increases the risk of respiratory illness.

Poor quality heating and cooking equipment and the absence of smoke detectors and other safety devices increase the risk of fire.[178]

Indoor air quality can be compromised by wood stoves, which are common in rural Aboriginal communities and emit a number of pollutants linked to respiratory disease. These include particulates, oxides of sulphur and nitrogen, hydrocarbons, carbon monoxide, organic hydrocarbons, formaldehyde, and others. The Commission notes, however, that a much greater risk to health from indoor air quality is posed by cigarette smoke.

Water, sanitation and housing quality have effects on mental and spiritual health as well. Crowding is an important contributing factor in mental illness, especially in relation to personal violence.[179] Design and construction can depress individual and collective self-esteem by ignoring cultural traditions. The location of individual units and the overall community layout can affect social interaction patterns and psycho-social comfort levels.

Studies of the ill health effects of substandard water supplies, sanitation facilities and housing stock in Aboriginal communities in Canada are few and far between. Many have been judged by at least one team of reviewers to be methodologically flawed.[180] Even so, it would fly in the face of experience in countries around the world to imagine that the ill effects are anything other than serious. We know that illness and death from infectious diseases are higher among Aboriginal than non-Aboriginal people. As well, particular water- and airborne infections (tuberculosis and otitis media, for example) are more common among Aboriginal than non-Aboriginal people. These conditions are typical of the effects of poor water quality, inadequate sanitation and overcrowded housing. The case of a recent epidemic of shigellosis in Manitoba is instructive.

Shigellosis is a highly contagious diarrheal disease that can require hospitalization and, in severe cases, cause death. In developed countries, including Canada, shigellosis has largely been eliminated as a result of high quality public water supplies and sanitation services. Nevertheless, a recent and serious epidemic occurred in Manitoba, lasting from 1 September 1992 to 31 August 1994. Although only about eight per cent of the population of Manitoba are registered Indians, 69 per cent of those who became infected with shigellosis were First Nations people. A study that looked at the

relationship between cases of shigellosis and living conditions (water, sanitation and housing) found that the disease was most likely to occur in circumstances where

• there were no public sewage disposal services (so that families have to use outdoor privies or indoor pails for human waste) and where there was no safe and easy way to dispose of soiled diapers;

• there was crowding; and

• there were no public water services of any kind, or where there was a truck delivery and barrel storage system.[181]

The study concluded that fully 90 per cent of shigellosis infections — as well as several other common intestinal, droplet and skin infections — could be prevented by supplying adequate water, sanitation and housing facilities to Aboriginal communities.

Aboriginal service providers are well aware of the gains in health and well-being that can come from improvements to water, sewage and housing facilities. In some places, such as Grand Lac Victoria in Quebec, pleas for government assistance have produced new services. In other places, similar pleas have produced only frustration:

At Grand Lac Victoria…the medical team observed very high sickness and mortality rates, infectious diseases — ear infections, pneumonia, nutritional diseases, accidents, et cetera. These pathologies were very prevalent….

In a very short time, we identified major sanitation problems: contaminated drinking water, accumulation of garbage around the houses, rudimentary toilet facilities, et cetera. To promote basic hygiene, we obtained the co-operation of other [government] departments for digging wells, developing a garbage collection system, improving access roads to camp sites, et cetera. Our program evolved into a classic public health program centred on prevention and sanitation. [translation]

Ghislain Beaulé
Research Officer
Quebec regional health and social services board of Abitibi-Témiscamingue
Val d'Or, Quebec, 30 November 1992

Council supplies 20 gallons of water to each family in Rigolet each day. The water is given in buckets and is trucked in summer and delivered by skidoo in winter. Sewage disposal is on the frozen harbour ice in the winter and dumped anywhere in the summer. This is very bad for the spread of germs and disease….

There are many benefits of having a good water and sewer system…. Health risks would be lowered, the quality of water would be improved. There would be more opportunity for residents to enter into business ventures. The community council would save money. The number of dumps in our community would be less. Food costs would be lowered. These are some of the benefits we could and should be enjoying. Having no water and sewer system is degrading, and holds communities back.

Henry Broomfield
Mayor, Rigolet
Makkovik, Newfoundland and Labrador, 15 June 1992

The solution to these problems is clear. What is needed is a capital construction program such that Aboriginal people can have what most Canadians take for granted: safe and adequate supplies of water, effective sanitation systems, and safe and adequate housing.

We have concluded that some extraordinary expenditure *is* indeed justified, given the crisis in Aboriginal health and the benefits to health and well-being that could be gained from such public works. Our proposals are detailed in Chapter 4 of this volume. Because of the cost implications, however, we advise that much more serious attention be paid to adapting or developing cost-effective technologies suitable for rural and isolated Aboriginal communities where the need is greatest. In this, inspiration could be taken from projects launched in developing countries, where cost is also a factor. Indeed, the Aboriginal community of Split Lake, Manitoba, has already benefited from an initiative to develop appropriate technology for water-quality testing (see box).

The health issues raised in this section are a small part of the ‘healthy cities, healthy communities’ concept, which has served as an organizing concept for the World Health Organization and other international health agencies. It is an updated version of an old and honoured approach to health promotion — community development. Community development situates individual health in a web of determining factors that are social and collective. Its starting points are that broad-based community participation in public life is essential to social

and individual health and that a strong, active community, with effective public support systems and informal mutual aid and self-help networks, offers the best chance to achieve the World Health Organization's goal of "health for all by the year 2000".[182]

Strategies to build the capacity of Aboriginal nations and their communities for self-government, as described in Volume 2, Chapter 3, together with the social development proposals made in this volume, build on these concepts. The plan for bringing housing and infrastructure in Aboriginal communities to basic standards that support health and self-esteem is particularly suited to the task of building local economies and skills and stimulating broad community participation.

The environmental envelope

Aboriginal people from almost every culture believe that health is a matter of balance and harmony within the self and with others, sustained and ordered by spiritual law and the bounty of Mother Earth. They have long understood that the well-being of people depends on the well-being of the air, water, land and other life forms. This belief has been confirmed by the findings of countless scientific studies of poor health in a compromised environment.[183] Although the details of cause and effect have not been fully established, the general scientific conclusion is clear: human health depends largely on the condition of the natural environment and of the built environment.

Using Appropriate Technology

The community of Split Lake is located on a peninsula on the north shore of Split Lake in northern Manitoba. It has a population of about 1,600, almost all of whom are members of the Cree Nation. The community is one of five which are seriously affected by the Churchill-Nelson hydro-electric project. The project has caused water levels in the lake to fluctuate widely as a reflection of fluctuating demands for power elsewhere. Changes in water levels in the lake in turn affect the quality of the communities' drinking water.

Water-quality monitoring in the region has been difficult. The required laboratory facilities are located hundreds of kilometres to the south. Current monitoring procedures, administered by Health Canada, require that a Community Health Representative (CHR) collect water samples at

predetermined sites. The samples are brought together, packaged, and delivered over land or by air to the laboratory. It takes 4-6 weeks for results to reach the communities, during which time conditions may change. Communities have alleged that the health implications of test results are not always made clear.

The need for local means of monitoring water quality is a world-wide issue. An international research team, working with the health services staff of Split Lake, came up with three simple, reliable, and inexpensive methods of testing water quality that can be performed in the field, on site. They are now successfully in use locally, and the Split Lake First Nation community is investigating the possibility of operating a test service for other settlements in the area.

Source: Gilles Forget, *Health and the Environment: A People-Centred Research Strategy* (Ottawa: International Development Research Centre, 1992), pp. 23-25.

Despite this dependence, human activity is the main source of damage to the environment. The willingness of our society to protect the ecosystems around us has not kept pace with our capacity to do harm. Thus, chemical pollution, toxic waste mismanagement, depletion of the ozone layer and other environmental problems have created serious hazards for human health. Exposure to toxic substances in contaminated air, water and soil has been linked to many ill health conditions, including cancer, respiratory illness, birth defects and reproductive problems, allergic reactions and chemical hypersensitivity, immune system suppression, and decreased resistance to disease agents of all sorts.[184]

Environmental degradation may have an especially damaging impact on Aboriginal people whose lives remain closely tied to the land. Many who live on-reserve or in rural settings depend for daily life on the resources at their front doors. Ojibwa families in northern Ontario, for example, pull their drinking water by pail from a lake or river year round, eat an average of two freshly caught fish per person every day in summer and an equivalent amount of moose, beaver and other wild meats in winter, spend almost all their waking hours working (or playing) on land and water, and derive their greatest peace of mind in natural settings.[185] Some Aboriginal people who live in towns and cities still escape to the bush as often as they can and retain strong practical and spiritual bonds with Mother Earth.

When treaties were negotiated, a number of First Nations bargained for territory at or near the mouths of major rivers to be close to traditional food sources and to have access to the natural transportation corridor into the interior where their traplines were located. Pulp mills, mining operations and other industrial complexes were attracted to these same rivers, placing those Aboriginal communities at particular risk for negative impacts.[186]

Environmental degradation affects the health and well-being of Aboriginal people in three ways. First, pollutants and contaminants, especially those originating from industrial development, have negative consequences for human health. Second, industrial contamination and disruption of wildlife habitat combine to reduce the supply and purity of traditional foods and herbal medicines. Finally, erosion of ways of life dependent on the purity of the land, water, flora and fauna constitutes an assault on Aboriginal mental and spiritual health. Urban Canadians, who are separated by generations from their roots in the land, may not fully appreciate this.

What we heard in public hearings regarding environmental degradation was like an extended lament, a refrain of loss and fear:[187]

There was a time when our people depended on the land for food, medicines and trade. The land was regarded as sacred, and because the people were very dependent on it, the land was referred to as their mother. The newcomers [from Europe] brought with them their different languages, cultures, religions and values, along with their diseases, weeds and insects that neither Mother Earth nor the [Indigenous] people could cope with. Today we see the evidence of these tragedies in clear-cut forests, insect-infested forests, knapweed invasions, water pollution, air pollution, and also in the suicides, alcohol and sexual abuse, incarcerations, unemployment and welfare.

Paul Scotchman
President, Western Indian Agricultural
Producers Association
Kamloops, British Columbia, 15 June 1993

Dams have created mercury [pollution]. Dams have polluted our fish, polluted our animals. Towns are dumping their [garbage] into the creeks, into the rivers….Timmins — and many other towns — has mining tailings which are not watched, are not monitored….When we go trapping now, we are afraid to dip the water out of the creeks to make a cup of tea because we are afraid it is polluted.

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

You can't even catch a rabbit. You shoot a rabbit now, you open it up, you'll see nothing but sores on them, and the same with beavers. Any kind of animal that's living out there around [the tar sands developments], you cannot eat them.

Nancy Scanie
Fort McMurray, Alberta
16 June 1992

Many people now go to town to buy their groceries because our traditional food is not there to survive on. With the disappearance of the forests, the animals don't number as many. As the tree line fades, the animals fade with it. When the land is flooded, it drowns, it cannot survive. Why is it so difficult for the non-Aboriginal people to understand the devastating effect that pollution, flooding and logging has on [us]?

Chief Allan Happyjack
Waswanipi First Nation Council
Waswanipi, Quebec, 9 June 1992

The federal government has issued a directive to their employees at Walpole Island not to drink the water on Walpole Island. The federal government supplies them bottled water….[But] we are drinking the water….We have a high incidence of respiratory disorders. Many [families] have machines for their kids to breathe, breathing apparatuses, on our island. There is a high incidence of cancer, a high rate of miscarriages….All the different diseases that are plaguing our people now, we cannot prove [they] come from pollution. [The authorities require] us to prove it ourselves. Meanwhile, our people, and our children are dying with cystic fibrosis, spina bifida, and some other diseases….

Ed Isaac
Walpole Island First Nation Community
Sarnia, Ontario, 10 May 1993

Whether the speakers were talking about damage to lands, seas, rivers, air, forests, wildlife, or other living things, their sense of ongoing violation was palpable. Of course, some non-Aboriginal people are equally critical of those who exploit the environment and its sources of life for short-term gain. But for

Aboriginal people who retain a grounding in traditional cultures and spirituality, their distress comes from a deeper place: a connection with the forces of the natural world.[188]

In traditional Aboriginal cosmologies, all life forms are seen as aspects of a single reality in which none is superior. The elements of nature — from muskrat to maple to mountain — are like parts of the self. Thus, loss of land and damage to lands, waterways and so on are experienced as assaults on one's own body and on the personal and collective spirit.[189] In contrast, the non-Aboriginal world view portrays nature as something apart from human beings — indeed, as something created (or fortuitously available) for human use.

To be sure, all peoples 'use' the resources of the earth in order to live, but their patterns of use are conditioned by cultural values they may scarcely perceive. In public testimony, many Aboriginal speakers commented on differences in values between Aboriginal and non-Aboriginal people, expressing the hope that one day, all people will acknowledge and learn from the respectful, Aboriginal approach to Mother Earth and the sacred circle of life:

Our experience from what we witness between governments and businesses [is] that exploitation of the land continues for the benefit of the almighty dollar….We promised our ancestors that we would preserve and protect the land and its natural resources for our children of today and tomorrow.

Peter Stevens
Eskasoni First Nation Council
Eskasoni, Nova Scotia, 7 May 1992

What happens on Mother Earth is important for Aboriginal people. We don't put ourselves on an island and isolate ourselves, because we know [nature] is all one network, it all works together….We have always known that there are ways you treat the things you love that make them last for generation after generation. [translation]

Ethel Blondin
Member of Parliament for the Western Arctic
Fort Simpson, Northwest Territories, 26 May 1992

How then do we create harmonious relations between, on the one hand, the Amerindian who respects life and, on the other, the dominating white man who thinks always about industrial and economic development since he imagines

that it is acceptable to dominate nature, and who has not yet understood that before you can order nature around, you must first obey? [translation]

Roger Julien
Montreal, Quebec
2 December 1993

There is going to come a time where the non-Indian people are going to come to us and ask us, what do we do? [They are going to say] we have abused our Mother [Earth] so much that we are now beginning to kill ourselves because we have polluted the life blood — the water, the air and all…that is around us. They're going to ask us, what we do? We have the answer whenever they come and ask us that question.

Roger Jones
Councillor and Elder
Shawanaga First Nation
Sudbury, Ontario, 1 June 1993

Aboriginal speakers made it clear to us (as they have told previous inquiries) that they are not naively opposed to development or modernity, as is sometimes alleged. They do not want to give up telephones, snowmobiles, or video games. They accept that industrial development is a necessary part of the economic fabric of every country. Indeed, many pointed to their need and desire for greater participation in Canada's industrial economy. But few Aboriginal people would choose to participate at the expense of the land and life forms that anchor them in their past and link them to the future.

We also recognize that the traditional ways that once served to limit Aboriginal use of land and conserve resources are changing. Some Aboriginal people, especially among the young, have lost their sense of connectedness with the environment and their responsibility to it. Even those who retain this sense have access to technology designed to make exploitation attractive and easy — snowmobiles, high-powered rifles, electronic fishing gear, and so on. We were warned by a few speakers in public testimony that Aboriginal people are just as capable of destructive behaviour as anyone else.[190] We were urged by others to recommend that federal, provincial and territorial governments retain control over all land and its use:

There are some Natives who choose not to use [their hunting and fishing] rights in a responsible manner, and have little or no regard in the taking of wildlife. Some of them practise methods that can be best termed as unethical, and are

often excessively detrimental to wildlife. There are many documented instances of night hunting, excessive netting at spawning times, the hunting of wildlife in the spring just before a new generation is being born, commercial-type hunting where refrigerated semi-trailers are brought into an area, often by status Natives that aren't residents of this province. There are many other types of these abuses….

Natives are one of the fastest growing groups in Canada. Their numbers in many areas now exceed that [which] existed at the time the treaties were signed and it appears that that trend will continue. We feel wildlife couldn't cope with that pressure even if primitive conditions and methods were used, but with modern technology such as four-by-fours, rifles, off-road vehicles, quads, it can very negatively affect and quickly negatively affect game populations.

Andy von Busse
Alberta Fish and Game Association
Edmonton, Alberta, 11 June 1992

Another aspect of the problem concerns the loss of income among outfitters as a result of overlapping activities with Aboriginal people….Non-Aboriginal big-game hunters are very reluctant to hunt in areas frequented by Aboriginal hunters because they know full well that Aboriginal hunters take their prey before hunting season begins….In our opinion, the Wildlife Conservation Act [of Quebec] should apply to everyone in the same way. [translation]

Thérèse Farar
Quebec Federation of Outfitters
Montreal, Quebec, 30 November 1993

The [Canadian Wildlife] Federation recommends that Canadian governments — federal, provincial or territorial — should maintain the authority to regulate and restrict harvests and harvesting methods. Any splintering of this authority would be detrimental to the health of wildlife resources.[191]

Issues of conservation, regulation and fair use are discussed in Volume 2, Chapter 4. Environmental stewardship, protection of country food and application of traditional Aboriginal knowledge in management regimes and international accords are considered in Volume 4, Chapter 6. Here, we are concerned with the ill-health effects of mistreatment of the land and its resources.

Pollution

Contamination of water, soil, air and food supplies by industrial and domestic wastes poses serious health hazards. The tailings from mining operations contain toxins that wash into streams or seep into ground water. The effluent from pulp and paper mills contributes hazards to health such as chlorine, dioxins and furans. Smelters and other processing operations release sulphur dioxide and a variety of airborne pollutants. Tankers and pipelines leak oil. Dams flood acres of bush and forested land, releasing poisonous methylmercury into the water. Within communities, crowded and inadequate housing encourages infectious diseases. Unsafe heating and wiring contribute to high rates of accident and injury. Untreated sewage is host to the bacteria responsible for various infectious diseases, most of them more common among Aboriginal than non-Aboriginal people in Canada.

Regulations to protect land and people from these contaminants are now more strict than they once were, but staggering problems remain: years of accumulated pollutants to be cleaned up, continuing denial and non-compliance from some polluters, the ever-present threat of accidental spillage, and always the fear that unseen agents are inflicting invisible damage to the delicate balance of life on earth.

The health hazards of environmental pollution became a contentious issue between Aboriginal people and Canadian governments in the 1960s, when it was first realized that methylmercury had entered the aquatic food chain and rendered fish, a dietary staple of many First Nations communities, unfit for human consumption.[192] Perhaps the best known case is that of the Grassy Narrows and White Dog First Nation communities in northwestern Ontario (see box).

This case is significant in reconsidering public health policy for Aboriginal people because contamination of aquatic environments is so prevalent. Mercury contamination in particular is a problem because it is an unintended consequence of the construction of dams for generating hydroelectric power, many of which have been built on lands used primarily by Aboriginal people. The reservoirs created by damming major rivers necessarily cover large tracts of land with water: 7,500 square miles in the case of the James Bay hydroelectric project in northern Quebec, for example. A great tonnage of submerged vegetation begins to rot. As part of the decomposition process, methylmercury is released into the water system, where it accumulates in the food chain over a period of decades.

The story of the Grassy Narrows and White Dog communities is also significant because it had characteristics that continue to hamper effective monitoring and control of environmental health hazards. In addition, compensating Aboriginal communities for hazards that remain uncontrolled has proved difficult. The continuing impediments are as follows:

• The communities involved were small, isolated, highly dependent on the river and its ecosystem, and did not have the political power or technical skills needed to overcome the inertia of governments and industry.

• The combination of federal responsibility for public health on-reserve and provincial responsibility for environmental protection and the regulation of industry off-reserve (where the problem originated) left the communities with no defined authority to appeal to or work with.

• The effects of industrial pollutants on the river system were difficult to prove; causal effects on community health were more difficult still.[193]

• The companies producing the contamination resisted the idea of pollution controls and continued to discharge suspect chemicals into the river until forced to stop by government order after more than 10 years of investigation.

• Contamination will stay in the food chain for several generations of Ojibwa. The people of Grassy Narrows and White Dog will not be able to use their most valued waterways and aquatic resources, no matter what future land settlements or economic development plans they may negotiate.

Decline of traditional food sources

An equally important health effect of environmental degradation is its impact on the traditional diet of rural Aboriginal people, many of whom depend largely on country food.[194] Two processes of change are usually at work simultaneously:

• Habitat destruction and related impacts of large-scale industrial development (manufacturing, mining, oil and gas extraction, hydroelectric power production and so on) reduce the supply of game and other country foods.

• The newly required labour force immigrates to the region from non-Aboriginal communities, stimulating an increase in the availability and attractiveness of

store-bought food.

The items most often bought are low-cost, quick-energy, low-nutrient foods — in part because the cost of importing more nutritious foods, especially fresh vegetables and fruits, to remote locations is high, and in part because preparation and cooking methods for imported foods are unfamiliar to many Aboriginal people.

Despite its significance, the impact of industrial development on traditional fod sources has received only limited attention in official project impact assessment statements.[195] What studies have been done show a significant decrease in the use of country foods and an increase in the consumption of starches, fats, sugar and alcohol where industrial development takes place.[196] Thus, the foods eaten to replace the country food lost or no longer harvested are nutritionally inferior:

Although more work needs to be done, the general indication is that the traditional diet of the northern Native peoples was far superior to the diet presently available to them. [A variety of studies] have all discussed the relative merits of wild game and store meats, and have concluded that the wild game is generally higher in protein, ascorbic acid and iron, and lower in fat content.[197]

The White Dog and Grassy Narrows Story

The English-Wabigoon River system is the source from which the Ojibwa people of Grassy Narrows and White Dog have taken most of their food and all of their drinking water since time immemorial. By 1970, it was so badly polluted with mercury-laden effluent from the pulp and paper operations of nearby Dryden, that the government of Ontario was forced to close commercial and sports fishing completely and for an indefinite period. In a single stroke, the people of Grassy Narrows and White Dog lost their two main sources of employment (guiding and commercial fishing), and their confidence in the safety of their food and water. Over 300 miles of a productive river ecosystem are expected to remain contaminated for 50-100 years.

Significant amounts of mercury had been dumped into the river system since 1962. The risks from its ill health effects had been on record at least since 1968[1]. No one had discussed them with the Ojibwa. Nor did the Ojibwa have any one to tell about the diseased fish and animals they

were finding in and around the river, nor any means of interpreting the unnatural animal behaviour they were seeing — especially in birds and cats, the fish-eating species.[2]

By 1975, the Ojibwa (with help from the environmental office of the National Indian Brotherhood) had learned a lot about the ill health effects of mercury, and about the early symptoms of Minamata Disease: loss of vision, loss of feeling in hands and feet, loss of coordination and concentration, tremors, nervous disorders. To their distress, they could see these very symptoms in the other fish-eating species living by the English and Wabigoon rivers: themselves. But they have never been able to prove a link between their ill health and the mercury in their food and water, at least not to the satisfaction of federal and provincial authorities.[3]

Federal authorities attempted to assist the suffering communities by importing clean fish from Lake Winnipeg, by promoting alternative economic activity, and finally, in 1990, by compensating the families who had lost the most in potential income and family sustenance. Yet, neither the food and water nor the economic base could be brought back. Nor could the people's faith in the land, in the "river of life" that was now poisoned, or in their place in the circle of life. The two communities have struggled with serious health and social problems for 25 years.[4]

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1 Mercury poisoning had been established as the cause of Minamata disease in 1962. Canadian health authorities had been warned several times during the 1960s about the dangers of mercury consumption, but showed no signs of alarm despite heavy use of the substance in several industrial processes. In 1967 and 1968, a graduate student from the University of Western Ontario, Norvald Fimreite, conducted doctoral studies that established a high mercury content in fish and fowl from mercury-contaminated waterways in Alberta, Saskatchewan and Ontario. (Norvald Fimreite, "Mercury Contamination in Canada and its Effects on Wildlife", PH.D. dissertation, University of Western Ontario, 1970.) Despite his urging, the government of Ontario took no action.

2 In Minamata, the people had dubbed the strange disease affecting them 'cat dancing disease' because, as the mercury destroyed the brains of the cats that lived on mercury-contaminated fish, they passed through a stage of spinning and whirling in madness. See W. Eugene Smith and Aileen M. Smith, *Minamata* (New York: Holt, Rinehart and Winston, 1975).

3 The extraordinary saga of their attempts, which included extensive testing by

Japanese medical experts, is detailed in Warner Troyer, *No Safe Place* (Toronto: Clarke, Irwin & Co., 1977), especially chapters 13-16.

4 See Anastasia M. Shkilnyk, *A Poison Stronger Than Love: The Destruction of an Ojibwa Community* (New Haven and London: Yale University Press, 1985).

Dietary change from wild meat and other country foods to less nutritious commercial products can have measurable health consequences. In particular, it increases the incidence of obesity, diabetes, high blood pressure and dental caries.[198] Commissioners heard testimony to this effect from front-line health care workers and researchers alike:

Not only is [the use of country foods] an important part of cultural expression, but it can be a helpful kind of a diet. In particular, for example, the person with diabetes. Use of wild game and use of fish, both of which are lower in fat than the beef and pork that you buy in the store, is a much better choice for people with diabetes.

Rhea Joseph
Health Policy Adviser, Native Brotherhood of B.C.
Vancouver, British Columbia, 3 June 1993

The diseases of the so-called “western diet” are striking [all indigenous peoples] — rural and urban, rich and poor alike. Chronic diseases that were unknown…are now on the increase among them, and building into an impressive list: obesity and diabetes, the cardio-vascular diseases, cancer, infant morbidity and mortality in higher frequencies are all part of this diet and [ill] health picture that has been emerging for indigenous people for the last 100 years.[199]

The trend toward higher rates of chronic disease is deepened by changes in local ecosystems that reduce the level of physical activity in Aboriginal people. Where self-sufficiency through trapping or the commercial sale of traditional fish stocks becomes impossible because of dwindling numbers or product contamination, unemployment and the tendency to adopt a low-activity lifestyle increase. Physical fitness, with its positive impact on health, declines proportionately.

Traditional foods, and traditional means of obtaining and preparing them, are part of a cultural heritage. Thus, food is holistically entwined with culture and personal identity, as well as with physical health. Dietary change is not often

mentioned in analyses of the loss of identity that is at the heart of the social dysfunction affecting Aboriginal communities. Yet many of the Aboriginal people who spoke to us expressed sadness and bitterness about the disappearance of fish, game and plants such as wild rice that their ancestors had long depended on. Where those foods have been contaminated, people can no longer trust the sources of life that were central to their cultures. Despite their increasing urbanization, this remains important to Aboriginal people:

Our rivers and our lakes, we can't even trust any more.

Nancy Scanie
Cold Lake First Nation
Fort McMurray, Alberta, 16 June 1992

Since I was younger, the urban population of Natives has almost tripled. One of the reasons [they move to the cities] is that the water is so polluted on Ohsweken. Down river, they can't even bathe their children in it, they get blisters. So the mothers are moving off-reserve just for their own protection, to raise the children.

Peter Cooke
Toronto, Ontario, 3 November 1992

Because of the focus on the contaminants, our community is going through a lot of fear right now, fear of the unknown….When we see these [water importation] trucks rumbling down our roads, we know that something is wrong [with the river], and it puts…fear into our community.

Dean M. Jacobs
Walpole Island Heritage Centre
Sarnia, Ontario, 10 May 1993

A case example that combines the problems of industrial contamination and the decline of a traditional food supply is that of fluoride contamination in Akwesasne, a Mohawk community located on the banks of the St. Lawrence River, near Cornwall, Ontario (see box).

Airborne contamination is a problem in many communities, but particularly in the Arctic. In winter, a layer of pollution haze from Eurasian industrial sites lies over a region the size of Africa.[200] In both Akwesasne and the Canadian North, the transborder origins of contaminants add enormously to the problems of

hazard identification, mitigation of effects and compensation for damages.

Mental and spiritual ill health

Among researchers studying addictions, depressive and suicidal behaviour, family violence and other social pathologies, there is endless argument about their causes. In our experience, Aboriginal people have no doubt whatsoever that the destruction of their ways of life, including the multi-faceted rupture of their spiritual ties to the land, is a major factor. The words of Paul Scotchman, quoted a few pages earlier, are one expression of a common conviction that damage to the land and its inhabitants is reflected in social disorganization in Aboriginal lives and spiritual emptiness in Aboriginal souls. Others have expressed the same theme:

Forests provide more than fuel, shelter and food to Native people. They are an essential ingredient in the cultural and spiritual well-being of the Indian population….Preservation of the natural habitat is a vitally important factor in the agricultural, cultural and spiritual practices of Indian bands.

Robert Moore
Program Manager, Six Nations of the
Grand River Forestry Program
Brantford, Ontario, 13 May 1993

We have listened to endless excuses, and sometimes, Mr. Chairman, to shameful deceptions. Meanwhile we have suffered, and continue to suffer…from a numberless list of specific impacts which combine as an ecological disaster and a social disaster.

Chief Allan Ross
Norway House First Nation
Manitoba Northern Flood Committee
Winnipeg, Manitoba, 17 November 1993

[The people promoting hydroelectric development in northern Quebec] live in the south. Their lives do not depend on the continued health of the land which they are presently destroying. Rather, they are proud of the fact that electricity is being taken from the area. They do not have to live on a day to day basis with the degradation of the environment which they have caused. My people live with this degradation. We are not proud of the La Grande project….It eats away daily at the soul of my people.[201]

When the bond between Aboriginal people and their lands is ruptured, it is as if they have lost their place in creation. Many have lost that place quite literally, in that they can no longer hunt and trap for sustenance or trade; at the same time they face great obstacles in developing what resources they possess in other ways. More important, they lose their symbolic place in the order of things, as stewards of a particular homeland, as skilled managers and survivors of its rigours. They may lose the very sense of their traditional names for themselves: 'people of the caribou', or of a particular river or island in the sea. They may see fewer and fewer reasons to stay on diminished homelands, yet find little welcome in the cities. Even urbanized Aboriginal people retain fragments of a land-based identity.

Fluoride Contamination at Akwesasne

Akwesasne is a Mohawk community straddling two borders, one between Ontario and Quebec, the other between Canada and the United States. According to local records, the community has been subject to damaging effects of environmental change since 1834, when British engineers began to modify the water levels of the river for navigation purposes. One hundred and twenty years later, the building of the St. Lawrence Seaway drew heavy industry to the area, particularly on the U.S. side of the border. By the 1970s, as a result of contaminants in the air and water, Akwesasne was widely thought to be the most polluted reserve in Canada.

By long tradition, Akwesasne was a farming community, raising and selling vegetables and cattle. In 1963, four years after a new aluminium smelting plant began operations a mile from the reserve, cattle began to sicken and die. It took almost a decade to identify the problem: airborne fluoride from the Reynolds Metals Company and, to a lesser extent, the General Motors Central Foundry, both on the New York state side of the reserve. Excessive fluoride was found in the air, in the water and on the surfaces of plants:

By 1972, we had effectively identified fluoride as being the problem, and it was coming from the [aluminium] plant in gaseous and particulate form, landing on vegetation on Cornwall Island and being consumed by the cattle. And the teeth would rot in the mouths of these animals. Some of our farmers…used to take porridge out to the cattle in buckets in order that they could eat, that's how close they were with their animals. But still

they saw the whole cattle industry begin to disappear.

Henry Lickers
Director, Department of the Environment
Mohawk Council of Akwesasne
Akwesasne, Ontario, 4 May 1993

As in the case of Grassy Narrows and White Dog, the cause and effect relationships between pollutants and patterns of ill health found on the Akwesasne reserve have been difficult to prove.[1] In 1972, under public pressure but not under government order, the offending plant installed pollution control devices, which reduced fluoride emissions by more than 75 per cent. Yet, even today, the people of Akwesasne contend that the damage continues; they say it merely takes longer for the cattle to become ill.

The consequences for human beings of long-term exposure to airborne fluoride are unknown. Whether or not residents are accumulating physical ill health effects from breathing and ingesting fluoride, they have already suffered indirect effects. Their diet now depends on imported, processed food rather than fresh, locally grown produce. In addition, as farming went into decline, so did fishing — a casualty of unrelated industrial pollution. Dependence on welfare has grown as ways to earn a living have shrunk. Social bonds forged by barter and support relations between farmers and fishers, which once gave the community its great solidarity, have weakened.[2]

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1 According to a study published in the veterinary sciences journal of Cornell University, "Chronic fluoride poisoning in Cornwall Island cattle was manifested clinically by stunted growth and dental fluorosis to a degree of severe interference with drinking and mastication [chewing]. Cows died or were slaughtered after the third pregnancy. Their deterioration did not allow further [productivity]. Studies by Dr. C.C. Gordon of the University of Montana Environmental Studies Laboratory indicated high levels of fluoride in hay and other plant life, suggesting that the emissions [of fluoride] may be responsible for declines in farm vegetable production as well." Doug Brown, "Akwesasne Pollution Project Report", *Indian Studies* (March/April 1984), p. 8.

2 James Ransom and Henry Lickers, "Akwesasne Environment: Appraisals of Toxic Contamination at the St. Regis Mohawk Reservation", *Northeast Indian Quarterly* (Fall 1988), pp. 24-25.

When the dynamics of a culture change in profound ways, a sense of disorientation and anxiety pervades the inner reaches of the human spirit.[202] Peace of mind and purpose in life are jeopardized. Dr. Brian Wheatley has suggested that environmental contamination and dietary change have a tip-of-the-iceberg relationship to the major social, economic and cultural transformations in Aboriginal life — which in turn contribute substantially to drug and alcohol use and high rates of injury, accidents and violence.[203] As traditional Aboriginal ways of life lose value and sustaining capacity, a kind of 'care-less-ness' takes hold: carelessness of one's own safety and the safety of others, carelessness of other life forms.

Nearly 20 years ago, the Berger commission (the Mackenzie Valley pipeline inquiry), argued that the profound social changes linked with the construction of a northern pipeline would aggravate already serious problems of alcohol abuse and other social pathologies among Aboriginal people in the North.[204] Studies of Grassy Narrows and White Dog, where rates of alcoholism and violence increased relative to neighbouring communities unaffected by mercury contamination, are consistent with this view.[205] So are the observations of Geoffrey York, who linked social dysfunction in Aboriginal communities in northern Manitoba with the decline of traditional hunting and trapping economies following major hydroelectric development.[206] Such economic decline is the most visible link in the chain of disruptions leading from environmental change to mental imbalance and social ill health in Aboriginal communities.

