

	Total Aboriginal*		**Total Population**	
	1981	**1991**	**1981**	**1991**
Dwellings with no central heating (%)	26.0	12.5	9.0	3.6
Dwellings in need of major repairs (%)	16.2	19.6	6.5	9.8
Dwellings without bathroom facilities (%)	13.1	3.2	1.1	0.6
Dwellings without piped water (%)	—	9.4	—	0.1
Average number of persons per dwelling	—	3.5	—	2.7
Tenant-occupied dwellings (%)	—	48.7	—	37.1

Notes:

— = not available.

* Total Aboriginal in 1981 refers to persons reporting Aboriginal origins on their census forms. Total Aboriginal in 1991 refers to persons who self-identified as Aboriginal on the 1991 Aboriginal peoples survey.

Source: Statistics Canada, Canada's Native People, catalogue no. 99-937 (Ottawa: 1984), Table 7; Statistics Canada, Disability and Housing: 1991 Aboriginal Peoples Survey, catalogue no. 89-535 (Ottawa: 1993).

In testimony and in briefs submitted to the Commission, we heard evidence that water, sanitation and housing conditions in many Aboriginal communities compare with those of developing countries:

We have a huge backlog in housing for our members which consists of families, single parents, bachelors, seniors and the disabled, for people who require medical attention and other special needs. Some cases we have 12 to 17 people sharing a 24 [-foot] by 36 [-foot] bungalow without indoor plumbing. And we are forced to dump our sewage in open pits and use our outdoor privies at 30 to 40 [degrees] below winter temperatures. This practice causes people of all age groups to get sick….

Water and sewer. This is the other major obstacle in providing the basic needs to improve the quality of life on our reserve. We have water lines…of which half are frozen due to the way they were installed, and due to the lack of funding to maintain the system. We can't provide…adequate fire protection — which we feel is a priority service to the community [because] to lose someone's home is a very devastating experience, and to lose a human being is even more tragic.

Chief Ignace Gull
Attawapiskat First Nation
Moose Factory, Ontario, 9 June 1992

It is the year 1993, and many of our communities still do not have running water or sewer lines. We need water and sewer for our children, for the health of our people. There are many children in our communities that require those very services. Certainly today governments cannot refuse that very service. The elders and other [vulnerable] users should not be without that running water. It's a health hazard. And today the present use of outhouses in many communities [is also a] health hazard.

The only facilities that seem to have the running water in northern communities are the stores, [and] of course the Royal Canadian Mounted Police, the fire halls, the nursing stations, the teachers. So what about the people that live [permanently] in that very community?….The Métis people feel they are excluded.

Sydney J. McKay
Manitoba Metis Federation
Thompson, Manitoba, 31 May 1993

Our homes [in Davis Inlet, Labrador] were built very poorly. Growing up in our large family of 11 and living in these houses proved to be very hard for us: no heating, no water and no sewer. Our home had only 2 rooms and 1 small room that was supposed to be a bathroom but [there was] no bathtub, toilet or even a sink, just an empty little room that we eventually used as an extra bedroom. As of today, our houses are still built that way….

Unsafe Drinking Water at Pukatawagan

In November 1993, the environmental health officer for the Cree Nation Tribal Health Centre in The Pas, Manitoba, issued an official 'boil order' to the people of Pukatawagan. The water system, he said, could not be relied on to provide safe drinking water. Samples collected over several months had indicated the presence of coliform bacteria, meaning that the water was unfit for human consumption.

By May 1994, the health officer was still unable to rescind the order to boil water before drinking and bathing. In correspondence with federal authorities, he listed the problems: the water treatment plant was much too small for the population; it had no filtration capacity; chlorination capacity was insufficient; and in winter, freezing threatened to rupture the intake lines. Moreover, there were contributing problems with the sanitation system: both the sewage treatment plant and lagoon had been constructed *upstream* from the water treatment plant, and from the most popular swimming spots on the Churchill River. The overflow was contaminating water and soil. Children were ill. Nursing station statistics indicated high levels of gastro-intestinal and skin disorders. He feared something worse, such as an outbreak of hepatitis A.

By June, illness and fear of illness were at such a pitch in the community that the chief of the Mathias Colomb Cree Nation escalated his attempts to generate a response. He wrote to Member of Parliament Elijah Harper and to the press. In responding to the subsequent *Winnipeg Free Press* story, provincial authorities said that the problem was the responsibility of the federal government; a spokesperson for the federal health department said that public health was now the responsibility of the band. The Chief pointed out that the faulty water and sanitation systems had been built by DIAND in the first place, and no monies for their improvement had been included in the budget drawn up when medical services were transferred to the Cree health board.

> At the end of June, the chief medical officer of health for Manitoba wrote to the minister confirming that an emergency situation existed in the community of Pukatawagan. He reported that the community had produced a plan to rectify its problems, but lacked money and skills to carry it out. He suggested that funds should be supplied by the federal government.