The difficulty of generating action

The precise relationship between environmental degradation and human health effects is, for technical reasons, often difficult to prove.[207] Most western nations thus have mechanisms for assessing the *probable* impacts of planned development, for monitoring the continuing effects of existing developments, and for adjudicating charges of damage. Although several agencies to protect people from environmental hazards exist in Canada, a number of Aboriginal people told the Commission they have difficulty persuading such authorities to act on what they perceive as a health hazard:

Fort McKay is [at] the epicentre of the tar sands development….The government tells us that there is no pollution. They have done studies that say there is no pollution. But we say they are wrong, because we have seen the changes that have taken place in the environment. The pollution has not only

damaged the environment, it has made the people of Fort McKay sick. For a small community of 300, we have high rates of

cancer and other illnesses….When we approach the government for funding to correct these problems, they tell us, you go see the next department, and then they give us the run-around. They tell us to set up a committee. So we set up a committee, and we sit around the table and we talk and we talk and we talk, but that's as far as it gets.

Chief Dorothy McDonald
Fort McKay
Fort McMurray, Alberta, 16 June 1992

[Walpole Island is] in the middle of the Great Lakes, [at the intersection of] three upper connecting channels and three lower connecting channels. That puts us in…the gut or the stomach of the Great Lakes. We are one of the real indicators of the health of the Great Lakes, because [whatever flows through those channels] goes through our community….We can't prove a direct connection [between our health problems and] the contaminants in the water. All the governments and agencies are always looking for the dead bodies or the two-headed babies, and that is unfortunate because we can't produce that right now. But our community knows there is a direct connection [between our health] and the pollution in the river.

Dean M. Jacobs
Walpole Island Heritage Centre
Sarnia, Ontario, 10 May 1993

The problem of stimulating action to protect the environment surrounding Aboriginal communities, whether for health or other reasons, begins with the issue of control. Aboriginal people have very little say in the management of lands and resources that affect their health and well-being. Not only are they prevented from exercising responsibility for the environment on their own behalf, they must struggle to make sense of a confusing map of governmental departments and agencies that might (or might not) have that responsibility. Such confusion is common with regard to issues affecting Aboriginal people. With responsibility divided between governments and among government departments, there is ample opportunity for buck-passing and failure to act. In the case of environmental health issues, the general problem of defining the segments of the Aboriginal population to whom government support and intervention programs apply is compounded by the fact that responsibility for the environment is itself divided among federal, provincial and territorial

governments.

Environmental problems that are fully contained within reserve boundaries are generally taken to be the responsibility of the federal government. Since the early 1960s, medical services branch has funded a corps of environmental health officers responsible for inspecting buildings and infrastructure facilities on reserves (for example, water and sanitation systems) and reporting any related adverse health and environmental effects. Unfortunately, however, there is no legislative or program mechanism to remedy such adverse effects. Each issue that comes up requires ad hoc action to investigate the problem, decide what can be done about it, and take remedial or compensatory steps. Since there is no established program, there is no budget line to cover such costs. Each case requires a special submission to Treasury Board and faces an uphill battle for approval.[208]

If an environmental problem on-reserve is sufficiently serious, or if its causes or consequences involve lands and people off-reserve (as in the cases of Grassy Narrows and White Dog and Akwesasne), provincial or territorial authorities must become involved. This further complicates the route to solutions. All provincial and territorial governments have monitoring, investigation and enforcement capacities designed to protect their citizens from the effects of environmental hazards, but not all recognize reserve communities as eligible for the protection provided by their legislation. Sometimes, an intergovernmental or inter-ministerial committee investigates. Such bodies generally lack the authority or mandate to make judgements and prompt remedial action. At other times, no such co-operation takes place, and those affected by the problem bounce between competing agencies, none of whom have authority to act.

To prevent or limit negative impacts from proposed new land uses, including those on health, all Canadian governments have discretionary mechanisms for environmental assessment and review in advance of development. No equivalent mechanism exists at present within the terms of self-government agreements to enable First Nations, Inuit and Métis people to control environmental impacts on their lands. Nor are the avenues for their participation in federal, provincial and territorial review processes either clear or satisfactory. The situation as it stands offers Aboriginal people no reliable means of protecting themselves from existing or potential health hazards. Clarity requires that all governments, in consultation with Aboriginal peoples and their organizations, develop written policies to

• specify the responsibilities of each level of government to provide environmental protection to Aboriginal people on and off reserves;

• establish guidelines for investigating problems that affect the health of Aboriginal lands and people, for rectifying those problems and for compensating victims; and

• define the extent of Aboriginal participation in preventive, investigatory and compensatory hazard assessment procedures at the provincial, territorial and federal levels.

Detailed discussion of jurisdiction and management regimes governing land appears in Volume 2, Chapters 3 and 4.[209] In Volume 4, Chapter 6 we propose a model of environmental stewardship that, although especially relevant to the territories, is a useful model for land management everywhere. In this chapter, we wish to make the point as strongly as possible that the regulation of environmental impacts is as much a health issue as it is an economic issue.

Without a clear and dependable regulatory framework to help Aboriginal nations protect the environment, some communities have taken their own initiatives to protect the natural resources on which they depend. The Six Nations of the Grand River (Ontario), for example, have established a multi-disciplinary natural resources department to develop a sustainable natural resource base according to Aboriginal needs and values and to protect it for all time.[210] The Mohawk Council of Akwesasne has had an active environmental department for almost 20 years.[211] The First Nations of British Columbia are establishing an Indian water rights commission to provide support and expertise to communities that identify clean and productive water issues as important to them.[212] The Eskasoni First Nation in Nova Scotia is developing a plan to take control of its resources and environment.[213] We take the position that, for Aboriginal people to develop and exercise responsibility for the health effects of the use and misuse of lands and resources, they must gain greater authority over their own lands and be included routinely as an interested party in land use planning for the territory that affects them.

1.5 Conclusion

In this brief investigation of the burden of ill health borne by Aboriginal people, we have seen that the problems are many, serious and persistent. Notwithstanding that medical services are now delivered to Aboriginal people

even in the remotest parts of the country and that some causes of morbidity and mortality have been brought under control, the gap in health and well-being between Aboriginal and non-Aboriginal people remains. It extends from physical ill health to social, emotional and community ill health. When we examine its patterns and dynamics over time, we are forced to conclude that, no matter which diseases and problems of social dysfunction are plaguing Canadians generally, they are likely to be more severe among Aboriginal people.

We have no doubt that Canadian governments have made and are continuing to make genuine efforts to improve the health and well-being of Aboriginal people. However, as we have shown here, the current system of services does not adequately address the causes of disproportionate rates of illness and dysfunction. The system's assumptions about Aboriginal health and well-being and how to promote them are wrong for the job.

Next, we examine the assumptions about health and wellness held by Aboriginal people themselves and establish their congruence with emerging insights from the field of population health (epidemiology). From this analysis we derive a new set of guidelines for health policy and action that *are* right for the job of restoring well-being to Aboriginal people, their nations and communities.

2. Toward a New Aboriginal Health and Healing Strategy

The preceding analysis showed that the factors contributing to ill health of Aboriginal people stem not from bio-medical factors, but from social, economic and political factors. Given the many causes of Aboriginal ill health, Commissioners are convinced that the problem-by-problem approach of Canada's health care system is not adequate; it does not address underlying causes and cannot trigger the fundamental improvements in life circumstances that Aboriginal people need. Nor can very much difference be made simply by providing 'more of the same' — more money, more services, more programs. Such responses would indeed help some individuals in poor health, but this will not stem the flow of ill and dysfunctional Aboriginal people to fill up the spaces left by the newly cured.

Although we were greatly disturbed by the evidence of continuing ill health in Aboriginal communities, we were also encouraged by the energy and imagination with which many Aboriginal people are tackling their health and

social problems. They know what ails them. In testimony and consultation, they offered a critique of existing health and social services and proposed alternative ways of making progress toward health and well-being. They are already acting on those ideas in some communities.

Commissioners were struck by the fact that many of the insights of traditional values and practices echo those at the leading edge of new scientific ideas on the determinants of health and well-being. We believe that there is, at the meeting point of these two great traditions — the Aboriginal and the bio-medical — real hope for enhanced health among Aboriginal people and, indeed, enhanced health for the human race. For Aboriginal people, the conviction that they have a contribution to make is deeply held and a source of strength. In the analysis that follows we show the solid ground on which this belief stands.

2.1 Aboriginal Perspectives on Health and Healing

Aboriginal people have not been passive in their dealings with Canada's system of health and social services. They have struggled to make it work and in doing so have developed a critical analysis of its failings. Many Aboriginal people say they have never had access to enough services that are sensitive to their unique history and needs. At a deeper level, they say the system is incapable of delivering health and well-being to Aboriginal people and that more of the same will not alter this fact. Many who spoke to us argued that strategies for health that originate from within Aboriginal cultures are the key to restoring well-being among Aboriginal people. The critique of existing service systems and the affirmation of the relevance of Aboriginal traditions of health and healing were consistent refrains in our hearings and research. We highlight here five main themes, often intertwined, in the scores of presentations we heard.

The demand for equal outcomes

The starting point for many presentations was that there is no equality of health status and social outcomes between Aboriginal and non-Aboriginal people. The findings reported earlier in this chapter amply demonstrate the truth of this contention. This is not just an abstract finding; Aboriginal people see the human consequences of unequal risk, unequal rates of illness, social dysfunction and inadequate services, and they measure the cost in the ill health and unhappiness of their neighbours, families and themselves.

The fact that Aboriginal people suffer an unequal burden of ill health in a country that espouses ‘equality for all’ is an outrage to many Aboriginal people. We believe it should be equally unacceptable to all Canadians and their governments.

The last two decades have witnessed the emergence of overwhelming health problems [among our people], such as cardiovascular disease, respiratory disease, renal disease, poor nutrition, cancers, dental caries, ear-nose-and-throat infections, high risk pregnancies, birth anomalies, multiple mental illnesses, poisonings and injuries, communicable diseases, and the re-emergence of tuberculosis. Any disease category related to the First Nations is two to three times higher than the national figures….

The federal government has had [years] to provide hospital and health services to the First Nations communities. Unfortunately, we are still facing Third World health conditions.

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

The average Canadian…is unaware of the degree of ill health in the Aboriginal population in Canada. It is a fact that in many areas of this country, the health of Aboriginal peoples is equivalent to poor Third World standards.

Dr. Chris Durocher
Yukon Medical Association
Teslin, Yukon, 27 May 1992

[There is an] epidemic of substance abuse and hopelessness that envelops our young people and results in the highest suicide rates among [youth] in the nation today. Of the 200 to 275 deaths by injury and poisoning that have occurred among First Nations in the last decade, fully three-quarters were in the 10-year to 20-year age group. Those deaths compare to the 65 to 70 deaths that occurred in the same category nationally….

Fetal and infant death among First Nations babies was nearly twice the national average reported since 1987. Once again the social and economic factors of poor housing, lack of sewage disposal and potable water, and poor access to health services were considered factors in the higher rate. As well, the poor health of the mother, inadequate nutrition and lack of pre-natal care,

as well as the adverse effects of drugs and alcohol, also contributed.

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

Canadians enjoy homes with a lot of rooms, [complete] with full finished basements, water and sewer facilities, central heating, infrastructure to support the community. In Fort Albany, I have 80-year-old elders that struggle to get water from [outside] sources of water, standpipes as we call them. I have them struggling in 40-below weather to empty sewage pails in the places where they can empty them. I have them sitting in houses that are sitting on the ground without a proper foundation, subjected to frost, cold, wind, made of plywood substandard housing….They are not living like Canadians. We can only ask that we be allowed to live like Canadians.

Chief Edmund Metatawabin
Fort Albany First Nation
Timmins, Ontario, 5 November 1992

In addition to the gap in health and social outcomes that separates Aboriginal and non-Aboriginal people, a number of speakers pointed to inequalities between groups of Aboriginal people. Registered (or status) Indians living on-reserve (sometimes also those living off-reserve) and Inuit living in the Northwest Territories have access to federal health and social programs that are unavailable to others. Since federal programs and services, with all their faults, typically are the only ones adapted to Aboriginal needs, they have long been a source of envy to non-status and urban Indians, to Inuit outside their northern communities, and to Métis people. Further, as we discuss at greater length in Volume 44, some Aboriginal women told us that health and social issues are given a back seat to the ‘hard issues’ of politics and economics by local (male) leadership — to the detriment of all, particularly women and children:

Women [have been] doing a lot in their communities…but they have been meeting a number of obstacles year after year after year, and it comes from the top. In the communities, who are the leaders? Well, mostly men. They do not have the political will [to address our concerns]….Our concerns are with the social problems of this society, and it doesn’t [stop] with Aboriginals. It covers the whole society in Canada. They are just not a priority for the governments, the different governments or the different representative groups out there. I think women now have to…hold their politicians…a little more responsive to the

social needs.

Margaret Eagle
Native Women's Association
Yellowknife, Northwest Territories, 7 December 1992

Pauktuutit's role in publicly addressing such issues as family violence, child sexual abuse, sexual assault, AIDS and numerous other health and social issues has reinforced the perception that these things fall into the female sphere of influence. This is not bad in itself, but it means that there is incredible pressure on individual women and the organizations which represent them to right the wrongs and heal the wounds that three decades of change have brought to the North….In spite of this, Inuit women are still under-represented in leadership positions. This is particularly true in relation to issues which are seen as falling more naturally into the male sphere of influence — that is, land claims, economic development, self-government, renewable resource management.

Martha Flaherty
President, Pauktuutit
Ottawa, Ontario, 2 November 1993

Our voices as women for the most part are not valued in the male-dominated political structures….The Aboriginal leadership is fond of saying that our children are our future. Is there an understanding of what is demanded by that belief? If our children are to have a future, the time is now to reshape the political agenda. We say this to the leaders of First Nations: Assess the status of children in our society, what are their real needs. For the first time in the history of the *Indian Act* leadership, define an agenda that will address the real conditions of our children and families in our society.

Marilyn Fontaine
Spokesperson, Aboriginal Women's Unity Coalition
Winnipeg, Manitoba, 23 April 1992

The belief in interconnectedness

Other presentations focused on solutions. The idea brought forward perhaps most often was that health and welfare systems should reflect the interconnectedness of body, mind, emotions and spirit — and of person, family, community and all life — which is essential to good health from an Aboriginal point of view. Further, this reflection should be substantial, not simply

rhetorical.

Classic Aboriginal concepts of health and healing take the view that all the elements of life and living are interdependent and, by extension, well-being flows from balance and harmony among the elements of personal and collective life:

The Native concept of health…is said to be holistic because it integrates and gives equal emphasis to the physical, spiritual, mental and emotional aspects of the person. The circle is used to represent the inseparability of the individual, family, community and world….The circle (or wheel) embodies the notion of health as harmony or balance in all aspects of one's life….[Human beings] must be in balance with [their] physical and social environments…in order to live and grow. Imbalance can threaten the conditions that enable the person…to reach his or her full potential as a human being.[214]

The Aboriginal concept goes beyond the conventional wisdom of bio-medicine, which focuses on the human organism and its symptoms of dysfunction.

For a person to be healthy, [he or she] must be adequately fed, be educated, have access to medical facilities, have access to spiritual comfort, live in a warm and comfortable house with clean water and safe sewage disposal, be secure in their cultural identity, have an opportunity to excel in a meaningful endeavour, and so on. These are not separate needs; they are all aspects of a whole.

Henry Zoe
Dogrib Treaty 11 Council
Member of the Legislative Assembly
Yellowknife, Northwest Territories, 9 December 1992

Being alcohol-free is just the first stage [in becoming healthy]. The next level is healing the mind and then the soul….If we begin with ourselves, then we can begin to help our families…and our communities.

Eric Morriss
Teslin Tlingit Council
Teslin, Yukon, 26 May 1992

The western notion the body is expressed in a metaphor [that] holds that the body is a machine….Scientific thought distinguishes the body from the person,

establishes a dichotomy between the body and the spirit, and separates the individual from the human and physical environment….

The Inuit vision of the body offers a holistic vision of the individual and his or her unity with his/her surroundings, a part of a whole that draws its meaning from the relationships that the human being entertains with whatever is living and whatever surrounds him or her….It is a model that is characterized by its continuity with the environment….

From the different representations of the body follow certain notions of health and illness, certain practices and behaviour, certain customs and conduct in restoring and maintaining health. [translation]

Rose Dufour
Laval University Hospital Centre
Wendake, Quebec, 18 November 1992

As these speakers described it, interconnectedness is a philosophical concept. But others described it as a practical idea with concrete implications for the design and delivery of medical and social services:

For a number of years, we had been receiving more and more specialists trained in medicine, in nursing, in mental health. But even though more and more health and social services were being put into place, we had more and more sick people. New specialists arrived, and they kept finding that we had new illnesses….Self-help groups are now beginning to emerge and share their knowledge of traditional healing, because modern medicine does not heal the whole person. [translation]

Danielle Descent
Director, health and social services
Innu Takuaikan Council
Sept-ëles/Mani-Utenam, Quebec, 20 November 1992

Government funding systems are presently administered by specialized departments…which address very narrowly defined social problems. Examples of this would be programs for violence against women as opposed to family violence. Or alcohol and drug abuse programs as opposed to a more overall program designed to address all of the related problems that accompany alcohol and drug abuse….

This means that there is no [long-term program for] solving the social problems, and [short-term programs] are vulnerable to political bandwagons. It is our recommendation that the Royal Commission on Aboriginal Peoples recommend programs and program funding sources that are more generic and can deal with the social problems in a more holistic, rather than specialized way.

Bill Riddell
Baffin Regional Council
Tuvvik Committee on Social Issues
Iqaluit, Northwest Territories, 25 May 1992

I don't believe that education, economic development, recreation, health, job creation and all of these programs can work in isolation of one another, and yet sometimes that happens in our Native communities.

Tom Erasmus
Alberta Mental Health Association
Lac La Biche, Alberta, 9 June 1992

These speakers and many others articulated a vision of health care in which each person is considered as a whole, with health and social problems that cannot be cured in isolation from one another, and with resources for achieving health that come not just from expert services but also from the understanding and strength of family, community, culture and spiritual beliefs. It is a vision quite different from that of mainstream health and social services, which tend to isolate problems and treat them separately. To operate on the basis of their vision, Aboriginal people told us they would have to take control of programs and services more completely than has been possible to date.

The transition from dependency to autonomy

The legacy of enforced dependence on (or, in the case of Métis people and non-status Indian people, neglect by) the Canadian state has left most Aboriginal nations without the levers of authority and control over health and social services that Canadian provinces and communities take for granted. (The issue of a transition from dependency to self-control is discussed with particular reference to the North in Volume 4.) Health transfer agreements (and the terms of the few existing self-government agreements) have begun to change the picture for some, but for the most part they work within systems that do not comprehend their deepest needs and within programs that they did not design and that do not reflect their priorities. Many believe that the

consequences of dependency and lack of control have been disastrous:

During the inquiry [into the accidental death of six Innu children in a house fire], we listened to each other speak about the impact that the government, the church, the school, the [health and social services] clinic and the police have had on our lives. Many of the people expressed the belief that we have lost too much by giving over power to these non-Innu organizations. If we are to have a future, we feel that we must be the ones who begin to take responsibility for such things in our lives once again.

As one of the couples in our village said during the inquiry, in the past, we were like we were asleep. White people were doing everything for us. We thought white people knew everything, but we were wrong. The advice they gave us never worked.

Chief Katie Rich
Innu Nation
Sheshatshiu, Newfoundland and Labrador, 17 June 1992

Often programs set up by Health and Welfare Canada to serve Aboriginal communities cause more harm than relief. Typically, these programs are imposed on Aboriginal communities without consultation and research to best address Aboriginal needs and values. In addition, the large overhead bureaucracy in Ottawa and…in the province[s] consume a major share of the resources available, leaving Aboriginal communities the task of managing foreign programs with inadequate funding. The design of health services for Aboriginal communities [should be done by] Aboriginal people.

Sophie Pierre
Ktunaxa/Kinbasket Tribal Council
Cranbrook, British Columbia, 3 November 1992

In our treatment centre we cannot say what [our money] can be spent on. The government tells us what it should be spent on….For instance, the government would probably not respect us for using our own traditional medicines within the treatment setting, but those kinds of things [are what work]….It would be nice to see some flexibility in some of these funding schemes. I think we are capable of designing the programs that we feel suit our clients.

Paul Nadjiwan
Weendahmagen Treatment Centre
Thunder Bay, Ontario, 27 October 1992

There are many examples we see in small communities where Native-run community health groups are very successful. That is because they are Native-run….There is no way we can cross that. It is unrealistic for us, no matter how good-hearted we [non-Aboriginal caregivers] are, to think we can cross it.

Dr. David Skinner
Yukon Medical Association
Teslin, Yukon, 27 May 1992

Aboriginal people told us that control will permit them to redesign health and social programs to more fully reflect their values and diverse cultures. Earlier in this chapter, in relation to the problem of compliance, we indicated how effective culture-based programming can be.

The need for culture-based programming

It is often pointed out that much of the content of Aboriginal cultures has been lost and that the dominant non-Aboriginal culture has been absorbed by Aboriginal people. This is true, but to exaggerate this point is to miss one of the central facts of Aboriginal existence: Inuit and the First Nations and Métis peoples of Canada are unique peoples, and they are determined to remain so. Traditional norms and values, though changed and constantly changing, retain much of their power. Often, the ideas and practices of the dominant culture — in health and social services and in all fields — simply fail to connect with Aboriginal feelings, Aboriginal experience and Aboriginal good sense. Better connections come from within. In fact, as several speakers told us, it is often the most distressed and alienated Aboriginal people who find the greatest healing power in the reaffirmation (or rediscovery) of their cultures and spirituality.

Even if the insights and practices of Aboriginal cultures were to add nothing to the health of Aboriginal people (which we think highly unlikely), they claim the right to find out for themselves:

I want the rest of the country to recognize that there is more than one way to heal. Social workers and medical people have to realize the validity of our ways. Your way is not always the right way.

Sherry Lawson
Native Education Liaison Worker, Twin Lakes Secondary School

Chippewas of Rama First Nation
Orillia, Ontario, 13 May 1993

The only way for our people to heal is to go back to those original instructions that were given to us, go back to the sacred fires, go back to the wisdom and knowledge that was given to us, and apply that to our lives today.

Alma Brooks
Wabanaki Medicine Lodge
Kingsclear, New Brunswick, 19 May 1992

It must be clearly understood that, when dealing with First Nations people, whether it be in education or with health, it must be in the context of the culture, whatever that culture may be, or it is just another form of assimilation.

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

Aboriginal people told us that the choice and flexibility inherent in the idea of cultural appropriateness should recognize the diversity among Aboriginal peoples as well. Just as non-Aboriginal approaches to health and healing are not necessarily right for all others, so too the programs and services developed by one Aboriginal nation may not necessarily be right for others. Métis people and Inuit, for example, strongly object to the imposition of programs designed for or by First Nations:[215]

The Métis Addictions Corporation of Saskatchewan exists because we are recognized as a separate people, culturally different from both the dominant society and the Indian people, but we have been denied the resources we need for our own research and development, so we have used models of treatment borrowed from the dominant society [and] of those developed by and for Indian people. Neither are culturally appropriate for us.

A clinical one-to-one approach does not work well for us, [because] we cannot divorce the healing of individuals from the healing of families and communities. Indian people often find spiritual wholeness in a return to their traditional ceremonies. That rarely works for us. Traditionally, our people were Roman Catholic or Anglican….We desperately need the resources, money and manpower to develop our own culturally appropriate programs.

Winston McKay

Métis Addictions Corporation of Saskatchewan
La Ronge, Saskatchewan, 28 May 1992

We found that Inuit women or Inuit communities need different solutions [to problems of violence] because of culture, different beliefs and isolation, and [because] there are hardly any programs or facilities in Inuit communities. That's why we decided to have different solutions, a different section for Inuit [in the report of the Canadian Panel on Violence Against Women]. But it was very hard for me to try to get the Inuit section, because I was lumped with other Aboriginal groups all the time. I fought and fought and fought. I kept saying…"I am not like other Aboriginal people…I am not white, I am not Indian, but I am Inuk." I had to tell [the other members of the Panel], it is like lumping Japanese and Chinese together [to put all Aboriginal people in a single category].

Martha Flaherty
President, Pauktuutit
Ottawa, Ontario, 2 November 1993

Culture-based programming has become more widely accepted in the human services field because of its effectiveness (and the welcome it has received). More controversial is the idea that the physical, psycho-social and spiritual healing methods of traditional practitioners might have direct applicability to today's health issues.

A new role for traditional healing

We believe that traditional cultures can — and should — act as a kind of source book of ideas for reconceptualizing and reorganizing Aboriginal health and social services. It is not a very big step from there to recognizing that traditional healers can (and should) play a significant part in redesigned care systems.

A number of thoughtful speakers argued that traditional healing methods and therapies can make two sorts of contribution: they are valuable in their own right for their direct efficacy in treatment, and they contain ideas that can be adapted to solve difficult problems in restoring whole health to Aboriginal people. The attitude of these speakers was not revivalism but inquiry into the past. They spoke of applying old practices to new problems, of combining them with western therapies in a spirit of experimentation and learning.

The majority of traditional healers were forced long ago to renounce their

practices (or to practise covertly) because of persecution by Canadian governments and Christian churches and contempt on the part of bio-medical practitioners for their ceremonies, herbal treatments and other therapies. Newcomers' disrespect was eventually mirrored in the feelings of most Aboriginal people themselves. Yet, traditional practices never faded away completely. In the Peguis First Nation, they are playing an increasingly important part in medical services (see box).

Only a few healers came forward to speak to the Commission. They told us of the ancient power of their traditions and of the interest in their work that is growing all over the country:

It is with great concern that I present this brief for the protection and preservation of our traditional and spiritual beliefs and culture. The inherent right to practise our traditional beliefs was given to us when the Creator first put the red man here on earth….In times of great difficulty, the Creator sent sacred gifts to the people from the spirit world to help them survive. This is how we got our sacred pipe, songs, ceremonies and different forms of government. These were used for the good health, happiness, help and understanding for the red nation….[Each tribe] had our own sacred traditions of how to look after and use medicines from the plant, winged and animal kingdoms. The law of use is sacred to traditional people today….

By the 1960s, traditional spiritual people were almost extinct except for those who went underground. A lot of our traditional spiritual elders went to their graves with much knowledge. Since then there has been a rebirth….[Even non-Aboriginal people] are coming to traditional spiritual people for help….The present health care system is in a crisis and heading for financial collapse unless there are alternatives. Traditional spiritual people want to create alternatives for all people to get help.

Elder Dennis Thorne
Edmonton, Alberta
11 June 1992

David Newhouse told the Commission that rekindled interest in traditional healing and its modern potential is part of a general restoration of respect for Aboriginal ways:

Within the Aboriginal community, over the past decade particularly, there has been a move to relearn the traditional ways and to move these ways back to

the centre of Aboriginal life….What is occurring is that today's Aboriginal identity [is being] examined and deliberately reconstructed to be as Aboriginal as possible….These reconstructed identities will provide a solid foundation for experimentation and perhaps change.

David Newhouse
Native Management Program, Trent University
Toronto, Ontario, 3 November 1992

Peguis Explores Cultural Roots

It was in the 1980s, after a period of intense social turmoil, that some members of the Peguis First Nation community in Manitoba began exploration of their fading cultural roots. Resulting interest in traditional medicine encouraged a new openness among the few who sought to rediscover and follow its practices. It also aroused fierce opposition from those who did not want to be branded 'ignorant' or reactionary — opposition that is only now beginning to subside.

As awareness spread, more and more people began to ask for access to traditional healers as part of the range of services provided by the local Health Centre. The Aboriginal nurse in charge of the centre agreed and sought financial help from Medical Services Branch to bring experienced healers to Peguis (and to send clients to healers elsewhere). Travel costs and related expenses became a special category within the Non-Insured Health Benefits Program.

Now, demand for a referral to the traditional healers who visit Peguis is as high as 30 to 40 per month. Interest is particularly high among those who suffer from emotional problems, including those related to alcohol and drug abuse, violence and suicide. Their positive experiences have influenced the community mental health program, which is experimenting with a blend of traditional and western approaches to healing.

Source: Benita Cohen, "Health Services Development in an Aboriginal Community: The Case of Peguis First Nation", research study prepared for RCAP (1994).

Many speakers thought it possible that Aboriginal and western healing methods might enrich each other, inspiring improved services and outcomes. The precise relationship between the two systems is a matter of continuing debate

among Aboriginal people. Some see traditional healing as an adjunct treatment service; others see it as a full partner with bio-medical and psychological therapies; still others insist on it remaining an alternative service, completely separate from western-style medicine and social services:

How can effective health care be delivered to the Aboriginal nations? I think what has to happen here is a common ground must be reached by Aboriginal people and the western medical profession to combine Aboriginal medical teachings and Western medicine in the delivery of health care services to Aboriginal people.

Traditional healers must be recognized by the college of physicians and surgeons in each respective province….Aboriginal people talking to doctors, and taking a look at traditional healing methods, traditional medicine, and putting it all together so that [we] can deliver an integrated service to Aboriginal people that has the Aboriginal component built in.

Harold Morin
Executive Director, Central Interior Native Health Society
Prince George, British Columbia, 1 June 1993

I want to be very clear that there are significant political differences [about]…the issues of establishing a comprehensive health care delivery system which seeks to bring traditional medicine into the fold, so to speak, as opposed to the view of bringing western medical know-how into the healing circle….I believe that the ideal model is one which aims to bring western medicine into the circle versus one that aims to bring traditional healing into the western medical framework. I believe that in choosing the latter we choose to give away our power.

Yvon Lamarche, RN
Treatment Co-ordinator, Georgian Bay Friendship Centre
Orillia, Ontario, 13 May 1993

What is clear is the interest of many in exploring the possibilities of the old ways and co-operation between Aboriginal and non-Aboriginal healing traditions. We heard evidence that the application of traditional approaches has already begun with statements of principles to guide Aboriginally controlled health and healing services and the design of programs to promote psycho-social healing from the effects of discrimination and oppression:

[We] believe it is important [for you] to have an understanding of the values and principles that guide health and social services in Kahnawake. These principles are based on the traditions of our people and are supposed to govern all our relationships with the world around us. They are the principles of peace, respect and a good mind.

We also operate and advocate the traditional ethic of responsibility. As I mentioned earlier, health is a responsibility given to us by the Creator….It is up to us to ensure that we take care of what He has given us. It is important for us to deal with others in an honest and forthright manner, always keeping in mind our responsibility to our community. We believe health is one of those responsibilities.

Rheena Diabo
Health Consultation Committee
Kahnawake Shakotii'takehnhas Community Services
Kahnawake, Quebec, 5 May 1993

One solution that we in the Prince George Native Friendship Centre have come up with is, we developed a Sexual Abuse Treatment Services Program, otherwise known as the

SATS program. What makes this such a unique program is that we have taken the holistic approach to healing. We will be providing treatment to [the whole family]….We have incorporated traditional and contemporary healing methods. For example, sweats, smudging, healing/talking circles, ceremonial rites versus art and play therapy, psychodrama, gestalt and psychotherapy. Our traditional healing methods were very effective before European contact. If they worked then, why can't they work now?

Lillian George
Director, Sexual Abuse Treatment Services Program
Wet'suwet'en First Nation
Prince George, British Columbia, 31 May 1993

Defining the place of traditional healing and healers in future health services is complex and challenging. We give it further consideration in Appendix 3A.

Conclusion

Throughout this chapter, we have referred to Aboriginal people's ideas,

innovative programming and recommendations for system change, described in presentations, briefs and documents tabled at our hearings. We have seen that they are part of a comprehensive analysis of what will restore health and well-being to Aboriginal nations and their communities. It would seem reasonable to support many or most of the ideas we heard simply on the grounds that Aboriginal people are likely to know best what will work in their own communities. We have also found other reasons to support and build on the vision of health and healing presented to us by Aboriginal speakers: its concepts and understandings are affirmed by the leading edge of scientific research on the determinants of health.

2.2 The Determinants of Health

For a long time, most Canadians have equated health with medical care. Doctors, drugs, hospitals, and the research that informs them, get most of the credit for keeping us free of disease and able to enjoy our increasingly long lives. We take for granted the achievements of the public health movement of the previous century: clean water, safe food, reliable sanitation, safe houses and workplaces, and public welfare. During the 1960s, the idea that individual health behaviour choices contribute to good or ill health started to take hold. Personal decisions — whether to smoke, eat well, use alcohol and drugs, keep fit and fasten our seat belts — have been found to play a large part in preventing ill health and encouraging wellness. In fact, health policy in Canada today is concerned mostly with maximizing those two factors: access to sophisticated bio-medical treatment and healthy lifestyle choices.[216]

Now, a new idea has been gaining force — one with the potential to transform our understanding of what makes people healthy. Research indicates that several other factors are probably more significant than the public illness care system and private lifestyle choices in determining health:

• wealth, poverty and other economic conditions;

• social, psychological and spiritual well-being;

• environmental conditions; and

• genetic inheritance.

One of the main reasons to rethink the determinants of health is the research

finding that, beyond a certain baseline, high levels of expenditure on illness care services do not yield corresponding levels of improved health.[217] Furthermore, the countries that spend the most money on illness care do not have the healthiest people. The United States and Canada have the highest levels of expenditure, but Japan, Sweden and Finland have lower morbidity rates and higher life expectancy.[218]

Analysis of these differences suggests that medical care, important as it is, is only one element in a complex picture of interdependent factors that determine health and well-being. Aaron Wildavsky has summarized the limits of the bio-medical model of ill health and how to treat it in this challenging way:

According to the Great Equation, medical care equals health. But the Great Equation is wrong. More available medical care does not equal better health. The best estimates are that the medical system (doctors, drugs, hospitals) affects about 10% of the usual indices for measuring health: whether you live at all (infant mortality), how well you live (days lost to sickness), how long you live (adult mortality). The remaining 90% are determined by factors over which doctors have little or no control, from individual lifestyle (smoking, exercise, worry), to social conditions (income, eating habits, physiological inheritance), to the physical environment (air and water quality). Most of the bad things that happen to people are beyond the reach of medicine.[219]

For brevity, we will use the phrase ‘the new determinants of health’ to refer to the non-medical factors listed by Dr. Wildavsky. Those working on the new determinants of health point out that the old determinants — public health (sanitation, food and water quality, housing conditions) and basic medical care — must exist at a minimum standard to ensure health. In addition to this, however, another set of factors must be considered. Among the new determinants of health, four are especially significant for public policy and the reform of Aboriginal health and wellness systems: economic factors, social factors, emotional factors and environmental factors.

Economic factors

The most powerful argument for thinking differently about the determinants of health is found in economic analysis. Major studies dating back 20 years and more have shown that population health gains in the nineteenth and early twentieth centuries were attributable in large part to the expansion of the middle class and the resulting spread of such amenities as soap, window glass,

fresh nutritious food, and the ability to buy them.[220] Today, the socio-economic status of individuals (their wealth or poverty and their social class position) is still a good predictor of life expectancy and the incidence of illness.[221]

The general prosperity of a nation also affects the health status of its people.[222] More important, the distribution of income within a country is associated with health status. Simply put, wealthy countries that have a relatively equitable distribution of income (for example, Japan) enjoy higher health status than countries where wealth is distributed less equitably (for example, the United States) — despite the fact that the United States spends twice as much as Japan on medical services per capita.[223] Countries where poverty abides, despite the wealth of the country as a whole, do not achieve the most favourable standards of population health. Thus, it appears that living in the just society — a society where wealth and life chances are equitably distributed and the quality of life is reasonably high for everyone — is good for your health.

The availability of jobs also contributes to health. Unemployment has been correlated with mental and physical ill health and with early death.[224] One Canadian study found that the unemployed reported more anxiety, depression, visits and phone calls to doctors, and days in hospital than did the employed.[225] The high level of stress associated with unemployment appears to be the explanation. The human ‘stress response’ triggers physiological imbalance, such as increases in blood pressure and blood lipids. Further, it is associated with behavioural risks to health such as increased rates of smoking, drinking, drug taking, and the consumption of so-called ‘comfort foods’ with their high content of fats and sugars. Stress (from any cause) is also known to depress the immune system.[226]

Social factors[227]

Those who do have jobs face risks to health as well — and not just the health and safety hazards associated with certain kinds of work. The famous Whitehall studies of the health of British civil servants found that, even among those fully employed in physically ‘safe’ white collar work, health status differed by rank and seniority. The closer people were to the top, the healthier they were.[228]

Upon investigating further, Dr. Leonard Syme, a professor at the University of California at Berkeley, reported that he found “a similar gradient almost

everywhere in the world and for virtually every disease that has been studied".[229] Those with the most power and authority were least likely to become ill. But why? Syme was struck by the fact that people farther down in the organizational hierarchy are less able to make their own decisions about work and life demands than those higher up. They are not in control of critical factors that affect their jobs and thus, their daily lives. He concluded: "The only hypothesis that I have been able to come up with is that as one moves down the social class hierarchy, one has less control over one's own destiny." In Syme's view, the absence of control explains a portion of ill health.

In our view, the issue of control is more than a work-related issue. If powerlessness at work is a factor in individual health status, it is reasonable to suppose that powerlessness in other areas of life may also lead to illness. Indeed, in his review of studies of this issue, Gus Thompson reports that

Personal attitudes such as optimism, assertiveness, and a belief that one can control one's environment are associated with lowered incidence of a variety of illnesses (major and minor). The reverse is true for those who are accepting of events, pessimistic, passive and compliant.[230]

Thompson is speaking about individual health outcomes, but we must also consider the probable effects of powerlessness on population health outcomes. Commissioners have concluded that the lack of economic and political control that Aboriginal people continue to endure, both individually and collectively, contributes significantly to their ill health.[231]

In addition to issues of control, a second set of social factors increasingly found to have significant health effects is the events of early childhood. One leading researcher put it this way:

Rapidly accumulating evidence is revealing an impact of childhood experiences on subsequent health, well-being, and competence which is more diverse, profound and long lasting than was ever understood in the past.[232]

Observation throughout the ages has revealed that if animals or people are raised without adequate nurturing and affection, they do not thrive.233 New insights from the neuro-sciences show that the stimulation people receive in childhood, when the brain is at its most 'plastic', affects behaviour, cognition, competence and the development of coping skills.[234] It appears that early childhood stimulation and complex experience actually build the biological

(neural) pathways that encourage these aspects of development and thus contribute to variations in health status.[235]

Even what happens in the womb is important. As discussed earlier, babies born with low birth weight (LBw) are at risk for physical and learning disabilities, increased rates of disease and premature death. LBw babies are more commonly born to women who are young, single, poor and who have below-average education, suggesting that social rather than medical factors are at work.[236] This profile applies disproportionately to Aboriginal women, whose risk is thus more difficult to eliminate.

Emotional and spiritual factors

The Canadian health care system approaches mental health with some unease; conditions such as depression and substance abuse are often ineligible for coverage under medical insurance plans — unless they are classified as 'diseases' and treated at least in part by medication. The complex relationships linking the mind, body and spirit are barely acknowledged, even in relation to these conditions. Nevertheless, there is growing evidence that psychological factors play a complex role in determining health.

The ill health effects of major life trauma are now well established.[237] Heart attack victims, for example, are often found to be suffering from severe stress, such as the death of a loved one or an instance of personal danger. Similarly, people who have just lost spouses are more likely to die suddenly than a matched sample of the same age.[238] Other evidence suggests that people who choose to struggle against life-threatening diseases and receive the support of psychotherapy and group therapy live longer than people with similar illnesses who receive no such support.[239] Still other studies have established firm connections among stress, personality type and the onset of heart disease.[240] Conversely, the ability to cope well with stress is associated with the ability to achieve metabolic control over diabetes.[241]

The precise explanation for these findings is not known. However, what is clear is that the mind and body are in direct communication through neuro-biological links involving the hormone and immune systems. In fact, whole new areas of scientific research are charting the pathways that connect mental and emotional functioning with biological functioning. Two examples are psycho-neuroimmunology and psycho-neuroendocrinology. These fields are beginning to show how physical functioning and resistance to disease can be affected by

feelings and perceptions — that neurological systems ‘talk’ to the immune systems through the endocrine system in ways that affect resistance to disease and the functioning of vital organs.[242]

In times of high stress, including periods of grief, depression or anger, changes in hormone production seem to depress the immune system, leaving a person increasingly vulnerable to invasion by disease organisms — and perhaps to careless or high-risk behaviour as well.[243] We have argued elsewhere that grief, depression and anger are endemic in Aboriginal life. On the basis of the research cited here, the restoration of whole health depends on effectively addressing their causes.

Environmental factors

For many years, the focus on high tech medicine and drug therapies to control disease masked the links between the health of the earth and that of its human inhabitants. Recently, however, that relationship has come back into focus. We have come to realize the extent of the damage borne by the natural systems essential to life on earth. We have come to understand that the health of the air, water and soil — not only in our own backyards, but in the vast world to which we are ever more closely connected by global patterns of food and commodity production — matters greatly to our own health.

In addition, the built environment of human communities and shelters has its own health hazards, just as it did in the nineteenth century when the champions of public health first fought for enforceable standards of housing quality, sanitation, and food and drinking water quality. New concerns are the effects of indoor air quality and the conditions leading to accidental injury and death. We discussed environmental health earlier in this chapter. We expect that the great sensitivity of many Aboriginal people to this dimension of well-being will lead to breakthrough ideas and programs in the coming era of Aboriginal self-management in health and wellness.

2.3 Two Great Traditions of Health and Healing

Commissioners see a powerful resonance between the findings of bio-medical researchers and Aboriginal philosophies of health and well-being. Principles of health and healing long held by

indigenous cultures are now being confirmed by scientific research. Penny

Ericson, speaking for the Canadian Association of University Schools of Nursing, made a similar observation:

The current paradigm shift in health care confirms what Aboriginal people have always believed about health and healing. For example, Primary Health Care is the World Health Organization's framework for health care in today's society….The principles of Primary Health Care are similar to those of the Circle of Life or the Medicine Wheel, which have served as a guide for health care for generations of some of Canada's Aboriginal people.

It is powerful for Aboriginal people to realize that one of their traditional approaches to health is now viewed as progressive and crucial by health care educators and policy planners within the United Nations and in Canada. The partnership between consumer and health care worker that underlies the teachings of Primary Health Care ensures a powerful bridge between traditional values and health care initiatives. The interplay of the physical, emotional, social and spiritual for achieving well-being has long been inherent in the Aboriginal health paradigm and is now appearing as a stated value in health care teaching in Canada.

Penny Ericson
Dean of the Faculty of Nursing
University of New Brunswick
Canadian Association of University Schools of Nursing
Moncton, New Brunswick, 14 June 1993

We identified several areas of convergence between Aboriginal concepts of health and those of mainstream health sciences. The first is at the heart of both discourses: the idea that true health comes from the connectedness of human systems, not their separate dynamics.[244] We have already described the Aboriginal concept of the circle that links body, mind, emotions and spirit and each individual to the community and the land in which the human being is rooted. The cumulative research on health determinants agrees. It paints an increasingly complex picture of the impacts on physical health of disturbances in the mind, emotions or spirit. 'Health' is the total effect of vitality in and balance between all life support systems.

The second common theme is the awareness that economic factors (personal and community poverty or comfort) play a particularly important role in determining health. Community living conditions identified as critical by nineteenth-century public health advocates are a vital component of this

thread. We discussed both earlier in the chapter.

A third converging theme is that of personal responsibility. In the health determinants field, this theme has taken two forms. One is the idea that personal health choices matter, and that we can all make a difference to our future health status by stopping smoking, reducing alcohol intake, eating properly, exercising regularly and so on. Added to this is the idea that medically trained experts are not the only ones with insight into health and wellness — that, in fact, the final judge of our well-being can only be ourselves. In the Aboriginal view, collective responsibility is also significant. Many speakers told us that solving health and social problems must become the responsibility of Aboriginal people taking action together, and that individual self-care must be matched by community self-care.

A fourth converging theme is the Aboriginal idea that the essence of good health is balance and harmony within the self and within the social and natural environments we inhabit. This idea is echoed in scientific studies of the role of stress in determining health and illness. Harmony and stress are opposing ends of a continuum: at one end, stress and ill health; at the other, harmony and good health.

A final converging theme is the importance of childhood. We have cited a great deal of evidence that health status, good or bad, begins in childhood — even before birth. The experiences and quality of life of Aboriginal children and youth have long-term implications for health, most dramatically in the case of abnormal birth weight, fetal alcohol syndrome and poverty, but also in relation to accident, injury and disability. Aboriginal people know the importance of a happy and healthy childhood as the foundation for life and of healthy children as the foundation of a people.

One area where convergence is still weak is in relation to the role of spirituality and the connection between people and the natural world. Non-Aboriginal definitions of health are beginning to recognize this dimension; Aboriginal people have always held that spirituality is central to health. Indeed, we were told more than once that, in terms of understanding the human spirit, Aboriginal people and their traditions have much to offer the world:

In the last 20 years there has been an increased effort to understand the psychology of the human being….Western consciousness has now incorporated the mind, body and emotions as critical elements of what it is to be human. Less explored and least understood is the human spirit. Spirituality,

the once-guiding force in the lives of indigenous people and many of the peoples of the world has become a footnote in the lives of [most] human beings….

Many contemporary writers have begun to propose that global change will require transformation of the individual, or a shift of consciousness. The underlying question is: What is the process of transformation and how does it happen within an individual, a community or a nation?…

We know that Indigenous people lived for tens of thousands of years in a spiritually based way of life which was harmonious with all of creation. It is imperative to begin the path of serious exploration of that aspect of ourselves, which can provide the essential transformative process, the healing and renewing of the human being and the earth. I see a day when Indigenous people will be sitting in the position where the white people and other people of the world will come to us and say, “Tell us what to do; tell us how to live on this earth. Tell us how to correct the damage that we have created on this earth.”

The assumption is always that we are the problem, but the truth is that Indigenous people are the solution to what is happening in the world today.

Dave Courchene, Jr.
Mother Earth Spiritual Camp
Fort Alexander, Manitoba, 30 October 1992

Commissioners believe that the convergence of Aboriginal and science-based knowledge presents an exciting and important prospect for Aboriginal and non-Aboriginal people alike. It suggests the possibility of sharing insights and understanding, of building genuine partnerships — and, quite possibly, of transforming human health.[245]

2.4 Characteristics of a New Strategy

One aspect of the work of royal commissions such as ours is to find the root causes of troubling conditions that have defied society’s efforts to improve them. To fulfil this role is to shift the terms of debate about life in Canada so that new energies for collective betterment can be released. We believe this need is nowhere greater than in relation to Aboriginal health and wellness.

According to almost every indicator we have examined, Aboriginal people are

suffering rates of illness and social dysfunction that exceed Canadian norms. The practice of the present system of services is to isolate symptomatic 'problems' — teen pregnancy, diabetes, disability and suicide — and design stand-alone programs to manage each one. In our public hearings, Aboriginal people called this the 'piecemeal' approach to health care. It is not working. Indeed, we have concluded that the business-as-usual approach to services *perpetuates* ill health and social distress among Aboriginal people. However much good a particular health or social program may do in the narrow sphere it addresses, it does not shift the overall picture of Aboriginal disadvantage — the pattern of poverty, powerlessness and despair — that determines health and illness.

The weight of the evidence in this chapter is clear: substantial improvements in the health and welfare of Aboriginal people will not be accomplished by tinkering with existing programs and services. Commissioners believe that to restore well-being to Aboriginal people — and their communities and nations — a major departure from current practice is needed. We have found guidance for this departure in the insights of Aboriginal people, coupled with our analysis of the new determinants of health. We hope to give force to these two powerful strands of thought by establishing and building on their convergence.

The Commission proposes that new Aboriginal health and healing systems should embody four essential characteristics:

• pursuit of equity in access to health and healing services and in health status outcomes;

• holism in approaches to problems and their treatment and prevention;

• Aboriginal authority over health systems and, where feasible, community control over services; and

• diversity in the design of systems and services to accommodate differences in culture and community realities.

Equity

Commissioners believe that, whatever health and healing system is put in place for Aboriginal people, it must deliver services equivalent to those available to other Canadians. Even more important, the system must produce

health outcomes that are at least equivalent to those of other Canadians. Aboriginal people in Canada should not have to experience disproportionate levels of illness and social problems; their experience of whole health and well-being should be at least as good as that of the general population.

The Innu of Labrador

The terms of union under which Newfoundland joined Confederation in 1949 make no mention of Aboriginal peoples. Arrangements for service delivery to the Innu and others were made later, under a series of federal-provincial agreements. Until recently, the government of Newfoundland provided all health, education, welfare and related services, and the federal government contributed 90 per cent of the cost of programs the province chose to deliver. The federal government has now begun to provide direct funding to the Innu for some — but not all — health and social programs.

The Innu have long held that federal refusal to treat them in the same way they treat First Nations registered under the *Indian Act* for purposes of program and service delivery constitutes discrimination, an infringement of their rights as Aboriginal people, and an abrogation of fundamental federal responsibilities. In August 1993, a special investigator appointed by the Canadian Human Rights Commission (CHRC) submitted a report on those allegations to the CHRC.

The special investigator found that the federal government had failed to meet fully its responsibilities to the Innu, allowing the province to intervene in the direct, nation-to-nation relationship. Further, he found that although it is difficult to compare the services available to the Innu with those available elsewhere, past federal-provincial agreements did not provide as high a level of funding as would have been available if the Innu had been registered under the *Indian Act.* As far as today's services are concerned, the investigator compared the provisions made for the Davis Inlet Innu with those made for a First Nation reserve community in Nova Scotia of similar size and in similar circumstances. The Davis Inlet Innu were disadvantaged in a ratio of $2.4 million to $4.1 million.

On these and other grounds, the investigator concluded that the federal government had breached its fiduciary obligations to the Innu. He concluded that government actions were discriminatory, that they

resulted in treatment that was inequitable relative to treatment afforded other Aboriginal people, and that the government failed to act for the benefit of the Innu as is its duty because of its special trust relationship with all Aboriginal peoples. The remedy he proposed was for the federal government to take immediate action to ensure that the Innu are "in the economic, social and spiritual situation they would have been in if government responsibilities had been properly exercised and appropriate human rights standards met".

Source: Donald M. McRae, "Report on the Complaints of the Innu of Labrador to the Canadian Human Rights Commission", 18 August 1993.

Our emphasis on 'outcomes' rather than 'services' is deliberate; equal services do not always deliver equal outcomes. In instances where threats to health are elevated above the norm, or where the causes or consequences of Aboriginal ill health are unique, enriched services are necessary. Enrichment is appropriate where a threat to health is spreading with particular rapidity among Aboriginal people (HIV/AIDS or shigellosis, for example). It is also appropriate where special measures are needed to relieve an outbreak of suicide or high rates of addiction or where a whole community needs to rebuild physically, socially and economically to restore well-being to its people. In the Commission's view, when the burden of ill health is greater than the norm, so too must be the healing response.

Equity, as we use the term, also means equity among Aboriginal peoples. The arbitrary regulations and distinctions that have created unequal health and social service provision depending on a person's status as Indian, Métis or Inuit (and among First Nations, depending on residence onor off-reserve) must be replaced with rules of access that give an equal chance for physical and social health to all Aboriginal peoples. The Innu of Labrador, for example, have long been denied equitable health and social services (see box). Theirs is only one case of inequity among many, but it is a particularly disturbing one because of the severe health risks facing Innu communities.

The present jurisdictional tangle makes some health and social problems almost impossible to solve.[246] For example, the problems of Aboriginal people with disabilities cannot be dealt with by any one level of government in the absence of co-operation from the others. Similarly, action to stop environmental contamination usually involves two if not three levels of government — none of which has sole authority or the motivation to bring about change. In Volume 4, Chapter 7, dealing with urban perspectives, we discuss in detail the

repercussions of divided and disputed jurisdiction as it affects Aboriginal people — and we recommend a solution.

Holism

Restoring health and well-being to Aboriginal people requires services and programs founded on an integrated, or holistic, view of human health.[247] In testimony, we heard a great deal about the fragmentation of services meant to solve interconnected problems. Aboriginal caregivers expressed great frustration because health and social programs are narrowly targeted to specific diseases and social problems, not to whole health. We learned that problem-specific programs may offer nutritional supplements for low birth weight babies but not vocational training for mothers who are too poor to eat properly; inoculations against infectious disease but not the means of cleaning up

contaminated drinking water sources; treatment programs for alcohol addiction but not counselling for the trauma of attending residential school; wheelchairs for people with disabilities but not appropriate housing or jobs; social assistance for those who are unemployed but not life skills education or vocational upgrading.

To be truly effective, Aboriginal health and healing systems must attend to the spiritual, emotional and social aspects of physical health problems and to the physical health aspects of spiritual, emotional and social problems. This entails

- attention to health education and the promotion of self-care;

- changing the conditions in communities and in their environments that contribute to ill health; and

- addressing the social, economic and political conditions that contribute to ill health.

An effective service system will no longer split human problems into separate symptoms and assign them to separate offices to be dealt with in a segmented, disjointed manner. A holistic approach requires that problem solving be comprehensive, co-ordinated and integrated, and that services be flexible enough to respond to the complexity of human needs. Services that affect health outcomes, such as child care and child welfare, education, justice,

recreation and others, must be delivered with reference to health objectives — and vice versa.

The holistic approach to health has been championed by a number of public health and population health experts in Canada and elsewhere for many years.[248] It is also featured in the systems approach to organizations. This kind of thinking has not had much influence on the illness care system, however, which continues to be dominated by specialists. In our view, integrated systems and services must have a central place in redesigned health and healing systems for Aboriginal people.

Control

The Commission believes that Aboriginal health and healing systems must be returned to the control of Aboriginal people. We base our position on three other conclusions reached in our deliberations.

First, we conclude that self-determination for Aboriginal peoples is an immediate necessity. As we discussed at length in Volume 2, the thrust of public policy historically has been to break up independent Aboriginal nations and replace their fully functional institutions (whether of government, justice, health care or any other) with those of Canada. Reclaiming control over health and social services is just one aspect of self-determination more generally.

We also believe, in light of the deep relationship between powerlessness and ill health, that Aboriginal health and healing systems must be returned to Aboriginal control. The evidence shows that people with more power over their life circumstances have better health outcomes and longer lives; we will have more to say about this extremely significant relationship.

Finally, we found overwhelming evidence that control of health and social services by outsiders simply does not produce good results — in any community. All across Canada, non-Aboriginal communities are being given more power over decision making about important services. This is happening in part because of the frequent failure of top-down approaches to community problems, that is, the failure to win support for solutions introduced from the top and failure to generate them from the bottom. Top-down approaches are not responsive to local conditions, priorities, resources and sensitivities; only local people know such things about their communities, and their knowledge is essential to implementing successful programs and services. It is now being acknowledged that centrally controlled programs and services often cost more

because of the administration needed to manage them from afar.

The persistence of ill health and social dysfunction in Aboriginal communities demonstrates that existing services fail to connect with real causes. It is not just that programs and services are based on the norms and values of other cultures (although they often are), or that they are directed by caregivers from other cultures (although they usually are), but that they reflect priorities and timetables developed outside the communities. Today's governments show a greater tendency to consult and work with Aboriginal people. Nevertheless, programs come and go, expand or contract, add new rules and subtract others — all without notice to or approval from the people they are intended to help.

We saw in relation to fetal alcohol syndrome that a former minister of health denied the need for special program support to Aboriginal communities, thus overruling the recommendations of a House of Commons committee based on evidence gathered from Aboriginal people (and others with relevant experience). With regard to pollutants, we saw that Aboriginal people have difficulty proving ill health effects to outside 'experts' who control environmental review processes.

However, we also saw that local control over birthing in one northern community led to an innovative new program with excellent health outcomes for Inuit women in a particular region. We saw that control over the design of diabetes prevention elsewhere led to culture-based materials that increased their effectiveness. We saw that increased control over welfare monies allowed several northern regions to provide support for struggling hunters and trappers (see Volume 2, Chapter 5).

In the words of one leading analyst, community control means that the decision-making processes and organizational structures within a community are especially designed to give all members of a community the power and means to manage their own affairs. Since society is primarily organized on a top-down basis, community control will necessarily require a transformation from hierarchical to non-hierarchical structures so as to allow for the maximum participation by community members in the decision making and development process.[249]

But control does not apply only at the level of the community. It applies at the level of the individual, and in the case of Aboriginal people, at the level of the nation. In Volume 2, we discussed the nation-to-nation relationship needed between Aboriginal and non-Aboriginal governments in Canada. In practice,

Aboriginal nations and their people will decide for themselves how to allocate authority and responsibility for programs and services, in keeping with their political cultures and traditions.

Diversity

We believe that health and healing systems for Aboriginal people should be free to diverge — as far as their users want them to — from the bio-medical and social welfare models that predominate in non-Aboriginal society. Aboriginal communities should also be free to diverge from one another. With this flexibility, they will be able to reflect Aboriginal cultures and traditions generally, the preferences of each Aboriginal culture specifically, and the diversity of local and regional conditions and priorities.

As we have seen, there are important differences between Aboriginal and non-Aboriginal approaches to health and healing, as well as among and within Aboriginal cultures and communities themselves. Any system that fails to recognize this diversity, or fails to offer sufficient scope for it, cannot be fully effective. Culturally appropriate program design and delivery is not a frill to be tacked on to health care and social services; it must be at the heart of generating well-being in any community. Programs must be designed and delivered by people familiar with the language and traditions of the community. It also means that a variety of health and healing strategies, including those of traditional medicine, must be made available so that the needs of everyone seeking care can be met.

We have already discussed some of the features and unique qualities of Aboriginal perspectives on health and healing. One of the means by which they will be given full expression in new health and social service systems is through the encouragement of traditional healers and healing methods. This important topic is explored more fully in Appendix 3A.

Aboriginal people must be recognized as the experts on their own health and healing needs. As they take charge of their own systems of care, and as those systems emerge and develop, they may look similar to the systems evolving in non-Aboriginal communities — or they may look very different. The differences are as worthy of respect as the similarities.

Conclusion

A new approach to Aboriginal healing that embodies the characteristics of equity, holism, Aboriginal control and diversity, has the power to do what the present system cannot: to go beyond services to focus on whole health. It will break down restrictive program boundaries to focus on healing, not just for individuals but for communities and nations. It will restore a focus on aspects of well-being that are lost in the current system: child and maternal health, health promotion and education for self-care, social and emotional health, the jurisdictional issues that block the way to health problem solving for all Aboriginal peoples. It will blend the insights of traditional and contemporary Aboriginal analysis with the emerging analysis of the determinants of health. It will honour the needs, values and traditions of those it serves.

The four characteristics of a new health policy — equity, holism, Aboriginal control, and diversity — are interdependent and mutually reinforcing. Only if taken together will they provide the basis for Aboriginal and non-Aboriginal people, working together, to construct the transformed health and healing systems that Aboriginal people have said they want and that all the evidence at our disposal says they need.

Recommendation

The Commission recommends that

3.3.1

Aboriginal, federal, provincial and territorial governments, in developing policy to support health, acknowledge the common understanding of the determinants of health found in Aboriginal traditions and health sciences and endorse the fundamental importance of

• holism, that is, attention to whole persons in their total environment;

• equity, that is, equitable access to the means of achieving health and rough equality of outcomes in health status;

• control by Aboriginal people of the lifestyle choices, institutional services and environmental conditions that support health; and

• diversity, that is, accommodation of the cultures and histories of First Nations, Inuit and Métis people that make them distinctive within Canadian society and

that distinguish them from one another.

The challenge is to begin now to construct new approaches to restore and sustain Aboriginal well-being on the foundation of analysis and hope laid down in the preceding pages.

3. An Aboriginal Health and Healing Strategy

3.1 Initiating Systematic Change

The essential characteristics of a new approach to enhancing and sustaining Aboriginal health are holism, equity, Aboriginal control and diversity. These concepts are goals to strive for and guidelines for action. However, concepts in the abstract are not sufficient to change reality. They must be translated into purposeful action capable of engaging the energy and commitment of those with a stake in better Aboriginal health — the Aboriginal community and Canadian society.

While health is not the outcome of services alone, the failure of services is a serious impediment to the achievement of well-being. Later in this chapter, we return to the issue of where health services fit in our proposed agenda for change. Our focus now is on strategies specific to health and social services.

Over the past two decades, many changes have extended services to Aboriginal people and made them more accessible and appropriate, especially for groups designated for federal government attention. We wish to acknowledge and applaud the efforts made to date. However, without a major reorientation of effort, the persistent problems illustrated in this chapter will continue to exact an enormous toll on the well-being of Aboriginal people, sapping the energies of Aboriginal nations and consuming the resources of the public purse. Far from abating, problems in some areas show disturbing prospects of becoming worse.

In devising an integrated health strategy, we looked to the goals and guidelines that emerged from our analysis. We considered criteria of efficiency and effectiveness that should be applied to any public program and that are especially important in times of fiscal restraint. We considered the huge and complex network of health and social institutions now in place — we are not beginning with a blank slate. We also considered that the urgency of immediate action on pressing concerns should be consistent with efforts to achieve self-

government and self-reliance, which will proceed in parallel with service reorganization.

The strategy we propose has four parts that complement and support one another:

1. the reorganization of health and social service delivery through a system of healing centres and lodges under Aboriginal control;

2. an Aboriginal human resources development strategy;

3. adaptation of mainstream service, training and professional systems to affirm the participation of Aboriginal people as individuals and collectives in Canadian life and to collaborate with Aboriginal institutions; and

4. initiation of an Aboriginal infrastructure program to address the most pressing problems related to clean water, safe waste management, and adequate housing.

The first part, and the one that will require the most significant reorganization of effort, is the restructuring of health and social service delivery through healing centres under the control of Aboriginal people. The concept of healing centres was brought forward by presenters in many parts of the country, either explicitly in requests for support of particular centres or implicitly in the plea for a place where health and social needs could be addressed holistically. Local centres for integrated health and social services are not a new idea. They have been introduced in Quebec and are part of current plans for service reorganization in Alberta and the Northwest Territories. Aboriginal healing centres would build on the strengths of current programs while reorienting services to correspond to the goals and guidelines we consider essential to an Aboriginal health strategy.

They could bring together resources to support families, monitor health, devise education programs to promote healthful living, make referrals or facilitate access to specialist services, emphasize priorities specific to the nation or community, and be larger or smaller depending on the population served. With the realistic possibility of influencing the way needs are met, local ownership and involvement in health initiatives could replace the present sense of powerlessness and alienation many Aboriginal people feel. Policy, planning and administrative experience gained through direct service, local boards and regional policy-making bodies could contribute significantly to the development

of institutions of self-government. Given the urgency of some of the needs we encountered in our investigation, the implementation of health and healing centres should not await the structural change in public institutions proposed in Volume 2 of our report. With the will to abandon fruitless debates about who is responsible, federal and provincial governments could begin now to co-operate with Aboriginal administrations and organizations to transform a fragmented and inefficient service delivery system, to fill gaps where localities and populations have been neglected, and to modify services to make them more appropriate to the needs of Aboriginal people.

The second part of our strategy is the mobilization and training of Aboriginal personnel through a major human resources development effort. Aboriginal control of human services is necessary because control over one's situation is a major determinant of health. In addition, only Aboriginal people can mobilize the capacity for self-care and mutual aid that is an essential complement to professional services. Only they can make effective decisions about the interventions that will make them well in body and spirit.

Preparation of personnel as planners, administrators, front-line workers and evaluators will be a significant part of the challenge of implementing self-government. The human resources development plan we set out here thus forms an important complement to our proposals for capacity building in Volume 2, Chapter 3 and our proposals for education and training in Volume 2, Chapter 5, and Chapter 5 of the present volume.

Part of the human resources requirement is to train personnel to develop distinct Aboriginal institutions and apply Aboriginal knowledge in unique ways. Another part is to involve Aboriginal people in mainstream service institutions as managers, professionals and informed consumers so that the Aboriginal presence in Canadian life becomes recognized and affirmed.

The third part of our strategy is the adaptation of Canadian institutions engaged in the delivery of health and social services. While Aboriginal institutions operating under the jurisdiction of Aboriginal governments form a significant part of the future we foresee for health and social services, they cannot occupy the whole field. They will predominate, most likely, in territories where institutions of self-government are established. Distinct institutions might also emerge to serve communities of interest in urban locations where substantial concentrations of Aboriginal people come together for recognition as self-governing entities. However, Aboriginal institutions cannot operate in isolation from the mainstream. Access to provincial medicare is just one example of an

area where co-operation between Aboriginal and mainstream institutions will be necessary. Others include billing of physicians' services, referrals between healing centres and hospitals, admissions and discharges, and co-ordination of auxiliary and home care services. Aboriginal people will continue to move between their home territories and towns and cities, and they should be able to have their culture and identity recognized and affirmed in interactions with mainstream institutions. These institutions also need to aid in the development of Aboriginal institutions by providing back-up and specialist services, mentoring and support for Aboriginal personnel.

The fourth part of our proposed strategy is an infrastructure program, concentrated in the first 10 years following the release of our report, to raise housing, water supply and waste management in Aboriginal communities to generally accepted Canadian standards of health and safety. Immediate threats resulting from inadequate infrastructure are so serious and so devastating that solutions cannot await the development of new partnerships or reformed service delivery systems. Such problems undermine the ability of Aboriginal nations to organize for their own future, and they ravage the spirit of individuals and whole communities. Details of a carefully targeted and adequately funded housing and infrastructure initiative are developed in Chapter 4 of this volume.

By focusing on policy in the social sector we do not wish to imply that the health and well-being of Aboriginal people in Canada can be secured solely by changing how health and social services are organized and delivered. While reorienting existing systems is important, health and social conditions must also be understood as natural by-products of a safe and healthy environment, economic self-reliance and the empowerment of individuals and nations. They are not determined by the range and quality of services alone.

Those involved in political, economic and other fields often fail to recognize that what they do is intimately bound up with the health of individuals and peoples. We believe that a stronger recognition of the interconnections between various fields is required and that positive health outcomes should be a consideration of all those involved in Aboriginal institutional development and self-determination.

Given the present distribution of authority and responsibility for health and social services, implementation of our proposed integrated strategy will require action on the part of federal, provincial and territorial governments. Since health is central to maintaining the well-being, identity and culture of Aboriginal

peoples, we believe that it falls within the core area where Aboriginal governments can exercise law-making powers on their own initiative. We anticipate that health and social services will be among the policy sectors where Aboriginal nations will wish to exercise authority at an early date. There will also be a practical need to harmonize Aboriginal service systems with those in adjacent jurisdictions.

It is essential to establish the environment within which changes can proceed, to ensure that health concerns are given appropriate attention in policy and institutional development, and to endorse the characteristics that we propose are essential to a new service system.

Recommendations

The Commission recommends that

3.3.2

Governments recognize that the health of a people is a matter of vital concern to its life, welfare, identity and culture and is therefore a core area for the exercise of self-government by Aboriginal nations.

3.3.3

Governments act promptly to

(a) conclude agreements recognizing their respective jurisdictions in areas touching directly on Aboriginal health;

(b) agree on appropriate arrangements for funding health services under Aboriginal jurisdiction; and

(c) establish a framework, until institutions of Aboriginal self-government exist, whereby agencies mandated by Aboriginal governments or identified by Aboriginal organizations or communities can deliver health and social services operating under provincial or territorial jurisdiction.

3.3.4

Governments, in formulating policy in social, economic or political spheres, give

foremost consideration to the impact of such policies on the physical, social, emotional and spiritual health of Aboriginal citizens, and on their capacity to participate in the life of their communities and Canadian society as a whole.

3.3.5

Governments and organizations collaborate in carrying out a comprehensive action plan on Aboriginal health and social conditions, consisting of the following components:

(a) development of a system of Aboriginal healing centres and healing lodges under Aboriginal control as the prime units of holistic and culture-based health and wellness services;

(b) development of Aboriginal human resources compatible with the new system, its values and assumptions;

(c) full and active support of mainstream health and social service authorities and providers in meeting the health and healing goals of Aboriginal people; and

(d) implementation of an Aboriginal community infrastructure development program to address the most immediate health threats in Aboriginal communities, including the provision of clean water, basic sanitation facilities, and safe housing.

3.2 Healing Centres

A snapshot of community services

It is 10 a.m. on a Monday morning in a remote First Nation of about 750 people. In one building, sometimes described as a health centre, but usually referred to by the historical term, nursing station, two non-Aboriginal nurses prepare to see the first of their clinic patients: one, a young mother with a cranky child, and the other, an elderly woman in obvious pain. The elderly woman is telling the clerk-interpreter, who is from the community, that the pain started the previous evening but she was unable to get relief because the clinic was closed. Her manner is mild, but it is clear that she sees the rigidity of the schedule as an indication of lack of concern on the part of the nurses. Although the clerk-interpreter is nodding in sympathy, she will not report this

conversation to the nurses, largely because neither has been in the community for more than a month.