The women of Pukatawagan began to organize ‘Walk for Life’ — a 600-kilometre trek…from The Pas to Winnipeg — to dramatize their fears of continuing illness, especially among children and elders. Media coverage of the issues continued to be intense. In July, the federal minister of Indian affairs visited the community, promising short- and long-term assistance. By the summer of 1995, the sewage discharge pipe had been moved to a point downstream from the drinking water source, but no action had been taken to upgrade the sewage treatment plant.

In summer, we’d fetch water from the nearest brook, and [my mother] would heat it up on a wood stove, and that’s where our hot water came from. In winter, she’d have to dig through 8-10 feet of snow and then through the ice [to get water] from the same brook with a small dipper. As of today, she still gets water the same way, and I do exactly the same….

As of today, we still don’t have any heating, nor water or sewer in our homes. [Last year] five children died [in one house fire] because they were trying to keep warm by an electric hotplate because there was no heating in their house. And there are still fire accidents happening, and more fire accidents will continue to happen if no improvement is made.[172]

Research studies confirm these descriptions, as discussed in Chapter 4 of this volume. In early 1995, a preliminary internal government report on community water and sanitation services in First Nations reserve communities concluded that 25 per cent of the water systems and 20 per cent of the sanitation systems are substandard. They either pose a danger to health and safety or they are in need of repairs to meet basic government standards.[173] Problems identified in the report include

- operational factors such as poor operation and maintenance procedures, chlorinators not working properly, lack of chlorine contact time, or contamination of buckets or barrels, which can result in high bacteria counts;

- contamination caused by agents such as trihalomethanes, fluoride, aluminum or lead;

- insufficient quantity of water to meet domestic and/or fire protection requirements;

- sewage effluent that does not meet discharge criteria after treatment; and

- deterioration of assets resulting from poor maintenance, equipment undersized for present use, and poor construction techniques.

At the time of the survey, conducted by environmental health officers from Health Canada, 10 communities were under 'boil orders' or 'do-not-use orders' with respect to their water systems.[174] Thirty-eight communities (nine per cent of those assessed) were judged to have sewage systems that posed an immediate risk to public health.[175]

In Chapter 4 of this volume, we document the extent of the housing crisis facing Aboriginal people:

- Standards of Aboriginal housing are measurably below what is required for basic comfort, health and safety.

- Problems include the need for major and minor repairs and new units for households occupying unfit or overcrowded dwellings.

- The major obstacle to meeting housing needs is the gap between incomes and costs, that is, affordability.

- On reserves, an estimated 84 per cent of 74,000 households have insufficient income to cover the full cost of housing. In housing policy terms, they are in 'core need'. Half of this 84 per cent are able to contribute to the cost of housing.

- Among all Aboriginal households (owners and renters), an estimated one-third are in 'core need', compared to between 11 and 12 per cent of all Canadian households.

- Substantial government contributions to housing construction on-reserve over the past decade have had minimal effect because of the rapid deterioration of relatively new housing stock.

- Urban and rural housing programs targeted to Aboriginal people have made significant contributions to quality of life and community relations. They are in jeopardy because of the termination of new investment by governments.

The ill health effects of unclean or insufficient water supplies, of inadequate sanitary facilities and of overcrowded or unsafe housing are well established in the international health literature. For example, a recent CIDA development issues paper said, “The provision of clean drinking water and safe waste disposal, combined with improved personal hygiene, leads to a reduction in sickness and death and in the percentage of people rendered less productive by disease. The International Institute for Environment and Development quotes World Health Organization estimates that 80 per cent of all sickness and disease in the world is attributable to inadequate water or sanitation”.[176]

Contaminated water is one of the most significant factors in the spread of infectious disease, especially where the source of contamination is human waste. Although it is sometimes said that the safe disposal of human waste matters less when a society can afford to treat its water supplies, the growing cost of such services, even in ‘rich’ societies, makes prevention preferable to treatment.

Water quantity is at least as important as water quality, and perhaps more so. Critical hygienic practices depend on easy access to water. People are much less likely to wash their hands after defecating or before handling food if they have to haul their water from outside the house or wait for the water delivery truck. There is a positive correlation between the greater use of water for personal hygiene and improved levels of health, even when the quality of the water is poor.[177]

Poor housing has been linked to a number of ill health conditions, including infectious diseases, non-infectious respiratory diseases such as asthma, chronic congestive diseases, and injuries. Crowding is a critical factor in the transmission of infectious diseases, both airborne and water-borne. The majority of the inter-human contacts that determine the incidence of communicable disease occur in the home or yard.

Poor quality construction of houses is also associated with health risks arising from cold, noise, airborne pollution, insects and rodents. Lack of central heating