In another examining room down the hall, a young male non-Aboriginal physician looks through the chart of his first patient of the day, a young man injured in an accident over the weekend. The physician arrived in the community for the first time an hour ago by aircraft and will return in three days to his home in the city after seeing nearly a hundred people for problems ranging from attempted suicide to diabetes to otitis media.

Across town in the band office, the community health representative, a local woman who has done this job for 20 years, prepares her equipment to collect water samples from several buildings in town. These she will mail to the provincial testing facility several hundred miles to the south. She will wait several weeks for the results. After lunch she plans to visit the homes of several elderly people in town to check their medication and provide foot care.

Across from the band office, an Aboriginal social worker who moved here two months ago and is originally from a reserve in another province reviews the client file of a young mother who is seeking supplementary welfare benefits. Her aunt from another community has joined the household recently in preparation for the time, a few weeks hence, when the mother will have to leave her older children to have her baby in a distant city. The aunt will provide child care, but her presence over-taxes the family's budget, because the family's only income is the minimum wage that the husband earns on a temporary employment project sponsored by the band council.

Later that day, in a partially renovated house in the oldest part of town, several older women and one elderly man are gathering for a meeting of the alcohol committee. Waiting for them is a middle-aged man who returned to the community several years ago after recovering from nearly a decade of alcohol abuse. He is now the local National Native Alcohol and Drug Abuse Program (NNADAP) worker and responsible for providing counselling to individuals with alcohol abuse problems in the community. The purpose of the meeting is to discuss preparations for the upcoming visit of several Aboriginal people from a church group on a reserve in another province who have developed a healing strategy for survivors of sexual abuse. Neither the meeting nor the upcoming workshop will be reported in any of the committee's records, because the funding policy for NNADAP activities is restricted to substance abuse problems.

Several miles out of town, a middle-aged man splits wood for the ceremonial

fire he will need to run his sweat lodge at sundown, while his 11-year-old son watches and helps. Later, he will collect some roots from a plant that grows near the nursing station and grind them into a poultice for a young woman suffering from a skin rash. He is thinking about two of the people who have asked for the sweat lodge: one recently returned from a provincial jail who wants to obtain a traditional name, and the other, a young man from an abusive family who recently attempted suicide after a long bout with solvent abuse.

In the history of this community, these service providers have never sat down together in one room to discuss their work or the needs of their clients. On occasion, the nurses might meet with other non-Aboriginal workers in the community, such as RCMP officers or teachers, to discuss community problems, but these meetings rarely produce integrated action plans. Furthermore, local administrators of housing, economic development and municipal services rarely discuss their responsibilities in relation to health issues.

There are many variations on the scenes described. Larger communities might have resident physicians; smaller communities might have only a community health representative supported by visiting nurses. Reserves and communities near larger towns or cities, on road systems, or in the southern parts of provinces may rely more heavily on service providers external to the community. In rural Métis communities and in many small towns with a substantial non-status Aboriginal population, there is a virtual service vacuum. Such communities often have to rely on provincial services that are geographically distant and culturally inappropriate and over which they have little influence. In cities there is a wide variety of services, but they rarely recognize the distinct social and cultural needs of Aboriginal clients.

Table 3.13

Comparison of Current and Proposed Approaches to Community Health Care

Current Approach to Community Health Care	Proposed Approach to Community Healing and Wellness

Historically grounded in infectious disease public health model	Oriented to health promotion framework encompassing spiritual, social, psychological and physical illness
Dominated by biomedical approach to treatment and care	Based on holistic, culturally appropriate understanding of illness
Hierarchical in the structure with professional expertise as determining factor	Consensual in structure, applying expertise indigenous to the patient and community
Segregation of program activities by discipline and/ or bureaucratic reference	Integration of program activities to reflect holistic perspective
Program-specific funding within that narrow definition of health	Block funding of healing centers under federal or provincial jurisdiction; intergovernmental transfers for centers under Aboriginal jurisdiction; permits program activity based on holistic understanding of health
Program and service providers accountable to authorities external to community	Programs and service providers function under Aboriginal jurisdiction, with accountability to the community served
Health research developed externally and divorced from community planning and priorities	Health research generated to respond to self identified needs of the nation and community
Health-care system encourages transfer of clients out of community to non---Aboriginal institutions	Health-care system encourages providing services to clients at home, in community or in regional Aboriginal institution

Services in these various settings have been undergoing change, as we will discuss, but for the most part they have common characteristics that are summarized in Table 3.13 and that contrast with the holistic and culture-based health and wellness services we propose. Transforming the present system into an effective Aboriginal system can best be accomplished by developing a network of healing centres and healing lodges. We begin the rationale for our proposal with a description of the kind of agency we propose.

Healing centres

Community health centres or local service centres, as they are sometimes

called, are designed to overcome the fragmentation of service delivery for social needs that are interrelated, whether in Aboriginal or non-Aboriginal communities. Different programs for income support, child protection, mental health and home care have evolved separately, often through different departments of government. In cities and towns, government services are often supplemented by voluntary or religious organizations supported by fundraising campaigns. Health centres operating in some provinces are intended to co-ordinate and integrate the different services, so as to avoid duplication or conflict. The range of services available, however, is determined by the agencies involved.

The holistic approach advocated by Aboriginal people goes further. It proposes that services be defined by the needs and situation of the person seeking help. For example, if the health problem presented is an infant's diaper rash, the need could be for an adequate water supply to do laundry; a holistic service would respond accordingly. A redefinition of services is needed to fill the gaps in the current system of delivery.

Aboriginal people speaking at our hearings made a distinction between a healing centre that adopts a holistic approach and a health centre dedicated to reacting to specific problems.

What I would like to see happening is more healing centres — not treatment centres but healing centres; there are a lot of treatment centres around — established within our own community and the urban centres as well, for young people….We have a lot of treatment centres and a lot of detox centres. And yes, I am talking about a physical building, a healing centre where people can go and go through the processes. Once you take the symptom away — and by the symptom I mean alcohol, drugs — then you have to deal with the root of the problem, because all those other abuses, substance and chemicals, they are a symptom of a much larger problem.

Cindy Sparvier
Social Worker, Joe Duquette High School
Saskatoon, Saskatchewan, 27 October 1992

A treatment centre, [in] my version of what it means to me…is basically for treatment for addictions. A healing centre is to heal oneself and provide healing for others, I guess, on a more personal basis, instead of addictions to drugs and alcohol, that could take in sexual abuse.

Della Maguire
Drug and Alcohol Counsellor,
MicMac Native Friendship Centre
Halifax, Nova Scotia, 4 November 1992

We use the term healing centre in this discussion as a symbol for the approach we are recommending. Presenters used different terms, and Métis people and Inuit may choose other words to describe the resources that we have in mind. The features of such centres were elaborated in presentations made to us.

Community healing centres should be based on traditional Aboriginal concepts of holistic health. While services might differ from community to community, depending on the size and particular needs and priorities of the community, the centres should provide a comprehensive range that might include services usually associated with a medical clinic (for example, basic assessment, preventive, curative, rehabilitative and emergency services). They might also provide child and family support services, addiction and mental health services, and income support and employment services. Many of the presentations described the broad dimensions that a healing centre should encompass:

The healing house could also be used as a gathering place for: support groups of our elders, adult day programs, social assistance recipients; Al-Anon, Alateen and Alcoholics Anonymous, alcohol and drug counsellors; [programs to end] domestic violence; teen programs, elder programs, men's and women's groups; offenders, long-term care; diabetic programs, women's clinics, AIDS education; [education programs on] fetal alcohol effect and syndrome, eating disorders; homemakers, public and long-term care nurses; general workshops on self-esteem…people returning from treatment centres; art and play therapy; positive Indian parenting programs, healthy baby programs, pre- and post-natal.

Mary Anne Wilson
Community Health Representative, Skidegate Caregivers
Prince Rupert, British Columbia, 26 May 1993

Community healing centres would play an important role in providing traditional healing and other culture-based programs. In some cases, traditional healers might wish to use the centre as a place to meet with clients; in others, the centre might refer clients to the healers. In all cases, however, the philosophical approach of the healing centre would be based on the cultural understanding of health in a particular community. In this way, it would provide an important forum for exploring how Aboriginal and western approaches could

work together to meet Aboriginal community needs.

To provide the range of services we have discussed, a team approach would be required. Traditional healers, elders, community health representatives, medical interpreters, nurses, addiction counsellors, midwives, therapists, social workers, doctors, psychologists, rehabilitation specialists and support staff might all be required, depending on the circumstances of the community. Aboriginal personnel employed currently in health and social services usually fill front-line positions defined as 'paraprofessional', for example, community health representatives and NNADAP positions. Some senior personnel are Aboriginal, but professional positions are filled predominantly by non-Aboriginal persons who come and go with unsettling frequency. Preparing Aboriginal personnel to staff healing centres is essential to provide the continuity of service and cultural sensitivity central to the strategy. The centres could play an important role in human resources development by providing training and education opportunities for community members, in collaboration with other Aboriginal and non-Aboriginal educational institutions.

In small communities, some of the more specialized service providers would not be required full-time. We foresee a regional system where more specialized staff would reside in one or two of the larger communities and be available to residents in smaller communities on a regular visiting basis. They would be responsible for developing in-service holistic training strategies for general staff such as community health representatives and community health nurses to enhance the range of skills.

We propose that healing centres deliver community-based services. We believe that a strong emphasis on community-based care would reduce the need for institution-based care. Indeed, we have learned from the example of some First Nation communities that have developed holistic, community-based healing services that this view is correct.[250] One of the main reasons for promoting community-based solutions is that most people want services to be provided in their own homes and communities.

Healing centres would provide the point of first contact for members of the community and they would be responsible for providing general care services to meet most community needs. If services could not be provided by the staff of the centre, appropriate arrangements would be made by the staff on behalf of the client. For example, this case management function might involve arranging for specialists to come to the community. In addition, staff would have a role in liaison with agencies and experts outside the community to ensure that orderly

access to needed services was assured. The centre, however, would retain overall responsibility for co-ordinating and integrating services to members of the community.

The development of services under Aboriginal control will also make the revitalization of traditional modes of helping more feasible. In Chapter 2 of this volume we talked about the helping networks based on reciprocal responsibility and mutual obligation that functioned in small kin-based societies. These networks still exist in many rural and reserve communities and they hold the promise of reinstating mutual aid for many needs, including in-family or customary care to replace formal foster home placement of children in need of care outside their nuclear family. They also seem particularly suited to reintegrating into communities street youth who are angry and disillusioned with the failure of conventional authoritarian service agencies.

While community healing centres would have an important service delivery role, we see them as having other important functions. These might include

• providing public education about health and healing;

• promoting community involvement in health and healing;

• promoting healthy lifestyles in Aboriginal communities;

• assessing local health and healing needs and contributing to health research on a broader basis;

• participating in local and regional planning;

• collaborating with other programs and agencies on primary prevention strategies (for example, those related to potable water, safe sewer systems or adequate housing);

• providing education and training opportunities for community members, especially youth exploring career options; and

• liaison with Aboriginal and non-Aboriginal health and healing organizations outside the community.

The role of community healing centres in participatory research and planning is

particularly important. Centres should have the capacity to monitor the health status of the community; conduct needs assessments; investigate the causes of ill health in Aboriginal communities; evaluate the effectiveness of programs and services; and develop plans and programs for addressing community priorities. In other words, they should play an important role in developing holistic health strategies. Without this capacity, centres could easily become preoccupied with treating symptoms of ill health.

While we have referred to community healing 'centres' throughout the discussion, what we have in mind does not necessarily require the construction of a new building. While the centre, or some of its programs, might be housed in a dedicated health and healing facility, some programs might not require a building at all. In some presentations made to the Commission, healing centres were envisioned in the context of community centres or urban friendship centres:

I consider it imperative that we institute immediate action to improve on the delivery of services from community centres irrespective of the location on- or off-reserve. When I look at community centres, I see places which were once our traditional gathering places. The gathering fire was the hub of the community; from this place all other activity evolved. I believe that a significant effort needs to be put into making our community centres into living community centres again, community centres which are a continuous beehive of activity, day and night. That whenever people desire to, or need to gather by the fire it will be there. No one need ever be alone and helpless again.

I realize that some people might scoff at this notion and ask where all the money will come from to run such a facility. Money is only a part of the solution. I say that it takes more than wood to build a strong fire, it must also have great spirit. Great leadership is also necessary to keep the fires burning brightly.

In conclusion, it is my opinion that some of the solutions to the process of healing lie in building strong, purposeful gathering places. That community centres, where they exist, can be strengthened to provide comprehensive health care services which stem from traditional practices and which incorporate western medical know-how. We can best address the issues of healing from those places in the centre of our communities.

Yvon Lamarche, RN
Treatment Co-ordinator,
Georgian Bay Friendship Centre

Orillia, Ontario, 13 May 1993

I am proud to say the Prince George Native Friendship Centre is one of the organizations using the holistic approach as a driving force behind any strategies or interventions we develop on behalf of our constituents. This one-stop shopping approach ensures we can provide services to the entire family in all areas of their lives.

Representation on this committee is from the Carrier-Sekani Tribal Council, the friendship centre, United Native Nations, and the Métis community. Although this committee is still in its infancy…we have been successful just because we have started to communicate.

Dan George
Prince George Native Friendship Centre
Prince George, British Columbia, 31 May 1993

Our community-centred approach reflects the following four philosophies: holistic learning, empowerment, relevance and healing.

Mary Clifford
Director, Health Services,
Prince George Native Friendship Centre
Prince George, British Columbia, 31 May 1993

Some services could be delivered from a number of different sites. Each community will require its own tailor-made solution. However, we wish to underscore the importance of integrating the delivery of services, whatever the physical arrangements for housing them might be.

Healing lodges

To complement the work of community-based healing centres we propose that a network of healing lodges be developed for residential treatment oriented to family and community healing. We are acutely aware of the need for facilities that can provide both treatment and lodging for the many people who become overwhelmed by social, emotional and spiritual problems. There has been a significant development of Aboriginal treatment facilities under the NNADAP program, with approximately 50 treatment facilities currently planned or in operation, and there are some outstanding examples of Aboriginal residential treatment facilities. The Nechi Institute and Poundmaker's Lodge in Alberta, for

example, both have an excellent reputation for training counsellors and treating addictions. Yet most First Nations people and Inuit suffering from addictions and substance abuse continue to receive treatment in urban medical facilities, isolated from their communities and cultures. Existing healing lodges are also constrained by narrow funding policies that focus on individual therapy for substance abuse and exclude broader social, emotional and spiritual approaches to healing.

Although we regard the community healing centre as the foundation for transforming the health and social services system, we heard from many presenters that residential healing lodges are also required as ‘safe havens’ for individuals and families who require some respite from community pressures when they commence their healing journey. Some of our presenters articulated the need for lodges situated in the community:

We need to do after-care and build after-care resources on the bands to deal with First Nations people coming now, but at the same time we still need a family-oriented treatment centre, so that I don’t think it’s an either/or situation. I think there is a very great need for both of them.

Sara Williams
Native Outpatient Centre
Meysncut Counselling Centre
Merritt, British Columbia, 5 November 1992

Commissioners also heard that there are a variety of needs for residential treatment and that they cannot always be accommodated in one facility. In some regions, shelters for women who are survivors of domestic violence are urgently needed so that they are not forced to leave children behind and relocate in distant urban centres. It would be inappropriate to expect women in abusive relationships to receive treatment in the same facility as their husbands. Young people might also require a specialized facility where peer counselling could be provided. Young people who are detached from stable families or who have become enmeshed in street life need safe places where they can learn to build connections with caring people. Our proposal respects these diverse and specialized needs, and we urge federal and provincial governments and Aboriginal organizations to ensure that adequate facilities are available.

We also heard that healing approaches that focus on the individual might not meet the needs of Aboriginal families, who require an approach that helps them

with the difficult task of rebuilding a healthy family unit. Indeed, we heard that individual approaches to treatment are sometimes as destructive as the historical forces that have created many of the problems, because they continue to isolate the individual from the family. A major concern is the situation where an individual receives treatment and then is forced to return to a dysfunctional family where problems are perpetuated.

As described in Chapter 2, the family is the core institution of Aboriginal society. It is central to all social needs, including governance, economy, education and healing. The Aboriginal view of the significance and centrality of the family is different from non-Aboriginal views, which recognize the importance of the family but often give precedence to individual rights and autonomy over family ties and obligations.

For this reason we propose that Aboriginal communities be given the necessary resources to expand the availability of family-oriented healing lodges. This proposal should not inhibit the continued development of more specialized healing facilities or the continued modification of non-Aboriginal services to meet Aboriginal needs. However, since few family-oriented healing lodges currently exist in the country, emphasis should be placed on developing these important facilities to complement the work of community healing centres.

One example of a family-oriented healing lodge was described in a presentation from the Rama First Nation, where the idea of locating these lodges away from communities was promoted:

During the past couple of days you have heard some of our speakers talk about and support the healing lodge. Our dream of a Native way of healing. For the past few years the Rama and Area Native Women's Association have had a vision — our own healing lodge located on the Chippewas of Rama First Nation.

At present, there are no Native treatment centres in any of the United Indian Council or tribal council areas. Non-Native treatment centres have little or no knowledge of Native traditional healing methods. As a result, very few Native people, if any, will attend non-Native treatment centres; therefore there is no progress in the healing process and the cycle continues, be it physical, sexual or emotional abuse — not to mention alcohol or substance abuse.

We must have our own healing lodge [which would ideally take] a holistic

approach to healing for all family members including extended families. The tragic cycle that many Native families find themselves in will not be broken until we can implement our own healing methods with a facility Native people will have a trust in and feel comfortable in…with our healers, our own elders, our own language, our own treatment centre where we will not be judged because we are different but will be accepted and respected for who we are. This will surely promote the trust needed to enhance our motivation to wellness as well as instill pride in our people and our traditional way of life.

The Chippewas of Rama First Nation has agreed to allocate the land for a healing lodge — a…quiet, peaceful location near the woods and the lake, and at the same time not far from our population. We must have this facility funded. As it has already been said, we have the resources; we just want to use them. We no longer want to feel like we are getting something for nothing. A dollar value is placed on everything Aboriginal people propose to do. We no longer want to feel that we are accepting charity. We must be able to feel that we are accepting our own fair share for all that we have lost. Also, we no longer want to feel that we are a burden to the taxpayers as wards of the Crown.

I don't want to dwell on things past because the past is gone, but my own son committed suicide at the age of 20 years. Last summer my sister died of alcoholism. There are many such stories as these. With our own treatment centre, perhaps some of these tragedies can be avoided. My parents were both alcoholics. We had nowhere they could accept treatment, so the cycle continued.

Until we can achieve our own on-reserve holistic healing lodge, our people will continue on the destructive path of family violence, of substance abuse, of suicides, of identity lost as well as the loss of our language and traditional values.

Joan Simcoe
President, Rama and Area Native Women's Association
Orillia, Ontario, 14 May 1993

The Gwich'in Tribal Council is using $1 million of its land claim settlement to develop the Tl'oondih Healing Camp on the Peel River, 28 miles from Fort McPherson. The camp will provide a residential 42-day substance abuse program for entire families. The healing program will rely on a mixture of traditional and modern treatment methods and involve a two-year program of follow-up counselling once families return to their communities.

Another model that could be adapted to place more emphasis on family-oriented healing is the Strong Earth Woman Lodge in Manitoba:

There is one thing that stays with us as Native people, one strength, and that is the power that comes from the Creator, the power and the strength of the traditional teachings. What we have done at Traverse Bay, together with people from this Sagkeeng First Nation, we have together built the Strong Earth Woman Lodge….

The Strong Earth Woman Lodge is a holistic healing centre based on Native spirituality and traditional teachings. Holistic healing is the healing of the mind, body, emotions and spirit. Traditionally, this is done through sweat lodges, fasting, vision quests, herbal medicines, ceremonial healing with the eagle fan and rattles, in which sacred songs and the drum are key components; traditional teachings at the sacred fire; sharing circles; individualized counselling; and guidance and direction through traditional teachings.

The Strong Earth Woman Lodge incorporates any or all of these into an individualized program based on the needs of each client. All clients are instructed in the seven sacred teachings and are encouraged to seek understanding of the four elements — fire, earth, water and air — and the four directions. The seven sacred teachings are respect, love, courage, humility, honesty, wisdom and truth. These teachings are carried by the spirits of the Buffalo, Eagle, Bear, Wolf, Sabe, which is the Giant, Beaver and Turtle respectively.

The Strong Earth Woman Lodge offers 24-hour care service towards holistic healing for grieving, loss of identity and suicide crisis intervention. Native spirituality fills the spiritual vacuum in the lives of people traumatized by residential schools and allows clients to find healing for sexual, emotional, mental and physical abuses. Strong Earth Woman Lodge is also a place for Native people just wanting to learn their culture. Although the lodge is based on Native spirituality, we welcome people from all faiths and from all nations. The recommended lengths of stay are four-, eight-, or twelve-day periods or as required.

The lodge is located on traditionally sacred grounds 70 miles northeast of Winnipeg and is run by Native women and men under the direction of the Creator.

Connie Eyolfson
Strong Earth Woman Lodge
Fort Alexander, Manitoba, 30 October 1992

The development of healing centres and healing lodges can begin now, with a commitment from federal, provincial and territorial governments to collaborate with Aboriginal community governments and organizations to make room for systematic change.

Recommendation

The Commission recommends that

3.3.6

Federal, provincial and territorial governments collaborate with Aboriginal nations, organizations or communities, as appropriate, to

(a) develop a system of healing centres to provide direct services, referral and access to specialist services;

(b) develop a network of healing lodges to provide residential services oriented to family and community healing;

(c) develop and operate healing centres and lodges under Aboriginal control;

(d) mandate healing centres and lodges to provide integrated health and social services in culturally appropriate forms; and

(e) make the service network available to First Nations, Inuit and Métis communities, in rural and urban settings, on an equitable basis.

Transforming the service system

The current array of services

As we begin to imagine the contours of a system of healing centres and lodges, it is important to remember that we are not starting with a blank slate. There is a large and complex array of services supported by federal and provincial governments that Aboriginal communities and service personnel have modified

to some extent to fit their needs. However, control of these services continues to be vested in external agencies and bureaucracies; narrow programmatic interests frustrate attempts to organize holistic responses to need; and variations in available services reflect systematic inequities rather than adaptations to community diversity.

Reserves and Inuit communities benefit from federal support of targeted health and social services. In 1994, Health Canada spent nearly one billion dollars on health care for people living on-reserve and in Inuit communities. In addition to providing non-insured health benefits, these funds supported various facilities described as health stations, nursing stations and health centres in more than 500 reserves and Inuit communities. Virtually all reserves and Inuit communities have similar facilities. Only communities with very small populations (under 100) do not have a health facility with permanent staff. These facilities are usually staffed by nurses and community health representatives (CHRs) and supported by family physicians and other specialists who visit the community periodically. Almost all CHRs and an increasing number of nurses are Aboriginal. In principle, at least, they provide a combination of primary care, public health and health promotion services to all community residents.

The federal government also supports some 50 residential treatment centres and seven hospitals scattered across the provinces, providing services almost exclusively to First Nations and Inuit patients. Many of the treatment centres are located within First Nations' territories. They are staffed largely by Aboriginal people and incorporate many of the principles of holistic, culturally based healing that we have described.

Many of the community health facilities were constructed in the 1970s or earlier. They range from old and decrepit clinics with limited capacity to provide a healing program, to modern, fully equipped health centres with an excellent capacity for primary medical care and general public health programs. In addition to requiring general renovation to meet contemporary standards, older facilities are crowded and unable to provide an expanded range of healing programs. For example, a representative of the Skidegate Caregivers' Society, speaking in Prince Rupert, British Columbia, described her community's problem with inadequate facilities:

Skidegate has been successful in obtaining funds to address some of our health and social needs but is facing the problem of finding space. Our health centre and band office are inadequate to serve a safe, therapeutic, culturally

sensitive program. There are no other rental spaces available in Skidegate and, as a result, we have had to rent facilities off-reserve….

The health centre was built close to 20 years now and there is room for two CHRs, a nurse and maybe a doctor's clinic. It's in a trailer and the walls are not even — it's not a good place for counselling.

When we hold workshops, we rent whatever space is available — the church, the community hall, wherever we can find space….We've had to rent office space for the counsellor out of the reserve because…the health centre's walls are so thin you can hear through the walls….There is no money for capital and there's no money for a building….

Mary Anne Wilson
Skidegate Caregivers
Prince Rupert, British Columbia, 26 May 1993

In the majority of Aboriginal communities, there is a foundation of basic services on which to build, although adequacy varies from one community to another. However, efforts to achieve a holistic approach to healing are frustrated by fragmented delivery structures and inappropriately trained personnel who are often ill-equipped to mobilize the strengths of the community in support of whole health. The challenge in this context is to transform the current system, building on the experience and investments already in place. This will require that

• resources be provided to Aboriginal governments to identify the changes necessary to transform existing programs and facilities;

• Health Canada's transfer policy be revised to reflect this new policy focus on community healing centres;

• federal, provincial, territorial and Aboriginal governments revise current health and social services policy to facilitate integrated service delivery; and

• federal, provincial, territorial and Aboriginal governments make additional resources available to facilitate the transformation of existing health and social service facilities into community healing centres and lodges.

Métis and other Aboriginal people residing off-reserve in cities or rural communities have not benefited from federally supported service delivery,

although the non-insured health benefits program has been available to some status Indians living off-reserve and Inuit outside their northern communities. For Aboriginal people living in rural areas, services are often inaccessible because of distance and inappropriate because they ignore social and cultural aspects of health and disease. A Métis presenter at Paddle Prairie, Alberta, described the situation in his district:

The Paddle Prairie Settlement stretches almost 30 miles along the Mackenzie Highway and is the same across. With the populations of Key River and Carcajou, there are almost 1,000 people living here, all of whom have been promised by the provincial government that they can have equal access to health services as any other Albertan.

But people have to travel to see a physician, dentist…[and for] all of our other needs. The health unit supplies home care visits and a nurse for two days a week to the hamlet of Paddle Prairie….

All of this leaves us with some confusion and a very fragmented health delivery system. Needless to say, this means extra cost for our people in travel…accommodation and meals, and often loss of pay. That is while they have to leave their jobs to travel to Grande Prairie or Edmonton. We think this is discrimination.

John Crisp
Paddle Prairie Metis Settlement
High Level, Alberta, 29 October 1992

For Aboriginal people in urban areas, the problems are more often failure to make contact with needed services, the lack of culturally appropriate services, and the absence of Aboriginal personnel who can overcome barriers to effective service.

Thus, Aboriginal people who do not live in communities that receive federally funded services tend to be served inadequately, sometimes to a severe extent. The evidence presented in our hearings and in the research studies and intervener participation reports prepared for us indicates that they suffer social and economic disadvantages that undermine health and well-being, experience social exclusion and barriers to effective service, and have the same concerns about the need for holistic, community-based services.

As noted earlier, most statistics refer only to Indian people on-reserve and

those served by federal programs. Consequently, little information is available on the priority health needs of Métis and other Aboriginal people in cities, towns and rural areas. Transformation of the service system for these populations must start with needs identification and planning. Aboriginal healing centres should be designed to provide holistic, culture-based services in the context of primary health care and health promotion and co-ordinate access to other non-Aboriginal health and social services. Métis and other Aboriginal communities in urban and rural areas should have the opportunity to develop healing centres and healing lodges as part of a national effort to restore and maintain Aboriginal health. However, in view of the general lack of service infrastructure off-reserve, the first requirement is resources for needs assessment and planning.

In Volume 4, Chapter 2 we described the many initiatives undertaken by women in the area of health and healing. They struggle to survive with uncertain funding, draining the energies of volunteers and underpaid staff. Demonstration projects and short-lived programs often have a great deal to teach, through both their successes and their difficulties. New initiatives should make maximum use of them and the dedication and expertise of the women who organized them, as well as the networks that continue to channel information and support new endeavours.

The beginnings of change

In many communities, a shift in the orientation of health and social services is already under way. Earlier we documented examples of Aboriginal communities where innovations in local service delivery are beginning to reflect holistic characteristics, Aboriginal control and local diversity and extending the range of services to provide more equitable access. The push for change and the exploration of more holistic strategies have been carried forward by federal and provincial governments as well as by Aboriginal people. Here we have in mind Health Canada's transfer initiative, selected provincial initiatives, the devolution of responsibility to community governments, and a new federal program for building healthy communities, all of which have points of congruence with the systematic change we propose.

In 1986, the federal government introduced the health transfer initiative, designed to transfer administrative authority for community health services over time to reserves in the provinces. Aboriginal people in the territories became involved in a similar transfer process through the devolution of responsibility for health services to the territorial governments. Inuit and some First Nations

people in Quebec achieved a considerable level of community control over health and social services through the James Bay and Northern Quebec Agreement and the Northeastern Quebec Agreement. These initiatives promise to provide opportunities for Aboriginal communities to assume greater responsibility for developing health services and programs at the community and regional levels. Views on the health transfer program were presented earlier in the chapter.

The research we commissioned and the briefs and submissions we received leave us singularly impressed with the extent to which health programs in communities that have participated in transfer initiatives increasingly reflect Aboriginal priorities. First Nations and Inuit authorities at the community and regional levels have responded creatively to a limited opportunity and have begun to transform health facilities and programs along the lines we envision. Indeed, the innovations introduced in some communities point the way to approaches we endorse in this chapter. Creativity in Aboriginal services is dampened, nevertheless, by policy and funding constraints imposed from outside Aboriginal communities.

Provincial governments have also recognized the value of decentralization, community involvement and integrated service delivery. As early as 1971, following the recommendations of the Castonguay-Nepveu commission, Quebec established a network of local community service centres for the integrated delivery of health and social services. They are intended to encourage teams of physicians, social workers, nurses, dentists, technicians and others to provide co-ordinated front-line services through facilities that ideally should have high levels of community involvement. The goal of an integrated service delivery system has never been achieved, however. Community health clinics continue to operate in most provinces, but they are at the margins rather than the centre of the health care system, which continues to revolve around the authority and professional norms of physicians.

In the past several years, provincial governments have begun to re-examine this approach to health care in an attempt to gain some measure of control over escalating expenditures. Central to these initiatives is the development of regional health authorities, with responsibility for rationalizing and administering health and social services, and the promotion of community health clinics with non-medical personnel (such as nurse practitioners, midwives and mental health counsellors) providing a full range of integrated health and social services.

Although most provincial reforms are directed to the general population, several provincial governments have recently launched similar initiatives for Aboriginal communities. Ontario announced its Aboriginal Healing and Wellness Policy in June 1994. It adopts a status-blind approach to developing health and healing centres for Aboriginal communities. Five new healing lodges and 10 new Aboriginal health access centres will be funded around the province. While this initiative will have particular benefits for Aboriginal people in urban areas, it will also provide resources to First Nations communities to enhance community healing centres. The program has brought together resources from the provincial ministries of health and community and social services, the women's directorate and the Native affairs secretariat. It fosters partnerships between Aboriginal people of various status categories on- and off-reserve and the creative use of band program funds, federal capital allocations and provincial operating grants.

In some parts of the country, Aboriginal organizations have initiated negotiations with the federal government to create new regional health systems under the jurisdiction and control of Aboriginal communities. For example, the Health Framework Agreement for First Nations People in Manitoba, negotiated in 1994 by the Assembly of Manitoba Chiefs and the federal health minister, was intended to provide a framework through which new structures and systems could be developed to implement the goal of a First Nations health system in Manitoba. It was not signed, however, because of federal reluctance to include in the agreement reference to health as a treaty right. For many First Nations, who look to treaties as the legal foundation of their relationship with Canada, the continuing refusal of the federal government to recognize health care as a treaty right will constrain further development of health and social systems. (For a full discussion of treaties as the principal instrument structuring the relationship of treaty nations with the Canadian state, see Volume 2, Chapter 2.)

At the district level, the Meadow Lake Tribal Council provides an example of how self-government and community healing are inextricably linked. In its submission to the Commission describing their plan for a First Nation-controlled health care system, the council states: "The intention is to ground the health system in a model of health that focuses on healing, personal and community development, and prevention". Programs serving nine communities will be managed by the tribal council through self-government agreements with the federal government, and community healing services will be administered through formal agreements between the tribal council and each member community.[251]

In some instances, the development of a system of healing centres and lodges could be undertaken by existing regional health organizations that have adapted already to the geographic and cultural conditions of the region and the jurisdiction and regulatory authority of the province or territory. The Nunavik regional government of northern Quebec is one example. The Labrador Inuit Health Commission is another. As of March 1996, a total of 195 tribal councils or multi-community agencies were involved in the transfer of health services. Of these, 66 projects representing 141 First Nations communities were the subject of signed transfer agreements with Health Canada, and 129 agencies or councils representing 237 communities were engaged in pre-transfer projects. In addition, Health Canada is funding special initiatives by the Labrador Inuit Health Commission, the Union of New Brunswick Indians and the Grand Council of Treaty 8 First Nations.[252]

The federal initiative announced in September 1994, Building Healthy Communities, promises to provide $243 million over five years to assist First Nations and Inuit communities in developing community health facilities and services. It also intends to provide for a more integrated approach to funding where program-specific funding can be rolled into integrated community-based health services agreements. These would enable First Nations and Inuit communities to target resources to priority needs. Health Canada has also announced that non-insured health benefits will be transferred to some First Nations and Inuit communities on a pilot-project basis, which should also provide greater flexibility in developing community-based services.

It is evident, then, that there are numerous instruments and relationships now in existence or in negotiation through which our proposals could be implemented. However, the fragmentation of programs supported by each level of government and the lack of co-ordination between federal and provincial governments create serious impediments to the effectiveness and cost-efficiency of programs. Recognition of Aboriginal jurisdiction in health and social services will provide a basis for holistic approaches to healing services. Within current jurisdictions, barriers to integrated services and intergovernmental collaboration should be removed.

Recommendations

The Commission recommends that

3.3.7

Federal, provincial and territorial governments collaborate with Aboriginal nations, regional Aboriginal service agencies, community governments and Aboriginal organizations, as appropriate, to adapt legislation, regulations and funding to promote

(a) integrated service delivery that transcends restricted service mandates of separate ministries and departments;

(b) collaboration and shared effort between federal, provincial/territorial and local governments; and

(c) the pooling of resources flowing from federal, provincial, territorial, municipal or Aboriginal sources.

3.3.8

Aboriginal organizations, regional planning and administrative bodies and community governments currently administering health and social services transform current programs and services into more holistic delivery systems that integrate or co-ordinate separate services.

Implementing a new system

Developing healing centres to serve Métis and other Aboriginal people in rural and urban areas will involve creating new organizational structures and redistributing resources from existing provincial and municipal institutions. As well, new resources will be required to deliver services where now they are unavailable.

The development of regional healing lodges, ideally serving all Aboriginal people who share history, culture or current affiliation in a regional community, might involve a significant planning period. Current residential services could expand their duties to address a broader range of needs and partially fill the gap we have identified in family and community healing.

The location and catchment area for particular healing centres should be determined through a planning process involving local residents.

TABLE 3.14

Communities With 1,000 or More Persons Who Reported Single Aboriginal Origins, 1991

Newfoundland	**Quebec**	**Yukon**
Urban	**Urban**	**Urban**
Happy Valley-Goose Bay	Chicoutimi-Jonquière	Whitehorse*
	Gatineau	
	Hull	
	Laval	
	Montreal*	
Manitoba	**Saskatchewan**	**Alberta**
Urban	**Urban**	**Urban**
Brandon	North Battleford	Calgary*
Thompson	Prince Albert*	Edmonton*
Winnipeg*	Regina*	Fort McMurray
	Saskatoon*	Lethbridge
Non-Urban	**Non-Urban**	**Non-Urban**
Division 19	Ile-a-la-Crosse	Improvement District 17*
Division 22	La Loche	Improvement District 18*
British Columbia	**Ontario**	**Northwest Territories**
Urban	**Urban**	**Urban**
Kamloops	Brantford	Inuvik
Port Alberni	Hamilton	Iqaluit
Prince George	London	Yellowknife
Prince Rupert	Ottawa	**Non-Urban**
Surrey	St. Catharines-Niagara	Arviat
Vancouver*	Sault Ste. Marie	Baker Lake
Victoria	Sudbury	Fort Smith
	Thunder Bay	Pangnirtung
	Toronto*	Rae-Edzo
		Rankin Inlet

Notes: *

Areas with 3,000 persons or more who reported a single Aboriginal origin. Statistics Canada defines urban as an area with a population of at least 1,000 and a population density of at least 400 per square kilometre at the previous census. Rural is defined as small towns, villages and other populated places with populations under 1,000 according to the previous census; rural fringe areas or census metropolitan areas and census agglomerations that may contain estate lots and other non-farm land uses, as well as intensive agricultural land uses; agricultural areas; and remote and wilderness areas. Both urban and rural areas listed in this table exclude reserves and settlements.

Source: Statistics Canada, 1991 Census, Aboriginal population by census subdivisions and census metropolitan areas, 1994.

We suggest that rural communities with an Aboriginal population of 250 should be eligible to participate in the planning process and that a more dispersed rural Aboriginal population of 1,000 should be eligible as well. In cities and towns, a base Aboriginal population of 1,000 should establish eligibility for planning purposes. A list of 44 urban communities and four non-urban districts with a minimum of 1,000 Aboriginal people who reported only Aboriginal ancestry is shown in Table 3.14.[253]

Whether urban or rural, healing centres will vary in size, level of staffing and type of services, depending on the size of the population served. For example, in Prince Edward Island and New Brunswick, provinces with small Aboriginal populations, urban centres might function more as referral and co-ordinating units with some capacity to provide culture-based services. In cities such as Montreal, Toronto, Winnipeg and Regina, centres should provide a full range of health and healing services on a more autonomous basis. In locations where on-reserve and off-reserve populations live in close proximity, services could be shared.

In our recommendations on urban service delivery (see Volume 4, Chapter 7), we propose that urban services be provided as a rule on a status-blind basis. We acknowledge, however, that the Métis Nation and treaty nations in the prairie provinces have a history of distinct development and that it might not be feasible yet to establish healing centres that serve Métis and First Nations people together. However, for reasons of efficiency and economy, as well as shared interests, we urge all Aboriginal communities to collaborate in the development of urban healing centres and regional lodges.

Recommendation

The Commission recommends that

3.3.9

Federal, provincial and territorial governments, in consultation with Aboriginal nations and urban communities of interest, co-operate to establish procedures and funding to support needs assessment and planning initiatives by Métis and other Aboriginal collectivities, in rural and urban settings, to

(a) form interim planning groups for rural settlements with a minimum of 250 Aboriginal residents, or catchment areas, whether urban or rural, with a minimum of 1,000 residents;

(b) compile an inventory of existing services, organizations and networks directed to meet Aboriginal needs, from which to build on existing strengths and ensure continuity of effort; and

(c) prepare plans to develop, operate and house healing centres, considering the goal of equitable access by Aboriginal people wherever they reside, the historical pattern of distinct Métis and treaty nation development in the prairie provinces, the availability and adaptability of municipal and provincial services, and the cost and efficiency of services.

In developing healing lodges, it should be possible to adapt or modify existing residential programs and facilities, but clearly there will be a need for new capital development as well as incremental service delivery costs to fill the gap in services oriented to family and community healing. Early identification of pressing needs will be required, along with formation of regional planning bodies to co-ordinate effort. Long-term budget forecasting will be necessary to ensure that facilities are strategically located and, in the operational phase, adequately equipped and funded.

The number and location of healing lodges across Canada would emerge as a result of regional planning. Since we anticipate that both federal and provincial governments will contribute to establishing and operating healing lodges, it might be most feasible to carry out planning on a provincial basis or, in the case of the Atlantic provinces, on a multi-provincial basis.

Recommendations

The Commission recommends that

3.3.10

Aboriginal, federal, provincial and territorial governments, as appropriate, collaborate on regional initiatives to develop healing lodges providing residential services oriented to family and community healing, with priority being given to

(a) needs assessment and planning that reflect regional Aboriginal initiative and responsiveness to the diversity of cultures and communities;

(b) services broadly inclusive of all Aboriginal people resident in a region or associated with the nations of the region;

(c) institutions that collaborate with and complement other Aboriginal institutions and services, particularly healing centres delivering integrated health and social services; and

(d) governance structures consistent with emerging forms of Aboriginal self-government in the region.

3.3.11

Aboriginal, federal, provincial and territorial governments incorporate in funding agreements plans for capital development and operating costs of a network of healing lodges.

Governance of health and healing institutions

Health and healing institutions deliver services under the authority of provincial legislation. Implementing the healing centres strategy might require arrangements to do things differently or exemption from certain regulations. One example is legislative recognition of Aboriginal custom adoption in the Northwest Territories.[254] Another is partial exemption from confidentiality rules that have prevented adoptees of status Indian origin from learning their identity and exercising their Aboriginal rights. In some provinces, Indian adoptees are entitled to be informed of their status on reaching the age of majority, while

adoptees of other origins do not have access to information that identifies their origins.

With the concurrence of the provinces and the support of the federal government in respect of Inuit and Indian people on-reserve receiving federal services, it is possible to begin to implement the healing centres strategy now. For Métis communities and Aboriginal people off-reserve in rural and urban settings, change is impeded by the policy vacuum. Provincial governments continue to resist developing or financing Aboriginal-specific programs, and the federal government declines to exercise its authority concerning off-reserve services.

In Volume 4, Chapter 7, we propose federal and provincial sharing of responsibility to break through the barriers to restructuring services for Métis and other Aboriginal people. We propose that provincial and territorial governments be responsible for financing services for Aboriginal people off-reserve that are ordinarily available to other residents. Provinces should also undertake the cost of making these programs appropriate for Aboriginal residents. The federal government would be responsible for the costs of self-government on Aboriginal territory, including health and social services delivered by Aboriginal governments. It would also be responsible for Aboriginal government services and treaty entitlements outside Aboriginal territory where these exceed benefits generally available. Given the picture of disadvantage detailed in this chapter, we propose further that the costs of affirmative action to compensate for historical disadvantage be shared by federal, provincial and territorial governments on a formula basis reflecting fiscal capacity. (For details, see Volume 4, Chapter 7.)

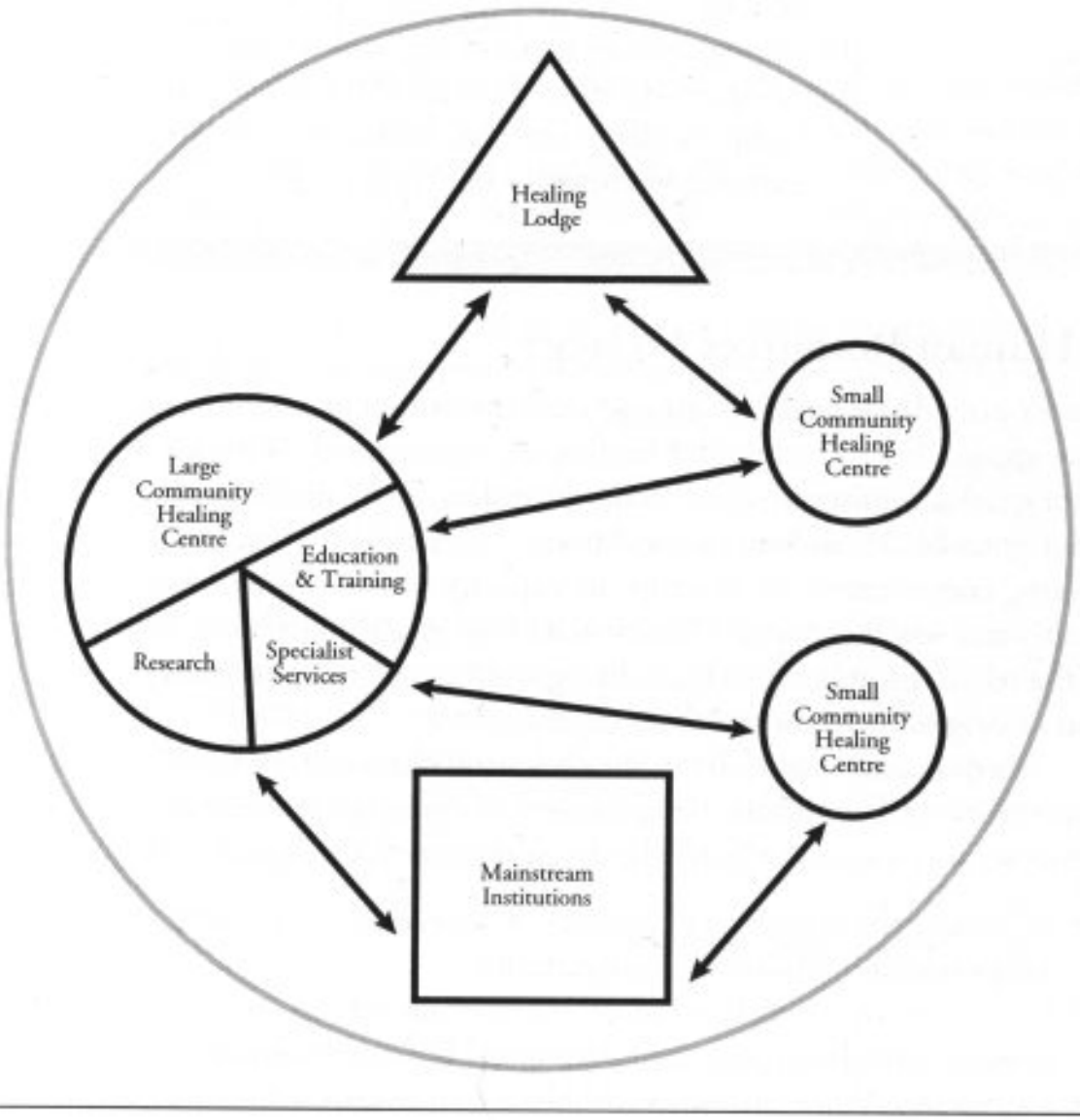
The urgent work of restoring the health of Aboriginal people should be undertaken without delay. The readiness of federal and provincial governments to support a new health strategy, which Aboriginal people have advocated and which we endorse, will be among the first tests of commitment to restructuring the relationship between Aboriginal people and the rest of Canada. The House of Commons Standing Committee on Health has also urged the federal government to “take the lead in co-ordinating and implementing [a comprehensive] plan of action for Aboriginal wellness” in collaboration with provincial and territorial governments and national Aboriginal organizations.[255]

Healing centres and lodges will operate under the authority of federal, provincial or territorial governments in the immediate future and will derive their authority from Aboriginal nation governments when self-government is

established in relevant territories. Under any of these jurisdictions, the healing centre or lodge would be guided in the fulfilment of its responsibilities by a board of directors drawn from the community or communities served. The board should represent the diversity of community members, paying particular attention to include in decision making the voices of women, youth, elders and people with disabilities. It should ensure that ethical practices appropriate to the culture are followed by staff, administration and political bodies and that appeal mechanisms are in place so that persons who believe they have been ill-served or injured have recourse.

One of the strengths of the proposed system will be its capacity to obtain specialist services and residential care on behalf of collectivities larger than single communities, sharing expertise within the Aboriginal planning community and achieving economies of scale. Co-ordination of regional services will require the establishment of planning bodies, which should include representation from relevant governments, mainstream and other service institutions affected by regional planning, and community members, in particular women, youth, elders and people with disabilities. The components of a regional service system that should be represented in regional planning bodies are shown in Figure 3.10.

FIGURE 3.10
Proposed Regional Health and Social Services System



The Commission assumes that health and social services will be designated as a core area for the exercise of self-government and that they will be among the first areas of jurisdiction to be occupied by Aboriginal governments. The major difference between service delivery under provincial jurisdiction and under self-government will be that Aboriginal nations will enact the laws and draft the regulations establishing conditions and standards. Intergovernmental transfers will supplement revenues from within the Aboriginal nation to support services. With implementation of the human resources development strategy set out in

the next section, we anticipate visible and progressive movement toward staffing service, administration and planning positions with Aboriginal personnel.

We urge federal, provincial and territorial governments and Aboriginal governments and organizations to support regional planning bodies, to bring together the interests and needs of communities that have the prospect of coalescing into self-governing nations or confederacies of nations. With co-operation between Aboriginal and non-Aboriginal authorities and among Aboriginal constituencies, healing centres and lodges can begin to advance the long-term goal of achieving whole health for all Aboriginal people.

Recommendation

The Commission recommends that

3.3.12

Federal, provincial and territorial governments, and Aboriginal governments and organizations, support the assumption of responsibility for planning health and social services by regional Aboriginal agencies and councils where these now operate, and the formation of regional Aboriginal planning bodies in new areas, to promote

(a) equitable access to appropriate services by all Aboriginal people;

(b) strategic deployment of regional resources; and

(c) co-operative effort between Aboriginal communities and communities of interest, consistent with the emergence of nation governments and confederacies.

3.3 Human Resources Strategy

Developing Aboriginal human resources is essential to ensure the success of the new approaches to health and healing we recommend. Without the necessary Aboriginal administrators and service providers, it will not be possible to improve Aboriginal health and social conditions. There must be a substantial and continuing commitment to develop the capacity of Aboriginal people to provide health and social services. This capacity building should be

an important part of the relationship between Canadian governments, mainstream service agencies and Aboriginal governments and organizations.

As discussed more fully in the education chapter in this volume and in the governance and economic development chapters in Volume 2, several broad strategies are required to foster the development of Aboriginal human resources:

• increasing the capacity and number of education and training programs that are provided by Aboriginal institutions;

• improving the contribution of mainstream education and training programs to the development of Aboriginal human resources;

• improving Aboriginal students' ability to pursue education and training through the provision of financial and other supports; and

• improving the cultural appropriateness and effectiveness of education and training programs to meet the needs of Aboriginal students and communities.

Our purpose here is to outline some of the ways these broad strategies can be implemented to increase the number of Aboriginal people involved in the health and social service professions.[256] Progress in this sphere is vital to the well-being of Aboriginal people, and current efforts to address the problem are inadequate. Although many reports and task forces have called for improvement, progress has been very slow.[257]

While the provision of health and healing services should not be seen as the exclusive domain of health and social service professionals, many aspects of the planning, delivery and evaluation of health and healing services do require the expertise of individuals with formal training. Therefore, part of the plan for Aboriginal health and healing must consider how these needs can be met.

The current status of Aboriginal human resources in health and healing

There was unanimity among Aboriginal representatives and representatives of professional associations and service organizations appearing before the Commission that improvements are needed in the recruitment, training and retention of Aboriginal people in the health and social services professions to meet current and future needs:

Both the federal and provincial governments need to recognize that we do need resources in order to better ourselves. We need to have the human resources — First Nations human resources.

Phil Hall
Alderman, District of Chilliwack
Victoria, British Columbia, 22 May 1992

We find that the key to better integration of health and social services in Aboriginal communities is an increase in the number of health professionals originating from these communities….The Royal Commission should recommend that priority be given to training programs that are accessible to and realistic for Aboriginal peoples. [translation]

Huguette Blouin
L'Association des hôpitaux du Québec
Montreal, Quebec, 16 November 1993

Services [are] obstructed by the shortage of necessary public health workers. The preferred avenue for the improvement of health status is an increase in the number of qualified and skilled Aboriginal public health workers in Canada providing public health services to Aboriginal communities.

Janet Maclachlan
Canadian Public Health Association
Ottawa, Ontario, 17 November 1993

We must seek control of our medical services and social welfare/child welfare programs. By doing so, we must also begin training of Aboriginals in all professional capacities involved with these programs. A mandate for the beginning of the next millennium must be a national educational program designed to capture the hearts, minds, and spirits of Aboriginal youth and provide them with the way to become obstetricians, pediatricians, psychologists, nurses, social workers, [addictions] counsellors, [and] therapists of the future.

April Prince
All Nations Youth Council
Prince George, British Columbia, 1 June 1993

The Canadian Medical Association recommends that the Canadian

government…increase access and support programs to encourage Aboriginal students to enter health careers.

Dr. Richard J. Kennedy
Canadian Medical Association
Ottawa, Ontario, 17 November 1993

I would like to see more emphasis on training of Aboriginal people for the health field. There have been a number of Aboriginal people who have gone into nursing. There have been some who have gone into social work, and very few who have gone into medicine.

Dr. Fred W. Baker
Canadian Paediatric Society
Ottawa, Ontario, 18 November 1993

The impact of Aboriginal hospital workers has been tested at Ville-Marie and other hospitals. The results clearly demonstrate improved accessibility of services…we support the training of Aboriginal community workers and social workers to provide community and social consultations and intervention services within the communities. [translation]

Ghislain Beaulé
Research Officer
Regional health and social services board of Abitibi-Témiscamingue
Val d'Or, Quebec, 30 November 1992

We need to involve our own people in our own way with our own human resources.

Gerri ManyFingers
Calgary, Alberta
26 May 1993

Regrettably, very little information has been collected systematically about the number of Aboriginal professionals involved in health and healing services. The Canadian Public Health Association, for example, in a recently published study on the recruitment and training of public health workers, described the current state of information in the following terms:

"We're Not Sure." This was the common response when key informants were asked if they knew the current numbers of Aboriginal public health workers

and/or Aboriginal students studying health care in Canada.[258]

Nonetheless, the Commission has been able to collect some information, and it confirms that there is significant and widespread under-representation. Several examples illustrate the point.

In 1990, it was estimated that fewer than 20 Aboriginal physicians practised in Canada.[259] In 1993, there were about 40 Aboriginal physicians,[260] and 22 Aboriginal students were enrolled in medical schools.[261] The Native Physicians Association reports 51 self-identified Aboriginal physicians.[262]

We estimate that the ratio of Aboriginal physicians to Aboriginal population is approximately 1:33,000. The corresponding ratio in the general population is about 1:515.[263] We estimate that only about 0.1 per cent of physicians in Canada are Aboriginal. These figures show that Aboriginal people are seriously under-represented in the medical profession.

Figures on medical school enrolment indicate that there will be about 35 Aboriginal physicians graduating over the next five years. While many will practise medicine, others will serve as consultants and administrators. While these new graduates will almost double the number of Aboriginal physicians in Canada, it could take five decades at the present rate of change to achieve equitable representation of Aboriginal people in the medical profession. This disparity must be addressed.

Similar under-representation is evident in other health and social services professions. In nursing, for example, a recent survey conducted by the Aboriginal Nurses Association of Canada revealed only about 300 Aboriginal registered nurses in Canada, although other estimates have been higher.[264] The number does not appear to have changed much over the past few years. According to recent statistics provided by the Canadian Nurses Association, there are 264,339 registered nurses in Canada, of whom 235,630 are employed in nursing.[265] Therefore, only about 0.1 per cent of registered nurses in Canada are Aboriginal. Moreover, there are only three Aboriginal dieticians in Canada,[266] and only about 70 Aboriginal dental therapists.[267] Similar information is unavailable for many other professional groups, because most do not keep records of the number of Aboriginal practitioners.

The medical services branch of Health Canada, which supports the employment of substantial numbers of Aboriginal people in health services,

combines the staffing numbers of Aboriginal and non-Aboriginal personnel, with the result that Aboriginal participation cannot be stated definitively. However, we know that most community health representatives and most counsellors employed in the National Native Alcohol and Drug Abuse Program are Aboriginal. Field staff in these two programs in 1993-94 numbered 616 and 465 respectively.[268] During the same period, 521 nurses were also in the field, the majority employed directly by the medical services branch and 118 employed by Indian bands. An additional 381 field staff were employed as clerk/interpreters, caretakers and housekeepers.

The concentration of Aboriginal personnel in paraprofessional positions is indicated in data collected by Statistics Canada in the 1991 Aboriginal peoples survey (see Table 3.15). Of 6,645 Aboriginal persons reporting that they were employed in medicine and health, 5,535 cited nursing/therapy related assistants as their occupation. If the figure from the Aboriginal Nurses Association survey is taken as definitive (about 300 Aboriginal nurses), then we can infer that the vast majority of Aboriginal people in this category are related assistants.

Just over 3 per cent of the Aboriginal labour force reported occupations in medicine and health, compared to 5.2 per cent of the Canadian population. An additional 3.3 per cent — 6,980 persons — reported social work occupations. These include welfare administrators, child welfare, day care and home care workers, and the staff of women's shelters and family violence projects. When we examine the proportion of the Aboriginal labour force involved in the combined categories of health and social services by industry, including all occupations associated with medical and social services, we see 8.8 per cent of the Aboriginal labour force, compared to 9 per cent of the Canadian labour force as a whole.

TABLE 3.15
Participation in Health and Social Services, Aboriginal and Non-Aboriginal Populations Age 15+, 1991

	Aboriginal Identity		Non-Aboriginal	
	#	%	#	%
By major field of study:				
Health professions/science/technology	8,825	10.4[1]	884,490	11.8
Social sciences[2]	9,745	11.5[1]	659,950	8.6
By occupation:				
Medicine and health	6,445	3.3[3]		5.2
Nursing/therapy-related assistants	5,535			
Health diagnosing and treating	115			
Other occupations in medicine and health				
Social services	6,980	3.3[3]		—
By industry				
Health and social services		8.8[4]		9

Notes: — = not available.

1. Population base is Aboriginal people age 15 or older who have completed a post-secondary program of any type.

2. Including anthropology, archeology, area studies, economics, geography, law, environmental studies, political science, psychology, sociology, social work.

3. Population base is Aboriginal people age 15 or older in the labour force.

4. Includes clerks, drivers, support staff.

Source: Statistics Canada, Major Fields of Study of Postsecondary Graduates, catalogue no.

93-329, p. 8; Statistics Canada, 1991 Census and Aboriginal Peoples Survey, custom tabulations; and Kerr et al., "Canada's Aboriginal Population, 1981-1991", research study prepared for RCAP (1995), Tables 4.1 and 4.2.

Another analysis treats education and health services as a single category. When persons employed in these sectors are considered as a proportion of the employed labour force, we see that
15.8 per cent of the Aboriginal labour force and 15.4 per cent of the non-Aboriginal labour force is employed in health and education services.[269] When we consider that professional employment in these sectors requires higher education, that most services staffed by Aboriginal people are on-reserve or in Inuit communities, that only 0.9 per cent of Indian people on-reserve hold degrees, and that the number of Inuit holding degrees is too small to register statistically,[270] it is clear that a major effort is needed in education and training.

The practical experience and cultural awareness of Aboriginal CHRs and NNADAP counsellors are highly valued by Aboriginal people. They realize, however, that if they want to assume control of health and social services at all levels, they will need greater access to higher education and professional training. If half the Aboriginal people in health and social service occupations were to advance their qualifications to assume professional and supervisory roles now filled by non-Aboriginal personnel, training would be needed for some 6,700 persons.[271]

Since most Aboriginal services are currently located on-reserve and in Inuit communities, staffing new Aboriginal services in urban and rural off-reserve settings will require more trained personnel. To be more responsive to Aboriginal clientele, mainstream institutions will also require an increase of Aboriginal personnel. Raising the number of Aboriginal people employed in mainstream institutions depends on raising the number of appropriately trained candidates. An additional 6,500 trainees to staff urban and off-reserve services and to fill positions in mainstream institutions is a reasonable projection. We therefore propose that governments and educational institutions undertake to train 10,000 Aboriginal people in health and social services, including professional and managerial roles, over the next decade.

Health and social sciences are already prominent among the courses of study chosen by Aboriginal people pursuing post-secondary education. Our analysis indicates that of Aboriginal people who have completed a post-secondary program, 8,825 (10 per cent) have studied in the field of health sciences, and 9,745 (11.5 per cent) have studied social sciences (see Table 3.15). The

challenge is to shift the level and length of study from short-term certificate training to long-term professional degree training.

Over time, Aboriginal institutions will become more involved in developing training programs or modules of study to complement technical training. Non-Aboriginal institutions and governments that fund them will continue to play a major role in meeting the goals of Aboriginal human resources development.

Difficulties created by the low number of Aboriginal professionals are compounded by the manner in which these scarce resources are distributed. Two problems are of particular concern to us. First, for a variety of personal and professional reasons, many Aboriginal professionals do not practise in Aboriginal communities.[272] The Native Physicians Association estimates that only 20 to 25 per cent of their members has a practice involving 50 per cent Aboriginal clients or more.[273] Of the estimated 60 Aboriginal nurses in Quebec, only one-third work with Aboriginal people.[274] We believe that similar patterns of distribution exist throughout Canada. They affect Inuit particularly. For example, we were told that there were no Inuit registered nurses serving on Baffin Island.[275] In addition:

Among the Inuit [in Northern Quebec], we still have no Aboriginal social workers. [translation]

Francine Tremblay
Montreal, Quebec 16 November 1993

In the eastern Arctic, there are no professional social workers that are university trained who are Inuit. Nor are there any Inuit doctors, nurses, architects, dentists, [or] lawyers.

Bill Riddell
Iqaluit, Northwest Territories
25 May 1992

Every year we have different nurses, we have different doctors coming in. This is really hard on the people, having to see different nurses and having to see different doctors, and telling your story all over again has been really hard on a lot of people here in the community.

Mary Teya
Community Health Representative

Fort McPherson, Northwest Territories, 7 May 1992

It is apparent that efforts to increase the number of Aboriginal health and social services professionals must be combined with efforts to encourage them to provide services to their communities.

Second, Aboriginal professionals are often concentrated in the lower ranks of organizations rather than in supervisory, management or policy positions.[276] To the extent that this situation prevails, Aboriginal people do not have the opportunity to influence program design, program delivery or resource allocation.

Governments, professional associations and service delivery organizations rarely collect information about the participation of Aboriginal people in the health and healing professions. We believe this reflects the low priority accorded to developing Aboriginal human resources.[277] The absence of this vital information is an obstacle to planning. The need for better information about Aboriginal human resources was highlighted in a presentation by the Canadian Public Health Association:

To undertake appropriate health human resources planning for Aboriginal communities, complete and comprehensive data sets are needed regarding the current number of and projected need for trained Aboriginal public health workers working in the field….A complete inventory of all professional and para-professional health-related training programs for Aboriginal students is needed to assess the availability, accessibility and relevancy of these programs.

Elaine Johnson
Canadian Public Health Association
Ottawa, Ontario, 17 November 1993

A comprehensive human resources plan for Aboriginal health and healing is needed. Developing it will not be easy, because the range of direct service work related to health and healing is broad. Within the field of public health alone, for example, some 50 different specialities have been identified in home care, inspection, medical care, dental health, pharmacy, nursing, nutrition, occupational health and safety, primary care, therapy, environmental health, ophthalmology, rehabilitation, medical research, and other areas.[278] Because of the holistic concept of health that Aboriginal people hold, we also want to emphasize the important contributions to be made by other practitioners: community animators and planners, traditional healers, midwives,[279] family and

child support workers, mental health workers, specialists in environmental health and community infrastructure, substance abuse specialists, interpreters, translators, and many others.[280]

When systems are being redesigned and reshaped in the way we have recommended, where there is a need for the effective management of scarce resources, and where creative solutions based on new approaches must be found, the work of many others will be needed to complement that of direct service personnel: community leaders, administrators, planners, evaluators, researchers, public education specialists, community development practitioners, and others. A comprehensive human resources development plan should consider these needs as well.

Support for Aboriginal training in health and social services has been targeted generally to entry-level positions in direct service delivery and local administration.[281] Although these programs are important, the emphasis needs to be shifted to educational opportunities in the areas of program design, evaluation and senior management skills. While this type of training has sometimes been made available to those employed by governments, few Aboriginal staff reach the levels where senior management skills are learned and practised.

Recommendations

The Commission recommends that

3.3.13

The government of Canada provide funds to the national Aboriginal organizations, including national Aboriginal women's organizations, to permit them to prepare a comprehensive human resources development strategy in health and social services that

(a) facilitates and draws upon regional initiatives, integrates information from diverse sources, and is structured to incorporate regular updating;

(b) builds an inventory of Aboriginal human resources currently available in health and social services, identifying where, in what field and at what level Aboriginal personnel are currently practising;

(c) assesses current and future Aboriginal human resources needs and identifies the actions needed on the part of governments, educational institutions and others to address these needs;

(d) assesses requirements for direct service personnel as well as for planners, researchers and administrators;

(e) collates an inventory and available evaluative data on training and education options;

(f) explores recruitment, training and retention issues;

(g) examines the personal and professional supports required to encourage Aboriginal professionals to practise in Aboriginal communities;

(h) develops proposals for a system to monitor the status of Aboriginal human resources; and

(i) develops an analysis of how, to the maximum extent possible, Aboriginal human resources development can be brought under Aboriginal control.

3.3.14

Federal, provincial and territorial governments commit themselves to providing the necessary funding, consistent with their jurisdictional responsibilities,

(a) to implement a co-ordinated and comprehensive human resources development strategy;

(b) to train 10,000 Aboriginal professionals over a 10-year period in health and social services, including medicine, nursing, mental health, psychology, social work, dentistry, nutrition, addictions, gerontology, public health, community development, planning, health administration, and other priority areas identified by Aboriginal people;

(c) to support program development in educational institutions providing professional training, with preference given to Aboriginal institutions; and

(d) to ensure that student support through post-secondary educational assistance, scholarships, paid leave and other means is adequate to achieve

the target.

We recognize that national Aboriginal organizations will not always be in the best position to implement the recommendations that emerge from the development strategy. Communities, nations and other Aboriginal organizations and institutions will also make an important contribution. However, it is our view that national Aboriginal organizations are in the best position to conduct a country-wide assessment of current resources and future requirements, beginning immediately and during the transition to self-government. Given the multifaceted needs and the extensive resources required to address them, we have concluded that a high level of co-ordination on a Canada-wide basis is warranted. Once needs and development strategies have been assessed, Aboriginal nation governments, regional planning bodies, federal, provincial and territorial governments, educational institutions and professional associations will be in a much better position to see how they can contribute to achieving the goals of the comprehensive strategy.

While a strategy will provide the detailed framework needed to advance Aboriginal human resources development, efforts must also begin immediately to address critical shortages of resources. Planning and research cannot be used as an excuse to delay action. Expanded training and professional development opportunities are urgently needed for personnel now in the field and for new roles already being defined. They must be provided as soon as possible.

As discussed in Chapter 5 of this volume, an important means of promoting Aboriginal human resources development is to increase the support available for education and training institutions under Aboriginal control. Here, however, we discuss some of the important contributions that can be made by mainstream education and service delivery institutions. We focus on programs that are already having a positive impact and that can provide a foundation for new initiatives.

Building on success

The Community Health Representative Program

One of the most successful programs involving Aboriginal people in promoting the health of Aboriginal people is the community health representative program. We believe CHRs can play an important role in developing healing centres and providing other health and healing services. In particular, they can

help Aboriginal individuals and communities learn to exercise personal and collective responsibility with regard to health matters.

The duties of CHRs include health promotion and education and participation in assessing health needs. CHRs have been successful in extending health and healing services to many Aboriginal communities and have helped improve the quality of services available from mainstream service providers. Through liaison between medical staff and community members, they have been particularly important in promoting sensitive treatment of community members and preventing unnecessary institutionalization.[282]

Despite the significant accomplishments of the CHR program, it has faced a number of challenges. An evaluation of the program, conducted by the medical services branch of Health Canada and the National Indian and Inuit CHR Organization, summarized a number of these problems.[283] Although CHRs are often called upon to provide assessment, treatment and emergency services, particularly in smaller communities where there are no resident medical staff, their training focuses on health promotion and education. Therefore, they might be ill-equipped to provide medical services if requested by the community. When they do provide these services, issues of competence and liability arise. Although a number of educational institutions are involved in providing CHR training, there are no Canada-wide standards. Furthermore, training has suffered from a lack of financial support from governments and educational institutions. Also, because of the involvement of communities and Aboriginal and non-Aboriginal governments and organizations, CHRs often have no clear lines of accountability. There is a need, therefore, to increase the number of CHR co-ordinators and supervisors. Finally, there are simply not enough CHRs to meet the demand for their services.

It has also proved difficult to retain CHRs. In part, this is because of the high job demands and isolation that CHRs often experience. They do not have access to the support systems available to urban practitioners. We were told:

The CHR program has not reached its full potential. While we are fortunate that our CHRs have received basic training…we have been unable to get ongoing refresher training programs for them. This is very important for a group of health workers who are operating alone in isolated communities….Our CHRs have not been recognized as full, participating members of the health care team by health professionals. This situation is improving, but we have to continue to promote our CHRs as key community health workers who have local knowledge that many of the health professionals lack. An introduction to

the CHR program could also be geared into the training of health care professionals before [they] work in northern communities.

Iris Allen
Labrador Inuit Health Commission
Nain, Newfoundland and Labrador, 30 November 1992

In the absence of respite, professional support, and opportunities for professional enrichment, CHRs often find themselves unable or unwilling to carry on. Related to these concerns, upgrading can be difficult, because their education and experience often are not recognized by mainstream educational programs or professions.

CHRs and other professionals can face additional frustrations when they relocate from northern and other remote regions. There they had a broader scope of practice and fewer restrictions than in the south, where common practices can come under careful scrutiny from professional bodies, employers and other practitioners. This can and does lead to situations where practitioners from the north are made to feel they are unqualified to fulfil responsibilities in areas where, in fact, they have developed a good deal of expertise.

One of the most serious limitations of the current CHR program is that CHR services are available only to First Nations people and Inuit living on their traditional lands. While the health and social status of urban Aboriginal people indicate that they also need access to health education and promotion services of the type provided by CHRs, the program is not available to them.[284]

We do not see the CHR program as a substitute for increasing the number of Aboriginal people in nursing, medicine, health administration, social work or other professions. However, this type of program is an important component of effective and accessible Aboriginal health and social services systems. Moreover, CHRs have extensive experience and a strong commitment to improving the health of Aboriginal people. Therefore, we would like to see much more attention paid to developing programs and policies that would enable CHRs to gain more experience and advance their professional training.

While we have called for a reorientation of the health and social programs available to Aboriginal people, and while we believe there is a need to train many more Aboriginal health and social service professionals, we do not foresee the need to displace existing staff. We believe Aboriginal people

currently involved in providing a range of health and social services, even though they might not have formal professional training, are the building blocks of future initiatives. Some should have the opportunity to pursue professional training, while others should have the opportunity for advancement to positions involving planning, training and administration. Many, however, should continue to provide primary care and education and promotion to Aboriginal communities.

The National Native Alcohol and Drug Abuse Program

Another program that has successfully involved Aboriginal people in health and social services delivery is the National Native Alcohol and Drug Abuse Program (NNADAP, now often referred to as addictions and community-funded programs). This program, which employed some 465 people in 1993-94, has made an enormous contribution to the development of Aboriginal human resources in the addictions and mental health fields. O'Neil and Postl have observed:

[NNADAP] has been responsible for the creation of hundreds of community-based alcohol prevention and treatment projects across the country. Since the early eighties, this program has contributed to the emergence of some of the most significant Aboriginal health initiatives in the country, including the Four Worlds Development Project, the Nechi Institute, the Alkali Lake prohibition strategy, and the more recent Healing the Spirit Worldwide conference in Edmonton.[285]

NNADAP was established some 20 years ago by the department of Indian affairs.[286] Its purpose remains

To support Indian and Inuit People and their communities in establishing and operating programs aimed at arresting and offsetting high levels of alcohol, drug, and solvent abuse among their populations on-reserve.[287]

It seeks to achieve this through three interrelated strategies: reducing the incidence of substance abuse; reducing the prevalence of substance abuse; and training prevention and treatment workers. The range of initiatives funded under NNADAP is very broad. It includes employing staff who provide prevention and treatment services, providing funding for treatment programs, including residential treatment programs, and providing resources to those involved in educating and training addictions workers. To date, the program

has funded some 400 community-based alcohol and drug abuse treatment projects and 51 First Nations treatment centres across Canada. The annual budget of the program exceeds $50 million.[288]

Staff involved in services delivery at the community level are generally employed directly by local Aboriginal governments. As with other programs that have been the subject of health transfer or alternative funding agreements, however, only program delivery, not program design or management, has been transferred to Aboriginal control.

NNADAP has been controversial; there is not universal agreement about the extent to which the program has achieved its objectives. In the latest evaluation of the program, conducted by the Addiction Research Foundation in 1989, concerns were expressed about the effectiveness of many of the prevention and treatment programs funded by NNADAP. However, even this critical evaluation concluded that the training component of the program was successful in preparing Aboriginal people to provide treatment services in the addictions field.[289]

Some stakeholders have been concerned that the program has not been as responsive to community needs as it should be because of the highly centralized approach to funding and contract administration. As a result of this centralization, limits are placed on the number of different services and on the way they are provided. This approach discourages innovation and sometimes has made it difficult to adapt programs to meet local priorities.[290] For example, echoing the concerns of other individuals and organizations,[291] one Aboriginal leader told us:

NNADAP…submitted a new submission to the Treasury Board…that was to address the alcohol and drug abuse needs of Aboriginal people in Canada. That process was to establish where grassroots people got involved in advising government on what the issues were. What happened with that process is that First Nations people got involved. We got involved and advised the government that these are our needs. Then our needs weren't recognized. The process was taken over by the bureaucrats. The NNADAP program now is run under Health and Welfare Canada and is run by bureaucrats without Native consultation. There has to be a change where consultation is continuing and…Native people have an opportunity to voice themselves.

Phil Hall
Alderman, District of Chilliwack

Victoria, British Columbia, 22 May 1992

NNADAP workers encounter many of the challenges associated with working in rural and northern areas that CHRs face. Many of the issues concerning CHR training, retention, career advancement, and recognition also affect NNADAP workers.[292] These must be addressed if the effectiveness of the program is to be improved.

Two additional concerns about NNADAP were raised in presentations to the Commission: the program does not extend beyond reserves to provide services to Aboriginal people living in urban centres; and it provides services to First Nations people and Inuit but not to Métis people. As we point out in Volume 4, Chapter 7, the quality of services for Aboriginal people in urban areas is a particular concern to the Commission.

[A]nother issue is off-reserve Native people, youth. NNADAP is an effective program, but it is only geared to on-reserve people. There is really nothing for off-reserve people…people in the urban centres….I have had a lot of confrontations with off-reserve youth organizations within the city saying, “It is for Native people, isn’t it? Why can’t we go?” And we say: “Well, it is not your money”….[F]unding must become available through the government; I am not sure, Health and Welfare Canada or the other governments. I am not sure where it would come from.

Cheryl Starr
Saskatchewan Indian Youth Advisory Committee
Saskatoon, Saskatchewan, 27 October 1992

Since a substantial percentage of Aboriginal people live in urban centres and it is not currently possible for them to have access to the same resources as those available in Aboriginal communities, this situation must be rectified. The problems of drug abuse are just as prevalent in the cities as they are on the reserves. Why not have a NNADAP officer in the cities? [translation]

Louis Bordeleau
Native Aid and Friend Centre of Senneterre
Val d’Or, Quebec, 1 December 1992

There should also be an alcohol abuse program (like NNADAP) for Métis people.

Sydney McKay
Manitoba Metis Federation
Thompson, Manitoba, 31 May 1993[293]

Provincial and territorial governments should co-operate with the federal government to provide services for treating and preventing substance abuse to Aboriginal people who do not reside on their traditional lands and to Métis people. Urban youth, particularly the increasing number who are coming into conflict with the law, and those living on the streets, detached from any stable community, are frequently involved in substance abuse. Services should be adapted to fit their needs and be under Aboriginal control.[294]

Recommendation

The Commission recommends that

3.3.15

Federal, provincial and territorial governments and national Aboriginal organizations, including Aboriginal women's organizations, explore how training approaches and personnel complements of current health and social services, including the community health representative and drug and alcohol abuse programs, can contribute to a more comprehensive, holistic and integrated system of services, while helping to maintain continuity and adequacy of Aboriginal community services.

Earlier in this chapter, we outlined our proposals for developing Aboriginal healing centres and lodges. We believe some residential treatment centres currently funded through NNADAP will want to continue focusing on the treatment of addictions. We concluded that there is a need for many more such programs across Canada. At the same time, other residential treatment centres want to expand the scope of their services, but they have been constrained by the terms of reference for NNADAP funding. We believe these centres should be given the opportunity to become part of the network of holistic healing lodges we propose.

Health Canada is considering a review of NNADAP to clarify how it works best and what directions it should pursue in the future. Such a review is warranted, because many concerns have been expressed about the program, and an evaluation has not been conducted for seven years. The issues raised here should form the basis of the evaluation and any future program planning.

Training in other areas

The CHR program focuses on health education and promotion services, while NNADAP focuses on services in the addictions field. While we have suggested a number of improvements to both, we believe the programs have had a significant effect on the health and social conditions of Aboriginal people already. Their success in promoting Aboriginal human resources development is particularly welcome. However, there are many other areas where improved services are still needed, where success will depend on the availability of qualified Aboriginal health and social service professionals, but where there is no program like NNADAP or the CHR program.

We are concerned about the current status of Aboriginal human resources in such important fields as social services, child welfare, mental health and social assistance administration.[295] There are no systematic, organized programs of support for training and professional development in these areas among federal and provincial government departments, post-secondary educational institutions, or Aboriginal and non-Aboriginal service agencies. Individual Aboriginal communities have had to find the funding for these activities from within their already limited program administration budgets.

Formal training programs at Aboriginal and non-Aboriginal post-secondary educational institutions will play a very important role in increasing the number of Aboriginal professionals. However, there is a need to co-ordinate training and education with opportunities for employment and advancement that serve the particular needs of Aboriginal communities, both urban and rural. (For a full discussion of job-related training strategies, see Volume 2, Chapter 5.)

An example of the limitations of current approaches to training and retraining is found in a study of a Manitoba Aboriginal child welfare agency and its workers conducted for the Commission (see box).

While planning for integrated and holistic approaches to service development and delivery, governments and the national Aboriginal organizations should also consider Aboriginal human resources development programs — like NNADAP and the CHR program — in other areas that are critical to the health and well-being of Aboriginal people.

Planning for Success — Overcoming Barriers

Human services agencies, as well as other employers, customarily obtain their staff 'ready-made' as graduates of post-secondary education programs offered outside the workplace and paid for mostly from general revenues. Such is not the case with First Nations and other Aboriginal employers. This is true, first, because they rightly want to employ First Nations people as far as possible. Second, in the local communities, even without any positively discriminating hiring policy, the only staff available are First Nations people….First Nations graduates of the same programs from which non-Aboriginal employers draw their staff are in seriously short supply.

A full range of responses, sustained over a considerable number of years, is required to attend to this shortcoming. These should include everything from in-service training to community college certificates; from degree programs to specially designed training programs. Some may require periods of study away from the community; others may be designed in a more decentralized fashion, enabling community-based part time study. Content and duration will vary depending upon the needs of the individual and the agency….

It is observed that quite unrealistic expectations are placed upon post-secondary institutions and training programs in terms of what they can deliver in what time frame. For example, a typical middle class non-Aboriginal student, entering a bachelor of social work program with all the academic pre-requisites, takes four years of full-time study to complete. This assumes no major financial or other interruptions to the student's program. The First Nations agencies on the other hand depend, at least for most of their local staff, on programs (degree or otherwise) in which existing staff can enrol. In other words, assuming half-time work and half-time study, it would take each worker/student eight years to complete. Granted, a degree program is at the high end of the continuum, and some short-cuts and accommodations can be made even in a degree program (practicums in the workplace, for example), but the time frames and sustained commitment from the agency, employee and funders outlined here far exceed any discussions on the subject of training this author has seen or heard.

Furthermore, the typical student referred to here hardly exists in First Nations communities….[V]ery few local staff have the usual

prerequisites. Completing the necessary remedial work may add yet more time to the study period….[M]any Aboriginal students enroled in programs offered by mainstream institutions speak of the difficulties they experience with cultural dissonance. This is experienced in both the content and process of instruction. It leads often to withdrawal, and at best, frequent time-outs to deal with their doubts….[I]n the foreseeable future, heavy reliance on the mainstream institutions for trained staff will continue. Planning for the necessary time frames, staffing patterns…and funding will need to be predicated on this fact.

Even if a period of apprenticeship with elders, and/or a more culturally relevant program at an Aboriginal-controlled post-secondary institution (of which there are few at present) were seen as appropriate, other sorts of crises conspire to disrupt the continuity of the period of study….

[T]he content of the journey of inquiry in human services training is more likely than for other students to trigger in the Aboriginal student memories of past abuse or other damaging experiences….When the individuals themselves feel whole and free of the crisis in their own identity, they are rarely free of the crises experienced by family members and others close to them. Deaths, births, family violence, suicide, ill-health, job loss, economic hardships of other kinds, are life events, most of a stressful kind, that are experienced by Aboriginal people more than the typical middle class student….Add to the elements listed above, the usual staff profile of a mature person (usually female), with extensive family responsibilities now combined with those of worker and student, and one begins to more fully appreciate the challenge to the individual, the employer, and the training institution….

This section of the report concludes with two thoughts. The first is that…none of the three parties [to the Manitoba Aboriginal tri-partite agreements, that is, Canada, Manitoba, and the Aboriginal organizations involved] have developed a serious long-term training plan that would be commensurate with the degree of importance attached to the issue….Second, none of the training programs provided to date, have planned for very many of the barriers to success which have been listed here. Time frames need to be planned in a more realistic fashion, staffing patterns need to be changed to allow for educational leave at the same time as the agency is obliged to deliver services, and a high level of supports of varied kinds need to be provided to the students. Where even some of these elements have been present, completion rates have

markedly improved.

Source: Pete Hudson "Politics and Program: A Case Study of a First Nations Child and Family Service Agency", research study prepared for RCAP (1994).

University-based initiatives

Program-specific training, such as that developed in the NNADAP and CHR programs, is important, but attention also needs to be focused on attracting Aboriginal students to post-secondary institutions and keeping them there for the duration of a degree program. As discussed more fully in Chapter 5 of this volume, Aboriginal education and training institutions are ready to take on more responsibility in this area, and they should receive the increased support needed to expand the range, quality and capacity of their programs. As well, some non-Aboriginal post-secondary educational institutions have made great strides in attracting and keeping Aboriginal students. Unfortunately, many others have made no measurable headway. Successful programs deserve recognition and support, and other institutions should be encouraged to implement them.

The progress made by several medical schools is noteworthy. Graduates of the University of Alberta, for example, will contribute a 35 per cent increase in the total number of Aboriginal physicians in Canada over the next five years. In addition, the university attracts Aboriginal students to programs in health administration, pharmacy, physiotherapy, occupational therapy and nursing. A significant proportion of practising Aboriginal physicians is made up of graduates of the University of Manitoba, which has had a pre-medical studies program for Aboriginal students since 1979. As well, the University of Toronto has a support program for Aboriginal medical students.

The Canadian Association of University Schools of Nursing presented a brief to the Commission about many innovative programs in nursing schools across Canada that are intended to attract and graduate Aboriginal nurses.[296] For example, Yellowknife has developed a registered nurses program; Dalhousie University in Halifax offers an outpost nursing program and a northern clinical program; the University of Saskatchewan has offered the National Native Access Program to Nursing since 1985; and Lakehead University in Thunder Bay, Ontario, has a Native Nurses Entry Program. Similar programs for other health and social service professions are also beginning to emerge. For example, the Saskatchewan Indian Federated College offers a Bachelor of Indian Social Work program, and McGill University offers a certificate program

in northern social work practice. St. Thomas University, in Fredericton, and Dalhousie University have offered bachelor of social work programs with modified content and schedules to accommodate Aboriginal people already employed. These are welcome developments.

Successful participation in professional programs often depends on students receiving financial and academic support as well as personal and family support. This requires a commitment from the educational institutions involved and from government. The University of Alberta, for example, has established an Office of Native Health Care Careers, and similar support programs exist at a number of other Canadian universities.

In the past, the adaptation of professional programs has usually depended on limited-term grant funding. We believe that it is the obligation of mainstream institutions to provide culturally appropriate services, including the education of personnel to staff such services.

Because of funding limitations and other restrictions, some training programs have had to place limits on the number of new admissions. In other instances, however, the existing infrastructure of faculty and other resources could support a larger number of students. We urge post-secondary institutions and funding bodies to explore creative ways to realize this potential. While there may be enough non-Aboriginal professionals in some fields and too many in others, for Aboriginal people there are serious shortages in every health and social service profession.

Although some mainstream institutions and government programs have shown leadership in improving educational opportunities for Aboriginal students pursuing professional training, others have shown little interest. It is difficult to see how a continuation of current practices alone will result in the significant increases in Aboriginal human resources that are required. While current supporters must increase their commitment, new ones should also be enlisted.

Educational institutions, governments, and provincial and national professional organizations, acting together with Aboriginal organizations, can do much more than they do now to address the shortage of Aboriginal professionals. Moreover, if the will is there, much can be accomplished within existing mandates and budgets. In this regard, it would be useful to examine the following questions:

• What barriers exist that prevent Aboriginal students from participating in

professional training programs, and how can these barriers be removed?

• How can Aboriginal people become more fully involved in the development and delivery of professional education programs?

• How can Aboriginal organizations and governments, mainstream educational institutions, professional organizations, and Canadian governments work together more effectively to increase the number of Aboriginal people in the health and social service professions?

Some institutions may conclude that they have little to offer, but others will discover that they can make a significant contribution.

We believe it is important to review the curricula of professional education programs to improve their cultural appropriateness and effectiveness for Aboriginal and non-Aboriginal students alike. We are persuaded also that the success of Aboriginal students in mainstream education programs is improved when there is a core group of Aboriginal students who can provide personal and professional support to one another. Where this is occurring, benefits for non-Aboriginal students are also being reported. Opportunities for the cross-fertilization of Aboriginal and non-Aboriginal knowledge, experience, and practice enrich the educational experience for all. (These ideas are discussed more fully in Chapter 5 of this volume.)

Circumstances across the country vary to such a degree that a single prescription cannot apply. However, when some answers to these questions have been pursued in the past, they have led to a remarkable number of creative approaches that have improved educational opportunities for Aboriginal people. Some of them have included

• establishing specific admission and retention targets for Aboriginal students;

• re-examining entry requirements;

• establishing pre-professional and pre-admission preparation programs;

• developing an organized system of financial, academic, personal and family supports for Aboriginal students;

• initiating innovative strategies to provide continuing support for Aboriginal

practitioners in the field;

• creatively using mentors, secondments, and exchanges;

• supporting program innovation in colleges and universities;

• adopting alternative modes of delivering professional education programs that increase access and effectiveness; and

• involving Aboriginal people in program planning.

Many successful programs are already in place. (For more details, see Chapter 5 of this volume.)

If the participation of Aboriginal people in mainstream professional training programs is to increase, post-secondary institutions should also examine the nature of current professional training, who provides it and how. Many programs are not well suited to Aboriginal students or to the challenges that Aboriginal professionals will face in providing services to their communities.

Aboriginal participation in professional training is not simply a matter of fitting Aboriginal students into mainstream programs. These programs should be changed to attract Aboriginal students, to value Aboriginal knowledge and experience, and to provide culturally relevant information and skills that will prepare Aboriginal students to work in their communities. We believe that mainstream educational institutions can accomplish this transformation by forging new relationships with Aboriginal organizations, governments and communities, as well as with Aboriginal students and professionals. We return to these issues in Chapter 5 of this volume.

Many presentations during our public hearings focused on the need to make professional training more relevant and effective for Aboriginal and non-Aboriginal students who will be providing services to Aboriginal people.[297] We were told:

Our education system is a model that appears quite incompatible with the reality, culture and traditions of Aboriginal people….[T]he Commission should make representations to the various educational groups to include in their educational programs for health professionals concepts related to the various… cultural approaches. [translation]

Dr. Paul Landry
Association des hôpitaux du Québec
Montreal, Quebec, 16 November 1993

Training of social work staff should become inclusive of cultural issues as they apply to Aboriginal people. I feel that this is something we all need…training on subjects that we don't have as much knowledge on as we should.

Rhonda Fiander
St. John's, Newfoundland
22 May 1992

Presently, many Native counsellors are trained through bachelor of social work programs, programs which fail to serve the specific needs of Aboriginal students and communities. We accept that some aspects of the BSw program are immensely helpful; however, Native counsellors require a broader range of training.

John Sawyer
Ontario Native Education Counselling Association
Toronto, Ontario, 18 November 1993

[We recommend] that cross-cultural training and preparation be mandatory for non-Aboriginal persons working amongst Aboriginal peoples. This would include those involved in policing, in correctional services, health and education, social services, and a variety of government agencies and departments. It is essential that such training be developed and directed by Aboriginal peoples.

Reverend William Veenstra
Christian Reform Church in Canada
Vancouver, British Columbia, 15 November 1993

I think it is essential to develop training, for example, in cross-cultural nursing or training for doctors who are going to work in the North and all personnel who are going to work in the North, to work within a cross-cultural perspective of communication with Aboriginal communities that helps view the culture not as a risk factor but as a coherent and intelligent system. For that, obviously much remains to be done….It requires more than open-mindedness and receptiveness; it also requires that the researchers innovate in providing the content of those approaches. [translation]

Rose Dufour
Department of Community Health,
Laval University Hospital Centre
Wendake, Quebec, 18 November 1992

Ultimately, there is an unavoidable need to re-examine thoroughly the professional training of non-Aboriginal socio-health staff while encouraging Aboriginal people through the use of approaches and practices that respect their culture and diversity. [translation]

Francine Tremblay
Montreal, Quebec 16 November 1993

There is abduction of our children because non-Aboriginal social workers have no understanding of the values and traditions of our people.

Doris Young
Founding President, Indigenous Women's Collective
Winnipeg, Manitoba, 22 April 1992

Cross-cultural training for health/hospital personnel and professionals [is required] — for example, physicians, optometrists, dentists, assistants, receptionists, ambulance drivers….All levels of government should enhance the knowledge and sensitivity of health care providers with respect to Native customs and traditions.

Gloria Manitopyes
Calgary Aboriginal Urban Affairs Committee
Calgary, Alberta, 26 May 1993

We received many briefs and presentations from those involved in post-secondary education telling us of steps being taken to develop more culturally sensitive approaches to professional training for Aboriginal students. A professor at McGill University summed up her view of the changes needed in universities in this way:

Universities must open their gates to Aboriginal communities, to their students, seek their counsel, instantiate their ideas, build programs and practices that will empower rather than marginalize, that will underline the strength and dignity of Aboriginal students' identities, their cultural holdings, their remaining languages, as well as recognize their struggles and serve to enrich the wider community and the populations of Aboriginal communities.

Martha Crago
McGill University
Montreal, Quebec, 2 December 1993

Recommendations

The Commission recommends that

3.3.16

Post-secondary educational institutions providing programs of study leading to professional certification in health or social services collaborate with Aboriginal organizations to examine how they can

(a) increase the number of Aboriginal students participating in and graduating from their programs;

(b) provide support for students to promote completion of programs;

(c) develop or expand specialized programs; and

(d) modify the curriculum of programs leading to certification so as to increase the cultural appropriateness and effectiveness of training provided to Aboriginal and non-Aboriginal students who will be providing services to Aboriginal people.

3.3.17

Post-secondary educational institutions and professional associations collaborate with Aboriginal organizations to ensure that professionals already in the field have access to programs of continuing professional education that emphasize cultural issues associated with the provision of health and social services.

A related issue (already discussed in relation to the CHR program and NNADAP) is the failure of mainstream educational institutions and professional organizations to recognize and affirm Aboriginal knowledge, skills and experience. This is a barrier to entry into professional training and into employment where professional skills can be developed further. It is also a

barrier to advancement. Formal credentials and work experience with non-Aboriginal organizations — even if they are not directly applicable to the needs of Aboriginal people — are often valued more than Aboriginal knowledge and experience working in Aboriginal communities.[298] In Chapter 5 we discuss a number of strategies to overcome these barriers.

As Aboriginal educational and professional institutions continue to develop, and as self-government proceeds, Aboriginal people will take a much more active role in recognizing and certifying Aboriginal professionals, based on Aboriginal standards and accreditation processes. However, mainstream educational institutions and professional organizations should examine how they can recognize the legitimacy and value of what Aboriginal people have learned through their education and life experience. There is an opportunity and a challenge for the organizations representing post-secondary educational institutions and university and college teachers to encourage their members to embrace the spirit and intent of our recommendations and to help bring about needed changes.

Recommendations

The Commission recommends that

3.3.18

Post-secondary educational institutions involved in the training of health and social services professionals, and professional associations involved in regulating and licensing these professions, collaborate with Aboriginal organizations and governments to develop a more effective approach to training and licensing that recognizes the importance and legitimacy of Aboriginal knowledge and experience.

3.3.19

The Association of Universities and Colleges of Canada and the Canadian Association of University Teachers encourage their members to implement the Commission’s recommendations with respect to professional training of Aboriginal people for health and social services, and that these organizations provide leadership to help ensure that the recommendations are implemented.

The need for government support

Post-secondary educational institutions will be unable to move forward in the directions we have recommended without the support of the governments on which they rely for much of their funding. We believe that governments have an obligation to participate in these efforts. Existing programs have proven effective, but their scope needs to be expanded significantly if the problems we have outlined are to be overcome.

The Indian and Inuit Health Careers Program is one example of how governments, Aboriginal communities and post-secondary educational institutions can work together to promote Aboriginal professional development.[299] Established in 1984 by the medical services branch of Health Canada, the program is intended to encourage and support Aboriginal participation in educational opportunities leading to professional careers in the health field. The program also seeks to overcome the social and cultural barriers that inhibit the educational achievement of Aboriginal students. Originally funded as a three-year pilot project, the program was approved for continuing funding in 1986.

The program provides support at the student, institutional and community levels. Some 80 per cent of its budget supports post-secondary education institutions in developing student support and counselling services, curriculum enhancements, and access programs for Aboriginal students entering health studies. Programs that receive support include the Native Nurses Entry Program at Lakehead University, the National Native Access Program to Nursing at the University of Saskatchewan, and the Native Health Care Careers Program at the University of Alberta.

At the local level, the program supports Aboriginal communities, efforts to encourage students to choose health careers through activities such as career fairs, workshops, role models and field trips to health facilities. It also provides orientation and on-the-job training for students pursuing health studies.

A small but important part of the program involves providing direct financial assistance to Aboriginal students. Since 1984, the program has awarded 200 bursaries and 70 scholarships to First Nations, Inuit and Métis students.

The Indian and Inuit Health Careers Program is an example of what government agencies can do to help Aboriginal people pursue professional training. We believe other government agencies — federal, provincial and territorial — should consider how they can encourage increased Aboriginal

participation in a variety of health and social services professional training and develop other such programs.

It is regrettable that the Indian and Inuit Health Careers Program has not been expanded over the years. The program's original annual budget was $3.1 million in 1984; however, the annual budget stood at $2.6 million in 1994-95. As a result, funding for some program components has been reduced, while for others it has been eliminated altogether. A further limitation of the program is that institutional support is committed for only three years at a time. This has been a serious obstacle to long-term planning.

Given the critical shortage of Aboriginal professionals and the importance of increasing their numbers, we consider the reductions in the scope of the Indian and Inuit Health Careers Program ill-advised. We believe that such initiatives should be expanded and transferred to Aboriginal control.

The Indian and Inuit Health Careers Program is one type of initiative that warrants support. The approaches validated by experience in the program should be expanded: support to educational institutions, direct assistance to Aboriginal students, and promotion of health careers through building community awareness.

Governments have also been involved in providing work-related training opportunities for Aboriginal people through the programs of the federal department of human resources development and other agencies. These programs have prepared some Aboriginal people for involvement in health and social services programs, but training is provided in many other areas as well. Some steps have been taken to involve Aboriginal people more directly in needs assessment and in the design and delivery of programs. However, as discussed more fully in Volume 2, responsibility for these programs must be in the hands of Aboriginal people if the needs of Aboriginal communities and nations are to be met.[300]

Community-based training and education

A comprehensive approach to the development of Aboriginal human resources must look beyond programs of study offered at post-secondary educational institutions, which by themselves will not be enough to meet the need we have identified.

In developing our ideas about community-based training, we considered a number of needs. A realistic and effective plan for developing Aboriginal human resources must provide for community participation and for recognition of traditional practices. Many of the most effective health and healing initiatives that have come to our attention have been instituted by Aboriginal community leaders who do not have the type of education or experience that would be recognized by mainstream educational and professional bodies. Therefore, any plan for developing Aboriginal human resources must consider how to support the efforts of community leaders to improve health and social conditions in their own communities.

Aboriginal communities and nations also need opportunities to share their ideas, to learn from one another, and to develop collaborative approaches to assessing and addressing education and training needs. They must also be able to voice their needs directly and seek their own solutions.

As discussed earlier in this section and in Chapter 5, structured programs requiring full-time study over a number of years at institutions far from Aboriginal communities are not accessible to many potential Aboriginal students. While innovations such as distance education are helping, it will be some time before a full range of professional training programs is available to most Aboriginal communities in Canada. Even in urban areas, where an increasing number of Aboriginal people reside, social, cultural and economic barriers inhibit access to mainstream post-secondary programs.[301] While these barriers are being removed, community-based training initiatives can be adapted to address community priorities and help to create a climate that prepares and supports Aboriginal people planning to pursue professional training.

Aboriginal professionals, particularly those practising in rural and remote areas, have a variety of needs with regard to continuing education and professional development once they have completed their initial training. With support, they can often make a significant contribution to the development of human resources in their communities. Support to those already in the field, so that they can promote awareness and training in their own communities, is an other important reason to provide for local training in a human resources development plan.

Aboriginal people are in the process of redefining professional training to make it more holistic, more grounded in Aboriginal experience, and more relevant to Aboriginal circumstances. Much of what constitutes the Aboriginal knowledge

and experience base is not recognized in formal programs of instruction or training, although, as noted earlier, some institutions are making progress in this area. To provide for the preservation and enhancement of Aboriginal knowledge and practices, Aboriginal people must have the opportunity to engage in knowledge development and transmission.

No top-down or centralized approach to education or training will be able to respect the diversity of needs and opportunities at the local community level. In fact, the quality of Aboriginal education and training will depend to a large degree on how knowledge and expertise currently available at the community level are used. Enhancing the ability of communities to participate in the design of education and training programs can only contribute to the quality of the programs that are developed.

Aboriginal education and training institutions, controlled by Aboriginal people, can make a very important contribution to addressing these needs over the coming years, as they evolve in tandem with other structures under self-government. However, we believe that additional measures are required now.

In 1994, the government of Ontario introduced an Aboriginal health policy and subsequently initiated an Aboriginal Healing and Wellness Strategy.[302] This strategy was developed jointly with the Aboriginal people of Ontario. Under the policy, the health ministry undertakes to provide funding for training Aboriginal personnel and volunteers engaged in programs related to Aboriginal family healing and health. Funding is available to Aboriginal communities or organizations, and collaborative projects involving several communities or organizations are particularly encouraged. The cost to organizations of analyzing policy and participating in the planning and management of initiatives is explicitly recognized. Eligible projects are those that will build Aboriginal knowledge and skills, such as projects to develop curriculum, training resources and materials, training programs or strategies, and specific training events. Funding is limited, but enhanced funding is available for collaborative projects and for projects in remote locations. Project results are to be shared with other communities through an Aboriginal health clearinghouse.

We believe that the approach adopted by the Ontario government will encourage the creative energies of Aboriginal organizations and communities. Funding to communities will give them an opportunity to proceed with training and education activities that they consider priorities. We are also confident that the Ontario approach will result in new partnerships between Aboriginal organizations and communities and with mainstream educational institutions.

Other governments are also recognizing the importance of community-based education and training. For example, the community wellness program adopted by the government of the Northwest Territories contains a significant community education and training component. The directions document points out:

When education and training programs are developed and delivered by outside experts, and held outside the community, not as many people are able to take advantage of the training opportunities. Some simply do not complete their training. Education and training programs must be culturally appropriate, delivered by Aboriginal people, and offered as close to home as possible. It is crucial they be relevant to community members for them to assume responsibility for their own care.[303]

Education and training also figure prominently in the Alberta government's 1995 strategy to improve Aboriginal health.[304]

While our earlier recommendations were aimed primarily at providing support for Aboriginal participation in formal courses of study at educational institutions, we believe that widespread adoption of the Ontario approach would result in the development of many worthwhile community training and education initiatives, such as

• education and training activities to support traditional healing and the knowledge on which it is based;

• special training measures in northern and isolated communities for social workers, nurses, police officers, CHRs, and community organizations to assist them in dealing with substance abuse, suicide, violence in families and other problems;

• in some regions, specially trained crisis response teams of health professionals who can react to emergencies;

• distance education and support programs to advance the training of students and practitioners in remote areas;

• well-qualified translators, interpreters and escorts trained to accompany people to medical appointments, because the services provided by these

individuals can have a profound effect on the accuracy of diagnosis and the effectiveness of treatment;[305]

• specialized training to help Aboriginal and non-Aboriginal professionals deal with the challenges facing Aboriginal people in urban areas;

• assistance in transferring ownership and responsibility for health and social services systems because of the long history of government control with limited community input;

• training and professional development opportunities for board members and staff in areas such as needs assessments, program planning, program evaluation, administration, community organization, and organizational development as new Aboriginal-controlled programs (such as healing centres and healing lodges) are developed;

• the opportunity for Aboriginal communities, organizations and governments involved in health and social services development to come together, to share ideas, and to profit from one another's experience and expertise; and

• assistance and support to reorient segmented service systems so that they are more holistic and more responsive to community needs.

The needs are diverse, and the priorities are best determined by the communities themselves.

As in the Ontario plan, any new approach should be flexible enough to respond to the full range of training needs identified by Aboriginal communities. It should also reward co-operation and collaboration — if Aboriginal communities or governments within a region see that there are benefits to collaborating with one another to address common needs, the program should be flexible enough to respond to these opportunities.

Recommendation

The Commission recommends that

3.3.20

Federal, provincial and territorial governments, in collaboration with Aboriginal

organizations and governments, allocate funds to support Aboriginal community participation in planning, program development, training, and promoting community awareness in relation to human resources development in health and social services.

Traditional healing and traditional healers

Our analysis of Aboriginal health and social conditions, and the strategy for Aboriginal health and healing based on this analysis, focused attention on the importance of promoting traditional Aboriginal healing practices as one of the essential components of effective Aboriginal health and healing systems. Many issues have to be addressed if traditional healing is to make a greater contribution to the well-being of Aboriginal people, including access to existing services, protection and promotion of existing skills and knowledge, regulation of traditional healing practices by traditional healers themselves, and co-operation between traditional Aboriginal and western practitioners. Our recommendations will encourage and support traditional practices, but here we want to provide some further thoughts about this important subject.

Traditional practices have survived years of ridicule, denunciation and prohibition, though a great deal of traditional knowledge was no doubt lost in the years of suppression. It would be easy to downplay the importance of traditional practices, because Aboriginal communities have often hidden them from non-Aboriginal eyes in order to protect them. In fact, some Aboriginal people might not be aware of the opportunities offered by traditional healing, and they might not even know about healing practices available in their own communities. It is important, therefore, that surviving practices be protected from further loss and misrepresentation, and that they be strengthened and adapted to contemporary conditions. Interested readers will find a more detailed discussion of traditional knowledge in Volume 4, Chapter 3.

To preserve existing traditional knowledge and explore its application to the health and social problems facing Aboriginal people today, a number of issues will have to be discussed and resolved by governments, health authorities and healers. (See Appendix 3A for elaboration of issues related to traditional healing practices.) The number of active healers, midwives and elder-advisers is unknown, but it is not likely to rise as fast as the demand for their services. This suggests the need for training and/or apprenticeship programs.

Along with a shortage of healers, intolerance of alternatives to bio-medicine in the United Sates and Canada over the last hundred years has led to a decline

in traditional practices. They are little known and only superficially understood, except among a small number of traditionalists — some of them elders, but many of them younger. Resistance to an increased role for traditional health and healing comes from those who believe Christian values conflict with traditional values, from the non-Aboriginal population, and from the bio-medical community. It will take consistent effort in public and professional education to change these views.

Traditional healing has endured major and deliberate assaults on its validity. To protect and preserve existing skills and knowledge, and at the same time develop and extend their application, active support — not just increased tolerance — is required. In non-Aboriginal society, this falls under the heading of 'research and development', an accepted and well-funded requirement of bio-medicine. An equivalent support structure, fully controlled by Aboriginal people, is needed to preserve and advance the potential of traditional healing.

These matters are primarily the business and responsibility of Aboriginal healers, communities and nations. As responsibility for the planning and delivery of health and social services is taken on by Aboriginal nations, it will fall to them to decide the place of traditional healing. Nevertheless, there is a role for governments — they can and should provide funds to help Aboriginal people now, and in the long-term they must establish financing frameworks to enable Aboriginal health and social services to develop traditional healing practices in the way and to the extent they see fit.

Recommendation

The Commission recommends that

3.3.21

Governments, health authorities and traditional practitioners co-operate to protect and extend the practices of traditional healing and explore their application to contemporary Aboriginal health and healing problems.

Implementing this recommendation will require immediate steps, such as conservation of the oral tradition by compiling written or video records, encouraging apprenticeships, and other means; patent protection for traditional pharmacological knowledge and substances; and controlled access to traditional knowledge that is considered sacred.

In addition, government and non-government funding bodies, such as the Social Sciences and Humanities Research Council, the Medical Research Council, equivalent funding agencies of provincial and territorial governments, and private foundations concerned with health and social well-being, should designate funds for the study, preservation and extension of traditional health and healing practices. These funds should be administered by a committee consisting of a majority of

Aboriginal people and chaired by a qualified Aboriginal person.

Aboriginal governments, health authorities and traditional healers should also co-operate in exploring the history, current role, and future contribution of traditional health and healing practices.

Finally, mainstream institutions should consider and implement strategies to extend understanding of and respect for traditional health and healing practices. These might include roles for

• schools, especially where there is a significant Aboriginal population, to explore the values and practices of traditional medicine as part of inculcating in students an overall sensitivity to Aboriginal cultures;

• Aboriginal health and social service professionals and their associations to explore the applicability of traditional values and healing practices to their area of endeavour and to work with non-Aboriginal professional associations to create a supportive environment for their use;

• social service agencies, especially those serving an Aboriginal population with persistent social problems, to explore the possibility of incorporating the values and practices of traditional healing in current programs.

A policy of enhancing the role of traditional healing in Aboriginal and mainstream health and social services will require co-operation between conventionally trained personnel and traditional practitioners. This has important implications for the training of non-Aboriginal health and social services professionals.

Institutions involved in training health and social services professionals, as well as professional associations, should develop ways to sensitize practitioners to the existence of traditional medicine and to the possibilities for co-operation

and collaboration across boundaries. In addition, Aboriginal and non-Aboriginal health care organizations and associations should continue to discuss the benefits of and barriers to collaboration and co-operation through periodic meetings or conferences, by the initiation of one or more demonstration projects to explore models of partnership, and through other means.

Recommendations

The Commission recommends that

3.3.22

Aboriginal traditional healers and bio-medical practitioners strive actively to enhance mutual respect through dialogue and that they explore areas of possible sharing and collaboration.

3.3.23

Non-Aboriginal educational institutions and professional associations involved in the health and social services fields sensitize practitioners to the existence of traditional medicine and healing practices, the possibilities for co-operation and collaboration, and the importance of recognizing, affirming and respecting traditional practices and practitioners.

There have been some important developments in these areas, particularly in recent years. But a more dedicated effort is required on the part of all concerned to increase the level of understanding and respect and to safeguard the traditional knowledge and practices that are so vital to the well-being of many Aboriginal people.

Conclusion

Human resources development is one of the most important aspects of building the capacity of Aboriginal peoples and nations to address pressing health and social needs. It is clear to us that more services, if imposed by outside agencies, will not lead to the desired outcomes.

There is very little current information about the status of Aboriginal human resources in health and social services in Canada, but what is available indicates shortages in critical areas. While information should be collected on a

more systematic basis, and while a comprehensive plan for Aboriginal human resources should be developed, these activities should not be allowed to delay the immediate action needed to increase the number of Aboriginal people who can design and deliver health and social services.

We have proposed a multi-faceted approach to the development of Aboriginal human resources in the health and social services fields. Educational institutions must increase their capacity to train Aboriginal students and make the training they provide more relevant to Aboriginal needs, but Aboriginal students must also be assisted to take advantage of the opportunities that become available. Mainstream institutions must lend their support, but there is also an increasingly important role for Aboriginal institutions. Formal courses of study are needed, but more flexible, community-based options for increasing competence and capacity are also required. Existing programs that have proved their value must be expanded, but other institutions must also become involved in expanding opportunities for Aboriginal students. Aboriginal people must have the opportunity to pursue professional studies, but it is also important that traditional knowledge and practices be preserved and enhanced.

By working together, Aboriginal and mainstream educational institutions, professional associations and service delivery organizations can make a difference. Many models of effective co-operation exist, but the scope of current initiatives must be broadened significantly to address present and future needs.

The health and social conditions facing Aboriginal people in Canada today constitute a crisis and a tragedy. No amount of external intervention, however well intentioned, will return Aboriginal people to the state of well-being they once enjoyed. What external forces cannot bring about, however, Aboriginal people can achieve for themselves. We firmly believe that a commitment to developing Aboriginal human resources will help to bring about the significant improvements in the health of Aboriginal people that are so desperately needed.

3.4 Enlisting the Support of the Mainstream Service System

It has become clear to us that more effective responses to the health and social needs of Aboriginal people will have to be achieved through two complementary strategies: the continuing development of health and healing

systems under the control of Aboriginal people; and the transformation of the mainstream service system so that it can make a more positive contribution to the well-being of Aboriginal people. Having discussed our ideas about Aboriginal institutional development, we turn now to the steps that should be taken concerning the mainstream health and social service system, including government programs, hospitals, health centres, drug and alcohol programs, family violence programs, child welfare programs, programs for persons with disabilities, public health programs, mental health programs and residential treatment programs.

Some might suggest that mainstream services have little to contribute to the improvement of Aboriginal health and social conditions. They have often failed Aboriginal people in the past, and if Aboriginal institutions and governments continue to develop as we recommend, there is no doubt that many Aboriginal people will look to institutions of their own design to provide services. Nonetheless, we believe mainstream health and social programs will continue to have a significant effect on the lives of Aboriginal people and that it is important to enlist the positive support of these programs.

These programs will continue to influence the well-being of Aboriginal people for several reasons. There will always be Aboriginal people who choose mainstream services, even if programs under Aboriginal control are readily available. This should not be surprising, because the element of choice is no less important to Aboriginal people than it is to other Canadians. No matter how good a particular service is, or how competent the service provider, it will not be the most effective or desirable option for every individual in all circumstances. In Canada, we value being involved in decisions that affect our well-being, and this involvement can have a significant bearing on the effectiveness of the services we receive.

Having choices among services and service providers, however, is likely to remain a distant dream for many Aboriginal communities. Owing to the small population and remoteness of many Aboriginal communities, some health and social services, particularly specialized services, may be available only from mainstream providers. In these instances, the well-being of the Aboriginal people who must use these services will depend on what the mainstream system has to offer. Especially in the period when Aboriginal health and social programs are being developed more fully across the country, reliance on mainstream services will continue.

The prospects for Aboriginal people who live in urban centres are similar. At

our public hearings, many organizations pointed out that an increasing number and proportion of Aboriginal people reside in urban areas, that they require health and social services, that the Aboriginal service infrastructure is not adequate to meet their needs, and that the services available from mainstream agencies are often not appropriate or effective. As discussed more fully in Volume 4, Chapter 7, the health and social needs of Aboriginal people in urban centres are multifaceted, and they arise for a variety of different reasons. In part, they result from the poverty that Aboriginal people often experience in urban centres. While many Aboriginal people come to cities in search of jobs, housing, educational opportunities, and a better life, the reality can be very different. Poverty brings with it an increased risk of a broad range of health and social problems. In addition, the culture shock of adjusting to life in a new, and culturally alien, environment can lead to social or health problems requiring attention from service providers.

Many Aboriginal people come to urban centres with needs that arose from health and social problems experienced in their own communities. For example, we learned that some Aboriginal women move to the cities to escape violence. In other instances, Aboriginal people move to urban areas to obtain health or social services not available in their own communities. We were told that elderly people often have to relocate to urban centres to obtain needed services.[306]

To address these concerns, we set out a plan for the development of urban-based Aboriginal services in Volume 4, Chapter 7. However, even with the development of these services, reliance on mainstream services is likely to continue for the foreseeable future.

The resources allocated to the mainstream health and social services systems are vast, particularly when compared with the resources under Aboriginal control. In considering options for the future, therefore, it is only reasonable to consider how the mainstream system can help. This is all the more important since incremental resources will be very scarce in the current climate of fiscal restraint.

Aboriginal and mainstream healing systems have much to offer one another. It would be detrimental to the development of both systems, and to those they served, if ways to co-operate and collaborate were not fully explored and encouraged.

For these reasons, we conclude that the potential of mainstream health and

social service programs to contribute positively to the well-being of Aboriginal people is great, even though it has not always been developed effectively in the past.

Reforming mainstream systems: the limitations of past approaches

In recognition of the fact that non-Aboriginal health and social programs have not served Aboriginal people very effectively, and in response to pressure from Aboriginal organizations, the courts, and human rights authorities, policy makers have instituted a number of strategies over several decades in an attempt to sensitize mainstream health and social services providers to the needs and aspirations of Aboriginal peoples. It is instructive to examine some of these approaches, to analyze why they have generally produced such limited results, and to explore what can be done differently in the future.

Initiatives to improve the effectiveness of mainstream health and social service programs have taken many forms, including

• affirmative action and employment equity hiring policies;

• specialized Aboriginal units staffed by Aboriginal employees within larger mainstream programs;

• cross-cultural education programs for non-Aboriginal staff;

• Aboriginal input into mainstream programs and decisions; and

• Aboriginal customary practices included in the services offered by mainstream agencies. Affirmative action

One strategy to make non-Aboriginal health and social programs more responsive to the needs of Aboriginal people has been affirmative action. A general discussion of affirmative action appears in Volume 2, Chapter 5; here we review some of the implications for health and social services.

Most agencies serving Aboriginal people report that they make a special effort to recruit Aboriginal staff. Some agencies have gone to considerable lengths and, in a number of instances, formal programs have been approved by human rights authorities. Even for agencies not involved in providing services directly to Aboriginal communities, federal, provincial and municipal laws and policies

often call for equitable employment practices.

Most affirmative action programs involve the design and implementation of specialized recruitment strategies. These might consist of recruiting at educational institutions with high Aboriginal enrolment, advertising in Aboriginal publications, asking Aboriginal leaders to identify suitable applicants, and using specialized recruitment firms. These and other methods have been used to recruit Aboriginal social assistance workers, family services staff, corrections staff, police officers, health workers, and many others.

Many presentations to the Commission discussed affirmative action. A full array of perspectives on this controversial subject was evident. Some felt that affirmative action had been beneficial, and they called on employers to make a stronger commitment to such initiatives:

Affirmative action hiring policies for staff and professors and administrators would be one area [where] non-Aboriginal peoples can start to share the power and the resources that they hold.

James Murray
Brandon University Student Union
The Pas, Manitoba, 20 May 1992

Industry and public service require quotas, employment equity and affirmative action programs. Some people are against them, but I believe…[they] will make an impact.

Raymond Laliberté
Métis Addictions Council
La Ronge, Saskatchewan, 28 May 1992

How do we eliminate systemic racism? The answer is that we begin with systemic change. In our opinion, three ways to start that process are cross-cultural training, affirmative action, and strong and effective anti-racism policies with teeth to them….[T]he [Saskatchewan Human Rights] Commission recommends mandatory implementation of affirmative action.

Theresa Holizki
Chief Commissioner
Saskatchewan Human Rights Commission
Saskatoon, Saskatchewan, 28 October 1992

We may have to start with affirmative action programs to get more [Aboriginal] women represented in the justice system within the government, but I think that eventually women would naturally be there. Women just need a chance to get their foot in the door.

Reana Erasmus
Yellowknife, Northwest Territories
7 December 1992

If you are going to make any headway, there has to be a strong, mandatory affirmative-action type of program to bring Aboriginal people into the workforce and promote them.

Dick Martin
Canadian Labour Congress
Ottawa, Ontario, 15 November 1993

Many other presenters provided a more critical assessment of what affirmative action has achieved to date. Some also raised questions about the underlying purpose of affirmative action and suggested that such programs may have a limited role in correcting existing inequities:

It has been abundantly clear and plainly evident…that the federal government has [attempted] to assimilate and otherwise integrate Indian people into the mainstream of Canada. This included an attempt to destroy our nations, lands, cultures and values, and to make us municipal governments made up of ethnic minorities whose proper place is within the multi-cultural minorities framework assisted and recognized by policies of affirmative action.

Chief Carl Quinn
Saddle Lake Band
Hobbema, Alberta, 10 June 1992

Basically, my position is that affirmative action has failed Native people in Canada. It was designed to facilitate their entry…in the workforce, and this has not been achieved anywhere in Canada….There is a danger in affirmative action….[T]he very fact we have affirmative action programs, the larger society seems to believe that they are doing something….[I]t makes them feel good…. These affirmative action programs can go on for years and make the larger society feel good and no Natives are being hired.

John Hart

Saskatoon, Saskatchewan
28 October 1992

Affirmative action initiatives have not gone far enough. Many more of our women and people are graduating from high school and university, yet they are unable to find meaningful employment. Most affirmative action programs establish ridiculously low target levels and after hiring one or two Aboriginal people, no further efforts are made to increase the Aboriginal representation among their staff. Nor do they expend much effort to retain the staff they did hire. Many Aboriginal staff leave in frustration, tired of often single-handedly fighting ethnocentric attitudes on the part of their employers and co-workers.

Kula Ellison
Aboriginal Women's Council
Saskatoon, Saskatchewan, 28 October 1992

According to the Aboriginal employees, the affirmative action program and efforts are not working. Aboriginal employees perceive that progress is painfully slow….[W]e are low in numbers and we are compressed and concentrated at the bottom level of the civil service.

Louise Chippeway
Chairperson, Aboriginal Advisory Council
Roseau River, Manitoba, 8 December 1992

What about affirmative action? I don't know what it has done for Native people.

Bobby Bulmer
Yellowknife, Northwest Territories
9 December 1992

Most of us object to affirmative action programs on principle and because we believe that such programs fail to achieve their intended goals. Although affirmative action programs may succeed in allocating people of a given description into the workplace, by and large it is felt that legislative requirements to hire what may be unqualified or minimally qualified people achieves nothing positive in the long run for either the employer or the employee.

Bill Gagnon
Hay River Chamber of Commerce
Hay River, Northwest Territories, 17 June 1993

You know, they talk about employment equity all the time. Let's practise it.

Chief Walter Barry
Benoit's Cove Band
Gander, Newfoundland, 5 November 1992

Employers claim that they are committed to increasing the number of Aboriginal people they employ and, generally, we believe they are. With a few exceptions, however, their efforts have been largely ineffectual. Even after these programs have been in place for some time, very few Aboriginal people are employed. As a result, employers have little evidence that affirmative action works. After more than two decades of affirmative action, the vast majority of Aboriginal health and social services in Canada continue to be provided by non-Aboriginal people working in non-Aboriginal agencies.

Although most affirmative action programs have met with limited success in recruiting, retaining and promoting Aboriginal employees, a few have made noteworthy progress. Moreover, the success of some employment equity programs for other under-represented groups (for example, programs to increase the number of women on university faculties) leads us to conclude that affirmative action programs can achieve much more for Aboriginal people than their record to date would indicate.

Many reasons for the failure of affirmative action programs have been identified.[307] During economic downturns, employers have few vacancies and, consequently, few opportunities to recruit Aboriginal staff.[308] Employers also say that Aboriginal applicants often fail to meet the requirements for positions that do become available. This is a valid concern, and it is why we believe it is necessary not only to provide employment opportunities for Aboriginal people but also to train more Aboriginal people in the health and social services professions. However, we also believe there are other reasons for the low number of Aboriginal employees in health and social services agencies.

Position requirements may be difficult for some Aboriginal applicants to meet, even if they are not strictly relevant to the duties of the position. Other requirements may be unreasonable or inappropriate to apply to Aboriginal applicants, for cultural or other reasons. Insistence that applicants meet such requirements may amount to a form of systemic discrimination. We were given many examples during the course of our public hearings. We were told how high school completion, aptitude test scores, and other measures that are subject to cultural bias are used to screen out potential Aboriginal employees,

even before an interview.[309]

As we have discussed, there are no generally accepted methods or systems in place to recognize and accredit Aboriginal knowledge and experience. Rather, the focus in hiring is usually on formal credentials and experience that can be obtained only from mainstream educational institutions and employers. This may serve to discriminate unfairly against Aboriginal applicants.

Another reason for limited employment numbers could lie in Aboriginal people's experiences with health and social services agencies. Aboriginal people might question the programs and policies of the agencies trying to recruit them, for example, particularly if the agency has shown a reluctance to examine the effects of its programs and policies on Aboriginal people. They may have had unhappy personal experiences themselves, or they may have seen the consequences of inappropriate or inadequate services in their communities. This happens particularly when the potential employer exercises a social control function, as in the case of child welfare agencies. Given the historical impact of non-Aboriginal child welfare policies and services, it is understandable that Aboriginal people have shown considerable reluctance to work for non-Aboriginal child welfare agencies. They might also feel that their families or communities would criticize them for becoming part of a system that has been unresponsive to Aboriginal needs or rights in the past. They might not want to put themselves in the position of having to continue agency practices that are ineffective or culturally inappropriate.

Aboriginal candidates for positions with mainstream agencies might feel uncomfortable accepting and keeping employment in an environment where they are in the minority, or where no support system is apparent to help them deal with the stresses of the workplace. It is sometimes difficult even to apply to a non-Aboriginal agency for employment when, as is usually the case, the recruitment process is presided over by non-Aboriginal people. When agencies have no record of employing, retaining, promoting and valuing Aboriginal staff, potential candidates may not see a job with a mainstream agency as a viable career option.

When Aboriginal people do join non-Aboriginal organizations, they often feel an absence of support for the personal and professional challenges they face in professional practice. There is evidence that some Aboriginal employees in non-Aboriginal agencies do not derive the sense of fulfilment from their work that they are seeking. Instead, they seek other employment, often with Aboriginal agencies, thus leading to high turnover rates and a perception of Aboriginal

employees as unreliable or lacking the requisite loyalty to the employer.

There is nothing wrong with Aboriginal staff gaining experience in mainstream agencies and then moving on to play leadership roles in Aboriginal organizations and governments. Indeed, many Aboriginal leaders have had this type of experience. It is a positive result of the initiatives of some mainstream agencies to hire, train and promote Aboriginal staff. Our concern, however, is that the experience of Aboriginal employees in mainstream agencies is often far less rewarding than it should be. We do not believe Aboriginal staff should feel compelled to leave mainstream agencies because the working environment is not supportive.

Perceptions of Aboriginal employees as unreliable may influence future hiring practices. Likewise, when reports of bad experiences circulate within Aboriginal communities, other potential applicants are discouraged from coming forward.

In addition to these concerns, there are problems with employment equity related to the depth of commitment by employers, the adequacy of existing legislation, and the lack of effective monitoring. These issues are discussed more fully in Volume 2, Chapter 5.

A number of these concerns were summarized in a presentation to the Commission from the Canadian Auto Workers:

There is a lengthy list of problems and obstacles to be addressed before Aboriginal people in Canada gain equitable access to secure, well-paying jobs. Identifiable issues are lack of commitment of employers, beginning with top management; weak administration and enforcement of employment equity programs; bias and racism directed at Aboriginal workers; hiring procedures that discriminate; unreasonable demands for qualifications; and work arrangements that affect the ability of Aboriginal workers to settle into a job and retain it.

Debbie Luce
Canadian Auto Workers
Toronto, Ontario, 19 November 1993

Aboriginal units within mainstream institutions

Recognizing some of the problems with affirmative action, some service providers have established specialized Aboriginal units, staffed by Aboriginal

employees, within larger non-Aboriginal programs and agencies. Perhaps the best known example of this approach was the RCMP's Indian Special Constable Program (now reorganized). Similar programs have been established for employment counsellors, social assistance workers, substance abuse counsellors, health care providers, and many others. This approach has also been used with success outside the health and social services field. The National Film Board, for example, established an Aboriginal studio based in Edmonton. Its purpose is to involve Aboriginal people more fully in the Canadian film industry and to ensure better representation of Aboriginal perspectives in Canadian films.

Some of these initiatives have been quite successful in attracting and retaining Aboriginal staff and in delivering quality services to Aboriginal people. However, they have encountered many of the same problems as affirmative action, although not always to the same degree. Often they are not accorded the same status as equivalent mainstream programs, resource levels may be inferior, and staff do not always have the same latitude as mainstream staff to carry out the responsibilities of their positions. As a result, they are often seen as 'second class' programs by administrators and the public.

This was certainly the case, for example, with the Indian Special Constable Program. 'Special' meant that Indian constables were not full-fledged RCMP constables — they did not receive the same level of training or remuneration as regular constables, and they were not permitted to wear the red serge, the ceremonial uniform of the RCMP. The drawing of these sorts of distinctions is not at all uncommon in the types of programs discussed here.

Cross-cultural awareness

Another approach to improving the effectiveness of mainstream health and social service programs has focused on promoting greater awareness among non-Aboriginal staff of the needs and circumstances of their Aboriginal clients. These initiatives have usually involved ad hoc programs of cross-cultural awareness, as well as related training and education programs. Such programs have been adopted widely in non-Aboriginal agencies with a large Aboriginal caseload.

The available evidence indicates that the effectiveness of these initiatives depends heavily on the program design and the knowledge and skills of the resource persons that deliver them. Results are not always positive; in fact, some programs have had the opposite effect. As the Assembly of First Nations

pointed out in their brief to us:

Optional, ad hoc approaches to training, such as voluntary, one-day workshops — once a year seminars in response to misunderstandings — accomplish very little.[310]

The AFN has expressed concern that these types of programs could solidify stereotypes and cause friction in the workplace, leaving the impression that people of other cultures are ‘difficult’.

Cross-cultural input

Other initiatives have taken the form of inviting Aboriginal input in decision making in non-Aboriginal programs. Elders are consulted about treatment options; the band council is asked about the apprehension of a child; committees are established to provide community input in the work of hospitals and other non-Aboriginal agencies.

These measures to secure Aboriginal input often result in improved relations between Aboriginal communities and those responsible for service delivery. In addition, there is some evidence that the effectiveness of some programs has improved because Aboriginal input has led to better decisions and greater community acceptance of decisions. Yet, the improvements in program effectiveness are often far from dramatic. Moreover, opportunities for Aboriginal input often rely on informal arrangements that depend on the interest and goodwill of individual officials in mainstream agencies. Because they seldom become institutionalized, these arrangements often remain in effect for only a limited time.

Introducing traditional Aboriginal practices into non-Aboriginal programs has also become fairly commonplace. Child welfare and young offender institutions, for example, sometimes permit sweat lodges, sweet grass ceremonies, and the attendance of elders and spiritual leaders; hospitals sometimes make provision for the services of traditional healers. At least in some instances, however, officials may not be fully committed to these efforts. Moreover, programs may not be accorded the same importance or respect as corresponding programs for non-Aboriginal clients. They may even be cancelled or modified to comply with the requirements of mainstream policies or programs.

During the Aboriginal Justice Inquiry of Manitoba, for example, Commissioners

Hamilton and Sinclair found that elders and traditional healers were discouraged from visiting Aboriginal inmates in correctional facilities because they and their sacred articles were not accorded proper respect by the correctional staff.[311] Meanwhile, non-Aboriginal clergy and health professionals were not required to undergo the same security procedures.

We heard about one program that introduced Aboriginal practices into non-Aboriginal programs:

Native social workers do indeed show up to help Native offenders cope with white man's justice. Similarly, all correctional facilities have social groups for members of the First Nations. We view these and most current programs, however, as only a token and reluctant recognition of our [Aboriginal] origins. All such programs fail to provide any significant recognition of the deeper cultural, spiritual and communal traditions at the First Nations level.

Brian Espansel
Vice-Chair, Native Sons
Toronto, Ontario, 25 June 1992

Imbalance in relationships

Although the kinds of initiatives described often involve considerable effort and expense, they have not always achieved the desired results. While some improvements in the effectiveness of health and social services have been brought about, the gains have usually been modest. Even with these types of reforms, non-Aboriginal programs do not usually achieve the level of effectiveness or acceptance in Aboriginal communities that these same programs enjoy in non-Aboriginal communities.

We believe these strategies have not had a greater effect primarily because they do not address the underlying imbalance in relations between Aboriginal people and the broader society. In fact, these approaches have sometimes been used to justify the continuation of this imbalance and to avoid more fundamental reforms. We have concluded that programs based on values and beliefs that may not be shared by Aboriginal people cannot be transformed into programs that are effective and culturally appropriate through the adoption of these types of approaches alone.

Remarkably little attention has been directed to promoting real Aboriginal involvement in and control of health and social services in Canada, or to

creating true partnerships involving Aboriginal and non-Aboriginal organizations and governments, although this has certainly begun to change in recent years. Rather, the programs and policies developed by mainstream agencies have too often been assumed to constitute the best possible approach to delivering services to all, including Aboriginal people. Various initiatives, such as those we have described, have then been implemented to help Aboriginal people fit in, accept, or adjust to non-Aboriginal programs and to the values and beliefs on which they are based.

This history constitutes the backdrop against which future plans must be laid. We believe the lesson of this history is clear: the types of initiatives we have described cannot succeed unless they are accompanied by more fundamental reforms that recognize and support Aboriginal self-determination. As one presenter told us,

This new relationship [between Aboriginal people and Canada] cannot be a mere tinkering with the status quo by way of affirmative action or employment equity.

Clem Chartier
Saskatoon, Saskatchewan
12 May 1993

The types of initiatives we have described can make an important contribution to improving the effectiveness of mainstream services, provided that they are accompanied by more fundamental reforms. The imbalance in relations must be addressed, the inherent right of Aboriginal people to govern their own affairs must be recognized, and Aboriginal institutions must be allowed to flourish. If these changes do not proceed, attempts to improve the effectiveness of mainstream health and social programs for Aboriginal people through these approaches will continue to lead to frustration and disappointment.

New approaches based on a renewed relationship

Mainstream programs and service providers can contribute to improving Aboriginal health and social conditions in two important ways: by encouraging and supporting the development of health and social service systems under Aboriginal control; and by improving the appropriateness and effectiveness of mainstream services provided to Aboriginal people.

Support for the development of health and social programs under Aboriginal

control can be provided in many ways. Mainstream organizations can examine how to transfer programs to Aboriginal control; they can encourage collaboration involving Aboriginal and western healing systems; and they can support Aboriginal organizations' efforts to develop plans, standards, and processes for accrediting their programs and staff. Other steps could include supporting the development of Aboriginal networks, creating resource centres with Aboriginal materials, and negotiating partnership agreements that strengthen Aboriginal organizations involved in service delivery.

During our hearings we learned about many examples of this type of collaboration. In Inukjuak, northern Quebec, we were told that an explicit part of the mandate of non-Aboriginal health and social workers is to pass their knowledge along to Inuit fellow workers, thereby promoting the development of Aboriginal human resources in Aboriginal communities. In Winnipeg, we heard of co-operative efforts on the part of government, non-government and Aboriginal organizations to establish an urban health and social services centre for Aboriginal people, staffed entirely by Aboriginal people. In Val d'Or, we learned about steps taken by a health and social services board to assist Aboriginal people in developing a community health promotion strategy. A number of professional associations told us about their involvement in cross-cultural exchanges and collaboration among Aboriginal and non-Aboriginal health and healing experts.[312]

In Montreal, we learned about a unique research and education initiative involving the Centre for Indigenous Nutrition and Environment at McGill University. The centre is a university program whose activities are overseen by a governing board made up of six Aboriginal organizations representing Inuit, First Nations and Métis people. The participatory research model used by the centre directly involves Aboriginal communities in defining research needs and carrying out research. The centre's program specifically recognizes the importance of cultural issues and indigenous knowledge and seeks to improve the capacity of Aboriginal communities to deal with issues affecting their nutrition and environment. In northern Quebec, the mainstream public health authorities have entered into an agreement with the Cree and Kativik boards of health to provide backup tertiary care and referral services and to support these boards in the areas of health programming and evaluation. These agencies and organizations are showing leadership, and we encourage others to learn from these positive examples of what can be accomplished.[313]

There can be no doubt about the importance of good will. However, relations must be developed in a true spirit of partnership, with the levels and types of

support provided by mainstream organizations determined by Aboriginal peoples themselves. Anything less will not succeed. One non-Aboriginal educator expressed the spirit of partnership this way:

As non-Aboriginal people, we must be tolerant and accepting of political and social agendas which are not of our own making. Aboriginal peoples must govern themselves in their own ways. We must also, however, recognize that we need ‘bridging institutions’ to cross cultural divides. These institutions must be built jointly and from both directions toward the middle, instead of from one side to the other.

Douglas A. West
Thunder Bay, Ontario
27 October 1992

The second way that mainstream health and social service agencies can contribute to improving the health and well-being of Aboriginal people is by taking steps to improve the quality of their services. Some examples of the steps that can be taken include

• increasing Aboriginal staffing and other forms of Aboriginal involvement in the day-to-day operations of mainstream programs;

• developing and implementing plans to provide for the structured, organized and systematic involvement of Aboriginal people in the design of programs and in the governance of mainstream agencies;

• examining the barriers that prevent the provision of traditional health and healing services, and implementing measures to overcome these barriers;

• developing and implementing a plan to combat racist behaviours;

• providing the services of interpreters and making literature available in Aboriginal languages;

• carrying out assessments of Aboriginal health and social needs and redesigning services to meet these needs;

• bringing needed promotion and prevention services to Aboriginal communities on a proactive basis, rather than waiting until there is a crisis;

• establishing a clear point of contact for Aboriginal people so that they can easily obtain any information or assistance they require about access to mainstream services;

• developing a protocol to ensure that any concerns or suggestions about services provided are acted on promptly; and
• developing a monitoring system to ensure that the quality and effectiveness of services provided to Aboriginal people are assessed regularly.

In every instance, Aboriginal communities and organizations should be engaged in designing and guiding initiatives.

We are particularly concerned about levels of Aboriginal staffing in non-Aboriginal health and social service agencies. We have already discussed measures to increase the number of trained Aboriginal professionals, but recruitment practices and workplace policies will also have to change if trained Aboriginal professionals are to be attracted to work for mainstream agencies.

Aboriginal staffing levels in mainstream organizations should be at least proportional to the percentage of Aboriginal people served by the organization. Moreover, proportional Aboriginal representation should be achieved throughout the agency hierarchy, from entry levels to the most senior positions. Where the number of applicants or the qualifications of applicants are not sufficient to achieve these objectives, there is a positive onus on mainstream organizations to institute measures to overcome barriers to Aboriginal employment. For example, organizations can develop pre-training and apprenticeship programs, provide bursaries and other forms of support, and institute educational leave and professional development policies to address inequities in opportunities.

A renewed commitment to employment equity is required on the part of mainstream health and social service agencies. This must entail the widespread adoption of practices that have proved effective.[314] These include developing a long-term plan; shifting the approach from individual applicants and positions to one that focuses on strategic partnerships and alliances with Aboriginal communities and institutions; adopting a more proactive approach to forecasting human resources requirements and how they will be met in the future; and strengthening auditing, monitoring and enforcement mechanisms to ensure that the goals of employment equity are achieved.

At least in the short term, and likely for some time, there will be a critical shortage of Aboriginal human resources. These resources are desperately needed in Aboriginal organizations and in the mainstream system. Therefore, one of the most important steps to improve Aboriginal health and social conditions is to accelerate training and professional development opportunities for Aboriginal people.

Earlier we referred to the limited results of many cross-cultural awareness programs, yet there is no denying the importance of cross-cultural sensitivity for personnel providing services to Aboriginal people. Therefore, we believe that mainstream agencies must renew their commitment to fostering

cultural sensitivity. The risks and consequences of failure are such that cross-cultural training must be planned and implemented to provide reasonable assurance of achieving the desired outcomes. Initial cross-cultural training in the curricula of professional education programs, as well as continued training through staff orientation and professional development, will help to ensure success. It is also important to involve Aboriginal people in designing and implementing these programs. In addition, success will be influenced by the climate of support provided by the organization and by the commitment of the organization's senior administrators to provide culturally appropriate services.

Cross-cultural training should not be seen as a panacea. In the absence of the many other improvements required in mainstream agencies, cross-cultural training cannot be expected to achieve miracles. Rather, a comprehensive approach to transforming the policies and programs of mainstream agencies is required; cross-cultural training is only one component, albeit an important one.

During our hearings we heard several examples of the types of initiatives discussed here. Some of these initiatives are fully operational, while others are in various stages of planning. In St. John's, we heard about an innovative partnership between the friendship centre and a psychiatric hospital to provide interpretation services to improve the quality of mental health care for Aboriginal people.[315] In Nain, we heard about the efforts of the Melville Hospital in Happy Valley-Goose Bay to ensure that Labrador Inuit referred to other hospitals had access to an interpreter who could help them get the services they needed.[316] In the Yukon, we were informed about one hospital's efforts to hire an Aboriginal social worker and the tremendous improvements in the quality of care for Aboriginal patients that had been achieved as a result.[317]

In Montreal, the Association des hôpitaux du Québec, which represents hospitals in the province, told us about encouraging its members to allow Aboriginal people to practise their cultural traditions in the hospital setting.[318] Also in Montreal, we heard of proposals to have health and social services personnel complete apprenticeships in Aboriginal languages, to improve communication with Aboriginal clients, and we learned of special admissions criteria at one educational institution linked to the applicant's commitment to practise in a region with a significant Aboriginal population following graduation.

In several presentations in northern and southern Canada, we heard about the importance of midwifery services for Aboriginal people and learned about apprenticeship programs to train Aboriginal midwives.[319] A number of municipalities told us about steps they had taken to improve the range and appropriateness of health, social, recreational, and other services for Aboriginal people. We were also told about partnerships that municipal governments had developed with Aboriginal organizations.[320]

In Alberta, we heard about plans for mentorship programs for non-Aboriginal mental health workers, where mainstream personnel would have the opportunity to become cognizant of Aboriginal cultures, languages and traditional practices.[321] In New Brunswick, we heard about proposals to bring non-Aboriginal service providers in health and social services together with urban Aboriginal organizations to improve services for Aboriginal people residing in the city. In Saskatoon, we heard about the efforts of one human rights authority to improve the cultural appropriateness of services and Aboriginal staffing levels in mainstream agencies. In Prince George, we heard about the development of plans for the involvement of Aboriginal and non-Aboriginal agencies in a co-operative effort to meet the multiple needs of victims of fetal alcohol syndrome and fetal alcohol effect.

Finally, in Sault Ste. Marie, we heard how Aboriginal agencies are providing cross-cultural training for non-Aboriginal agencies, organizations and service providers involved in support services for Aboriginal women.[322]

We wish to recognize those involved in bringing about these creative improvements in service delivery, and we call on others to follow in their footsteps.

Plans developed by mainstream service institutions should contain a number of common elements. They should set out the organization's goals with reference

to

• attracting, retaining, and promoting Aboriginal people;

• overcoming barriers to Aboriginal involvement at all levels in the organization (for example, service delivery, program management and design, and agency governance) and how these obstacles will be overcome;

• ensuring that non-Aboriginal staff are equipped to provide culturally sensitive and effective services to the Aboriginal people;

• improving the availability of effective services to Aboriginal clients;

• monitoring Aboriginal health and healing issues; and

• supporting Aboriginal institutional development.

The specific components of each action plan will vary with the responsibilities of the organization concerned and the service environment in which it operates.

Other groups

In addition to educational institutions and mainstream health and social services agencies, the support and leadership of many others will be needed to implement the directions we have outlined. While space does not permit a detailed examination, we would like to discuss professional associations, the voluntary sector, and the labour movement.

During our hearings, we received presentations and briefs from a number of professional associations in the health and social services field — organizations such as the Canadian Medical Association, L'Association des hôpitaux du Québec, the Canadian Paediatric Society, the Ontario Psychological Association, the Canadian Public Health Association, the Ordre des infirmières et infirmiers du Québec, the Corporation Professionelle des Médecins du Québec, and others.

These organizations are involved in the design of initial and continuing professional education, and in some instances they license and set standards for their members. They advise governments and service providers on professional practice issues, they conduct research on the efficacy of services

and on other issues, and they take an interest in issues that affect the development and effectiveness of their members. These organizations told us they are deeply concerned about the health and social status of Aboriginal people. They advised us on the critical issues to be addressed, they outlined the steps they had taken already in their own professions, and they told us about their genuine desire for partnership with Aboriginal people.

Professional organizations can make a significant contribution to improving the health and social conditions of Aboriginal people. In addition to the extensive resources and experience at their disposal, they are strategically placed to help overcome barriers to improved services. In a number of areas, including professional training, licensing, standard setting, accreditation, and the recognition of Aboriginal knowledge and experience, professional organizations have the opportunity to play an important leadership role.

The contributions of non-profit, voluntary agencies to the health and well-being of Canadians is immeasurable. These organizations provide direct services, raise public awareness, promote research, advocate for the needs of their members, and participate in the design of health and social programs. During our public hearings, we received presentations and briefs from many such organizations, including the Canadian Diabetes Association, the Canadian Association for Community Living, the National Anti-Poverty Organization, the Canadian Mental Health Association, St. John's Ambulance, the Canada Safety Council, and many others. As discussed earlier in this chapter, several of these organizations have taken significant steps to become more informed and involved in the issues of Aboriginal health and social conditions. These organizations want to participate in finding and implementing more effective strategies to address Aboriginal health and social issues, and we believe they have an important role to play.

Some of Canada's leading labour organizations, including the Canadian Labour Congress, the Canadian Auto Workers, and the United Steelworkers, also made presentations during our public hearings. As with the organizations already mentioned, the unions are genuinely concerned about the health and social conditions of Aboriginal people. They rightly believe they have an important role in promoting social justice for Aboriginal people. For example, labour leaders told us:

We come here to express our solidarity and our support and our concerns about government inaction to resolve Aboriginal issues that have been plaguing our country for such a long time.

Hassan Yussuff
Canadian Auto Workers
Toronto, Ontario, 19 November 1993

We went and got Aboriginal members and Aboriginal leaders from our union and formed a small working group. With them, we studied two areas that we thought were important, where we would be able to get a first-hand view of the shortcomings of the union in dealing with our Aboriginal members and to get input from our Aboriginal members about things that we could do to start down the path….We are doing a lot of work to change what has been primarily a white, male-dominated union, to create opportunities for all of the people in our society….[O]ur goal is eventually to have our organization and its staff and employees and leadership reflect the make-up of our society….I think one of the important roles that this Commission could play is to recognize the important role of the trade unions….The experience of the last several years in our union is a real desire to be allies with the Aboriginal community, in particular with Aboriginal workers.

Leo Gerard
National Director, United Steelworkers of America
Toronto, Ontario, 19 November 1993

We wish to begin by reiterating the labour movement's support for the inherent right of Canada's Aboriginal peoples to self-determination, including the right of self-government and jurisdiction over lands and resources. We outlined this position in a major policy statement at our last 1992 Vancouver convention which is included with our brief….Aboriginal people are starting to move into staff and executive positions within labour. Unions have begun organizing in Aboriginal communities….The improvement of Aboriginal employment opportunities is a primary area for coalition building between labour and Aboriginal people and organizations.

Dick Martin
Canadian Labour Congress
Ottawa, Ontario, 15 November 1993

Many health and social agencies, whether they are government agencies or agencies operated by quasi-governmental or non-governmental authorities, are governed by collective bargaining agreements. As a result, the way they hire, retain and promote staff is often influenced in important ways by the provisions of these agreements. Given the low representation of Aboriginal professionals

in the labour market, a number of presentations to the Commission expressed concern that these agreements, and particularly the provisions related to seniority, could have the effect of denying Aboriginal people employment and promotion opportunities.[323] However, in several presentations to the Commission, we learned that labour representatives are actively seeking ways to overcome these barriers, and they are committed to improving employment prospects for Aboriginal people.

Other mainstream organizations could be added to the list of stakeholders discussed here — municipal governments, churches, private sector organizations, and many others. Although we do not discuss these sectors separately, all have an important contribution to make.

Recommendation

The Commission recommends that

3.3.24

Non-Aboriginal service agencies and institutions involved in the delivery of health or social services to Aboriginal people, and professional associations, unions, and other organizations in a position to influence the delivery of health or social services to Aboriginal people

(a) undertake a systematic examination to determine how they can encourage and support the development of Aboriginal health and social service systems, and improve the appropriateness and effectiveness of mainstream services to Aboriginal people;

(b) engage representatives of Aboriginal communities and organizations in conducting such an examination;

(c) make public an action plan appropriate to the institution or organization involved, outlining measurable objectives and a timetable for achieving them; and

(d) establish means to monitor and evaluate implementation of the plan by the institution or organization itself and by Aboriginal representatives.

In addition, in Volume 5, Chapter 4, we discuss the need for a public education

strategy to promote awareness of and respect for the history and cultures of Aboriginal nations and peoples and their role in the life of Canada. The initiative outlined there will help to heighten awareness about current health and social conditions and about the challenges that lie ahead for mainstream institutions in developing a renewed relationship with Aboriginal peoples.

Implementation strategies

We urge every mainstream agency, educational program and professional body involved in health and social services for Aboriginal people to take up the challenges outlined in this chapter. Some have already done so, but the present level of commitment is not sufficient to bring about all the changes that are needed.

Federal, provincial and territorial governments provide significant funding for health and social services through mainstream agencies, and there are many professional bodies with the authority to accredit professional education programs. The time has come for these influential funding and professional bodies to provide leadership. Incentives can be provided by allocating financial and other resources to organizations willing to implement reforms. But this alone will not overcome intransigence and resistance in some quarters. Therefore, we believe granting and funding bodies as well as professional associations should actively encourage the development and implementation of action plans of the type just discussed. Where the agency serves a significant number of Aboriginal clients, the existence of an action plan, and regular evidence that the plan is being implemented, should be required.

Recommendation

The Commission recommends that

3.3.25

Governments responsible for funding and professional bodies responsible for accrediting non-Aboriginal institutions and agencies engaged in the delivery of Aboriginal health and social services

(a) establish as a criterion for continuing funding and accreditation the preparation and implementation of goals and standards for services to Aboriginal people; and

(b) require that Aboriginal people, communities and nations affected by such services be fully involved in the development, implementation and evaluation of such goals and standards of practice.

Mainstream health and social programs continue to fail Aboriginal people on a massive scale. If the crisis in Aboriginal health and social conditions is to be addressed, mainstream programs must be reformed in a meaningful way to ensure that they make a much more positive contribution to finding and implementing the solutions that are needed so urgently.

Given the magnitude of the problems to be overcome, and the high human and economic cost of failure, we believe our recommendations are entirely appropriate to the circumstances. (An analysis of the costs of maintaining the status quo is presented in Volume 5, Chapter 2.) Agencies involved in service delivery, as well as bodies responsible for funding and licensing or accrediting these agencies, must come together to demonstrate the commitment that is required. Anything less will prove a recipe for insupportable human and financial costs.

3.5 Housing and Community Infrastructure

The fourth component of our strategy to transform the health status of Aboriginal people is the resolution of the long-standing, debilitating and worsening crisis in Aboriginal housing and the eradication of threats to public health posed by unsafe water supplies and inadequate waste management in rural and remote Aboriginal communities.

In Chapter 4 of this volume, we set out our analysis of the magnitude of the problems, the obligations of federal, provincial and territorial governments to take action on the problems, the barriers to resolution, and a strategy to achieve adequate community infrastructure within five years and an adequate housing supply within 10 years. While a substantial investment is required to achieve these ends, the payback in terms of improved health and well-being and stimulation of Aboriginal economic activity will quickly generate offsetting gains.

Implementing the four components of our strategy will do much to foster whole health in Aboriginal populations, but maintaining health improvements over the long term will depend on a much broader transformation of the conditions of Aboriginal life. We urge action now on health concerns, because a healthy

citizenry is essential to building vital nations. At the same time, effective government and productive economies are equally essential to sustaining the health of the people.

4. The Journey to Whole Health

To identify a sound basis for the re-establishment of health and well-being among Aboriginal people, we have tried to come to a new and deeper understanding of what makes people well. We had the benefit of carefully considered proposals from frontline caregivers and health administrators (both Aboriginal and non-Aboriginal) and of new insights from health researchers who are reconceptualizing the determinants of health. From their collective wisdom, we have concluded that good health is not simply the outcome of illness care and social welfare services. It is the outcome of living actively, productively and safely, with reasonable control over the forces affecting everyday life, with the means to nourish body and soul, in harmony with one's neighbours and oneself, and with hope for the future of one's children and one's land. In short, good health is the outcome of living well.

Whole health, in the full sense of the term, does not depend primarily on the mode of operation of health and healing services — as important as they are. Whole health depends as much or more on the design of the political and economic systems that organize relations of power and productivity in Canadian society. For Aboriginal people, those systems have been working badly; before whole health can be achieved, they must begin to work well.

Some Aboriginal leaders despair of the continuing tunnel vision of non-Aboriginal authorities who insist on the capacity of bio-medical and social welfare regimes to bring health to Aboriginal people. At a circumpolar health conference in 1984, Peter Penashue, an Innu leader from Labrador, spoke about freedom from domination as the route to improved health for his people:

The Innu are sick and dying because of a well-documented syndrome of ill health brought on by the enforced dependency and attempted acculturation of an entire people. This ill health will improve or worsen not according to the…level of health care funding, but only as a result of a political choice by those now engaged in the extension of control over Innu land and Innu lives….

The fact is, that for the Innu, health and ill health are profoundly political issues, inseparable from social and economic considerations. The arrival of an

elaborate health care system among the Innu has coincided with a rapid worsening of Innu health. This is not to imply that one has led to the other but rather to emphasize that the health or ill health of the Innu has been [determined] by factors that have very little to do with the health care system. We feel that those who are sincere in wanting to promote Innu health rather than merely developing a larger, self-serving medical system must be prepared to address problems to which traditional medical disciplines do not have the answers.

The World Health Organization has recognized that individual good health can best be assured through maintenance of healthy socioeconomic and cultural systems, and that, conversely, the exploitation and humiliation of societies will inevitably lead to both collective and individual ill health.

For the Innu, the real health system will be one which will allow Innu society to function properly again, one which will remove foreign domination, and one which will offer the Innu respect as a distinct people.[324]

Thus, the sum of Aboriginal experience, population health research and World Health Organization analysis adds up to the same conclusion: health, like every facet of human experience, is the handmaiden of power. What happens to the ill health conditions described in this chapter depends as much on the allocation of power in Canada as on the reorganization of health and healing systems.

The reorganization of health and healing systems can do much to improve the well-being of Aboriginal people. And good health, in turn, can contribute to the political and economic renewal of Aboriginal people to a degree that has long been underestimated by Aboriginal and non-Aboriginal people alike. Whole health may depend on politics and economics, but the dependence is mutual. The new political and economic systems that Aboriginal people are now struggling to build will not achieve the peaks of creativity, efficiency and integrity of which they are capable unless and until the health of all the people becomes a contributing force:

Self-reliance, self-determination, self-government and economic development will not be achieved unless the people enjoy health and wellness, be this on an individual, family or community basis….[The Meadow Lake Tribal Council's vision of health] calls for achieving balance and harmony in the physical, mental, emotional and spiritual aspects of life….The vision…is to build services for Indian people by Indian people, giving them the power to make positive

change in their communities. This power will only come from well adjusted individuals, who have pride in themselves and their communities.[325]

In a sense our entire report is about restoring and maintaining whole health among Aboriginal people. In Volume 1 we considered the evidence of efficacy and equilibrium in Aboriginal cultural systems when Europeans first encountered them, along with the tragic errors that undermined relations of mutual respect and benefit between Aboriginal and non-Aboriginal peoples and compromised the political, economic, social and spiritual well-being of Aboriginal nations. In Volume 2 we proposed structural changes that can set the relationship on a different course, freeing Aboriginal people to pursue well-being in ways they determine freely and restoring the lands and resources to make that possible. The subject of the present volume is the range of practical steps that can be undertaken to start the journey to whole health. Volume 4 articulates the particular visions of well-being held by different Aboriginal constituencies. Volume 5 makes the argument that restoring the political, economic and social health of Aboriginal people will enhance the well-being and vitality of the whole of Canadian society.

In this chapter we have proposed an Aboriginal health strategy with four essential components to promote health and healing in Aboriginal nations, communities, families and individuals. The strategy is relevant and urgently required no matter which government is in charge. It can be implemented immediately by federal, provincial and territorial governments in consultation with Aboriginal people. This chapter also sets out challenges that Aboriginal nation governments will have to take up when they assume jurisdiction.

The costs of inaction are too great to be borne any longer. The potential rewards of resolute action are limitless. The time to begin is now.

Notes:

***** Transcripts of the Commission's hearings are cited with the speaker's name and affiliation, if any, and the location and date of the hearing. See *A Note About Sources* at the beginning of this volume for information about transcripts and other Commission publications.

1 United Nations Development Programme, *Human Development Report 1994*

(Toronto: Oxford University Press, 1994), p. 93. In the three UNDP reports published from 1991 to 1993, Canada was ranked either first or second.

2 Health and Welfare, *Health Indicators Derived from Vital Statistics for Status Indian and Canadian Populations, 1978-86* (Ottawa: Supply and Services, 1988). Most statistics collected by the federal government refer only to registered Indians (as defined by the *Indian Act*) and sometimes to Inuit living in the Northwest Territories. These are the categories of Aboriginal people most likely to be served by the programs of the department of Indian affairs and the medical services branch of the federal health department. Statistics may differ significantly between regions. For example, Simard and Proulx specify that for Northern Quebec, the variation from national standards of life expectancy is three years for Crees and 10 years for Inuit (Jean-Jacques Simard and Solange Proulx, "L'état de santé des Cris et des Inuit du Québec nordique: quelques indicateurs statistiques de l'évolution récente", *Recherches amérindiennes au Québec* XXV/1 (1995), pp. 5-6).

3 Calculating the infant mortality rate (IMR) for any population is a complex procedure. This generalization summarizes a picture in which the IMR is from one-and-a-half to three times greater for Aboriginal than non-Aboriginal people, depending on whether we are referring to infant, neonatal or post-neonatal deaths; and whether we are referring to registered Indian people or Inuit. The rate is greater in all categories among Inuit.

4 Royal Commission on Aboriginal Peoples [RCAP], *Discussion Paper 2: Focusing the Dialogue* (Ottawa: Supply and Services, 1993).

5 'Whole health' is the term we have adopted to signify the concept of health used most often by Aboriginal people, encompassing the physical, emotional, intellectual and spiritual dimensions of the person and harmonious relations with social and environmental systems that are themselves functioning in a balanced way.

6 Nicholas Denys (1672), quoted in Cornelius J. Jaenen, *Friend and Foe: Aspects of French-Amerindian Cultural Contact in the Sixteenth and Seventeenth Centuries* (Toronto: McClelland and Stewart, 1976).

7 Historian George Wharton James (1908), quoted in R. Obomsawin, "Traditional Indian Health and Nutrition: Forgotten Keys to Survival into the 21st Century", in Thomas Berger (Commissioner), *Selected Readings in Support of*

Indian and Inuit Health Consultation, Volume II (Ottawa: Health and Welfare, 1980), p. 44.

8 Virgil J. Vogel, *American Indian Medicine* (Norman, Okla.: University of Oklahoma Press, 1970), p. 159.

9 Olive Patricia Dickason, *Canada's First Nations: A History of Founding Peoples from Earliest Times* (Toronto: McClelland and Stewart, 1992), pp. 43-44. The quotation is from Chrestien Le Clercq, *New Relation of Gaspesia: With the Customs and Religion of the Gaspesian Indians*, William F. Ganong, ed. (Toronto: Champlain Society, 1910), p. 296.

10 See P.M. Ashburn, *The Ranks of Death: A Medical History of the Conquest of America*, ed. Frank D. Ashburn (New York: Coward-McCann, 1947); Henry F. Dobyns, *Their Numbers Became Thinned: Native American Population Dynamics in Eastern North America* (Knoxville, Tenn.: University of Tennessee Press, 1983).

11 See Robert Larocque, "L'introduction de maladies européennes chez les autochtones des XVIIe et XVIIIe siècles", *Recherches amérindiennes au Québec* XII/1 (1982), pp. 13-24.

12 Vogel, *American Indian Medicine* (cited in note 8), p. 154.

13 See also Denys Delâge, "Epidemics, Colonization, Alliances: Aboriginal Peoples and Europeans in the Seventeenth and Eighteenth Centuries" (translation, unpublished, 1993).

14 Denys Delâge, *Le pays renversé: Amérindiens et Européens en Amérique du nord-est, 1600-1604* (Montreal: Boréal Express, 1985), p. 101.

15 Roger Gibbins and J. Rick Ponting, "Historical Overview and Background", in J. Rick Ponting, ed., *Arduous Journey: Canadian Indians and Decolonization* (Toronto: McClelland and Stewart, 1986), pp. 18-57.

16 George F.G. Stanley, "As Long as the Sun Shines and Water Flows: An Historical Comment", in A.L. Getty and Antoine S. Lussier, eds., *As Long as the Sun Shines and Water Flows: A Reader in Canadian Native Studies* (Vancouver: University of British Columbia Press, 1983).

17 E. Brian Titley, *A Narrow Vision: Duncan Campbell Scott and the Administration of Indian Affairs in Canada* (Vancouver: University of British Columbia Press, 1989). The legacy of these assimilationist policies is still evident today among some older people in First Nations communities who fear that if they participate in traditional ceremonies they will be arrested.

18 James B. Waldram, D. Ann Herring, and T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995), pp. 156-158; Health and Welfare, *Aboriginal Health in Canada* (Ottawa: Supply and Services, 1992), pp. 12-13.

19 Waldram et al., *Aboriginal Health in Canada*, p. 164.

20 Corinne Hodgson, "The Social and Political Implications of Tuberculosis Among Native Canadians", *Canadian Review of Sociology and Anthropology* 19/4 (1982), pp. 502-512; John D. O'Neil, "The Politics of Health in the Fourth World: A Northern Canadian Example", *Human Organization* 45/2 (1986), pp. 119-127; W. Vanast, "The Death of Jennie Kanajuq: Tuberculosis, Religious Competition and Cultural Conflict in Coppermine, 1929-31", *Études/Inuit/Studies* 15/1 (1991), pp. 75-104.

21 John D. O'Neil and Patricia Leyland Kaufert, "*Irniktakpunga!*: Sex Determination and the Inuit Struggle for Birthing Rights in Northern Canada", in Faye D. Ginsberg and Rayna Rapp, eds., *Conceiving the New World Order: The Global Politics of Reproduction* (Los Angeles: University of California Press, 1995), pp. 59-73.

22 See John D. O'Neil, "The Cultural and Political Context of Patient Dissatisfaction in Cross-Cultural Clinical Encounters: A Canadian Inuit Study", *Medical Anthropology Quarterly* 3/4 (1989), pp. 325-344; Dara Culhane Speck, *An Error in Judgement: The Politics of Medical Care in an Indian/White Community* (Vancouver: Talonbooks, 1987); Joseph M. Kaufert and John D. O'Neil, "Biomedical Rituals and Informed Consent: Native Canadians and the Negotiation of Clinical Trust", in George Weisz, ed., *Social Science Perspectives on Medical Ethics* (Dordrecht, The Netherlands: Kluwer Academic Publishers, 1990).

23 Health and Welfare, Communiqué 1979-88, "Statement on Indian Health Policy" (19 September 1979).

24 *Report of the Advisory Commission on Indian and Inuit Health Consultation*, Thomas R. Berger, Commissioner (Ottawa: 1980).

25 Health and Welfare Canada, *Discussion Paper: Transfer of Health Services to Indian Communities* (Ottawa: Health and Welfare, 1981).

26 Interested readers may wish to consult a comprehensive bibliography on this subject compiled by David E. Young and Leonard L. Smith, *The Involvement of Canadian Native Communities in their Health Care Programs: A Review of the Literature Since the 1970's* (Edmonton: Circumpolar Institute and Centre for the Cross-Cultural Study of Health and Healing, 1992).

27 The agreement was later formalized by a special act of the Quebec National Assembly passed in 1984 (*An Act to ratify the Agreement concerning the building and operating of a hospital centre in the Kahnawake Territory*, R.S.Q. c.13). For more details on its history and current operations, see Ann C. Macaulay, "The History of Successful Community-Operated Health Services in Kahnawake, Quebec", *Canadian Family Physician* 34 (October 1988), pp. 2167-2169; and Louis T. Montour and Ann C. Macaulay, "Editorial: Diabetes Mellitus and Atherosclerosis: Returning Research Results to the Mohawk Community", *Canadian Medical Association Journal* 139 (1988), pp. 201-202.

28 For contrasting perspectives on this debate, see Richard F. Salisbury, *A Homeland for the Cree: Regional Development in James Bay 1971-1981* (Montreal: McGill-Queen's University Press, 1986); Sally M. Weaver, "Self-Government Policy for Indians 1980-1990: Political Transformation or Symbolic Gestures", revised version of a paper presented at the 1989 UNESCO Conference on Migration and the Transformation of Cultures in Canada (Calgary, April 1991); and Daniel Beauvais, "Autochtonisation des services de santé: réalité ou utopie?", in *James Bay and Northern Québec: Ten Years After*, ed. Sylvie Vincent and Garry Bowers (Montreal: Recherches amérindiennes au Québec, 1988), pp. 98-101.

29 When Newfoundland joined Confederation in 1949, the government of Canada did not apply the terms of the *Indian Act* and the services of the department of Indian affairs to the Aboriginal people of Labrador. Instead, an agreement was signed whereby the provincial government would be responsible for Aboriginal people and the federal government would provide most of the program funding. No Aboriginal people or nations were signatories to the agreement. In recent years, the federal government has entered into direct funding arrangements with Aboriginal people in Labrador, but on an

inconsistent basis that the people view as arbitrary and capricious. (For more discussion of the circumstances of Labrador Aboriginal peoples, see Volume 4, Chapters 5 and 6.) For further information on LIHC, see I. Allen “Community Health Representatives Working in Labrador Inuit Communities”, in *Circumpolar Health 90: Proceedings of the 8th International Congress on Circumpolar Health, Whitehorse, Yukon*, May 20-25, 1990, ed. Brian Postl et al. (Winnipeg: University of Manitoba Press, 1990), pp. 151-152.

30 For a description of history and activities see the AIHCC reports (1983-1992) and Richard N. Nuttall, “The Development of Indian Boards of Health in Alberta”, *Canadian Journal of Public Health* 73/5 (September/October 1982), pp. 300-303.

31 See Anishnawbe Health Toronto, *A Proposal to Establish a Community Health Centre* (Toronto: Anishnawbe Health, 1988); V. Johnston, “Health: Yesteryear and Today”, in *Multiculturalism and Health Care: Realities and Needs*, ed. Ralph Masi (Toronto: Canadian Council on Multicultural Health, 1990); and C.P. Shah, “A National Overview of the Health of Native People Living in Canadian Cities”, in *Inner City Health æ The Needs of Urban Natives: Proceeding of the Ninth Symposium on the Prevention of Handicapping Conditions*, ed. W. Yacoub (Edmonton: University of Alberta, 1988).

32 Young and Smith, *Involvement of Canadian Native Communities* (cited in note 26), p. 19; Linda C. Garro, Joanne Roulette and Robert G. Whitmore, “Community Control of Health Care Delivery: The Sandy Bay Experience”, *Canadian Journal of Public Health* 77 (July/August 1986), p. 281; Waldram et al., *Aboriginal Health in Canada* (cited in note 18), p. 236.

33 The non-insured health benefits program provides funds to registered Indian people and Inuit for a variety of health-related goods and services that are not covered under medicare. The main items covered are dental care, vision care, transportation out of community for necessary medical procedures, payment of provincial medical insurance premiums and the cost of prescription drugs. The program is administered by the medical services branch of the federal health department, but its administration is currently under review, with the apparent goal of shifting responsibility to Aboriginal hands.

34 Dara Culhane Speck, “The Indian Health Transfer Policy: A Step in the Right Direction, or Revenge of the Hidden Agenda?” *Native Studies Review* 5/1 (1989), pp. 187-213.

35 Waldram et al., *Aboriginal Health in Canada* (cited in note 18), p. 238.

36 G. Connell, R. Flett and P. Stewart, “Implementing Primary Health Care Through Community Control: The Experience of the Swampy Cree Tribal Council”, in Postl et al., eds., *Circumpolar Health 90* (cited in note 29), pp. 44-46. In our public hearings, spokespersons from the Mohawk First Nation at Kahnawake explained why they made the decision *not* to enter the transfer process. See, for example, Rheena Diabo, Kahnawake Shakotii’takehnhas Community Services, transcripts of the hearings of the Royal Commission on Aboriginal Peoples [hereafter RCAP transcripts], Kahnawake, Quebec, 5 May 1993.

37 Information supplied by Health Canada, Medical Services Branch, Program Transfer, Policy and Planning, March 1996.

38 Meredith A. Moore, Heather Forbes and Lorraine Henderson, “The Provision of Primary Health Care Services Under Band Control: The Montreal Lake Case”, *Native Studies Review* 6/1 (1990), pp. 153-164; Waldram et al., *Aboriginal Health in Canada* (cited in note 18), p. 237; and Benita Cohen, “Health Services Development in an Aboriginal Community: The Case of Peguis First Nation”, research study prepared for RCAP (1994). For information about research studies prepared for RCAP, see *A Note About Sources* at the beginning of this volume.

39 For a critical evaluation of the situation in Quebec, see André Tremblay, “L’organisation de la santé dans une réserve montagnaise” and Francine Tremblay, “Complexité des discours et des pratiques de développement et de gestion dans le réseau Kativik de la santé et des services sociaux”, both in *Recherches amérindiennes au Québec* XXV/1 (1995), pp. 21-40 and pp. 85-94 respectively.

40 As well, the Commission notes growing evidence that infectious diseases are not in fact well controlled in the world generally. (See, for example, Laurie Garrett, *The Coming Plague: Newly Emerging Diseases in a World Out of Balance* (New York: Farrar, Straus and Giroux, 1994.) Most but not all of the newly emerging diseases originated outside North America. However, since poverty, poor housing and social dysfunction are considered to contribute to their emergence, the Commission is concerned about the vulnerability of some Aboriginal communities.

41 In fiscal year 1992-93, federal, provincial and territorial governments together spent approximately $2 billion on health care and $2.2 billion on social development programs for Aboriginal people.

42 T. Kue Young, *The Health of Native Americans: Towards a Biocultural Epidemiology* (Toronto: Oxford University Press, 1994), pp. 37-38.

43 Health and Welfare, *Aboriginal Health in Canada* (cited in note 18), p. 33.

44 Young, *The Health of Native Americans* (cited in note 42), p. 37. According to Young, this was a “most remarkable achievement” because it has taken other populations much longer to make equivalent gains.

45 Health and Welfare, *Aboriginal Health in Canada* (cited in note 18), p. 33. See also note 2.

46 Because of small numbers of Aboriginal people in some measured categories, as well as the peaks and troughs in particular disease conditions over time, the statistical picture for any one year may differ from the picture resulting from statistics averaged over several years, as was done to create Table 3.1 (and others). Furthermore, data collection in relation to Aboriginal people is uneven. Most often, it encompasses only registered (status) Indian people and Inuit living in the Northwest Territories. In most reporting regions, only registered Indian people living on-reserve are included, while in others, data pertaining to those living off-reserve are collected as well. No data on the health of Aboriginal people in British Columbia or the Northwest Territories have been collected since 1985. See Volume 1, Chapter 2 (particularly the endnotes) for a general discussion of the sources of data used by the Commission in this report.

47 For data specific to Inuit in Quebec, see Tremblay, “Complexité des discours” (cited in note 39).

48 We discussed comparative rates of suicide in RCAP, *Choosing Life: Special Report on Suicide Among Aboriginal People* (Ottawa: Supply and Services, 1995. We discussed violence in families in Chapter 2 of this volume.

49 Canadian Medical Association, “Canada’s Doctors Call on Government to Improve Health of Aboriginal Peoples”, news release, Ottawa, 17 November 1993.

50 Abdel R. Omran, “The Epidemiological Transition: A Theory of the Epidemiology of Population Change”, *Milbank Memorial Fund Quarterly* 49/4 (October 1971, Part 1), pp. 509-538.

51 The transition from the second to the third stage began in the 1940s. At that time, about 70 per cent of (U.S.) health care dollars were spent controlling infectious diseases. Now more than 80 per cent of the available dollars are spent on managing chronic diseases and their complications. See D. Etzweiler (President, International Diabetes Center), “International Concerns about Diabetes and Indigenous Peoples”, in A. Kewayosh, ed., *Sociocultural Approaches in Diabetes Care for Native Peoples: Proceedings of the Second International Conference on Diabetes and Native Peoples* (Ottawa: First Nations Health Commission, Assembly of First Nations, 1993), p. 14.

52 These data are an average calculated over the 1986-1990 period. See T. Kue Young, “Measuring the Health Status of Canada’s Aboriginal Population: A Statistical Review and Methodological Commentary”, research study prepared for RCAP (1994). In the 1950s, when the network of federal health facilities first began to reach the Northwest Territories, the infant mortality rate (IMR) for Inuit was 240 deaths per 1,000 live births. Despite rapid and remarkable improvement, the IMR for Inuit living in the Northwest Territories today is still the highest of all Aboriginal peoples.

53 Canadian Institute of Child Health (CICH), *The Health of Canada’s Children: A CICH Profile*, 2nd Edition (Ottawa: CICH, 1994), p. 143.

54 J. Fraser Mustard and John Frank, *The Determinants of Health*, CIAR Publication No. 5 (Toronto: Canadian Institute for Advanced Research, 1991), pp. 18-19.

55 David J.D. Barker, “Rise and Fall of Western Diseases”, *Nature* 338 (30 March 1989), pp. 371-372.

56 CICH, *Health of Canada’s Children* (cited in note 53), p. 37.

57 See, for example, the testimony of Anne Rochon Ford and Vicki Van Wagner of the Interim Regulatory Council of Midwifery describing community consultations with Aboriginal women in Ontario, RCAP transcripts, Toronto, Ontario, 2 November 1992. See also John D. O’Neil and Penny Gilbert, eds., *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural*

Perspectives (Winnipeg: Northern Health Research Unit, University of Manitoba, 1990).

58 Health and Welfare, *Strengthening Prenatal Health Promotion for Disadvantaged Families* (Ottawa: Supply and Services, 1994), p. 1.

59 Nancy Waters and Denise Avard, *Prevention of Low Birth Weight in Canada: Literature Review and Strategies* (Ottawa: Canadian Institute of Child Health, 1992).

60 For more ideas about action in this field, see the testimony of Marlene Thio-Watts, RCAP transcripts, Prince George, British Columbia, 1 June 1993, as well as Waters and Avard, *Prevention of Low Birth Weight in Canada* (cited in note
59); and Health and Welfare, *Strengthening Prenatal Health Promotion* (cited in note 58).

61 Marilyn Van Bibber, “FAS Among Aboriginal Communities in Canada: A Review of Existing Epidemiological Research and Current Preventive and Intervention Approaches”, research study prepared for RCAP (1993).

62 There has been some dispute about the validity of the research demonstrating a causal link between alcohol consumption and the constellation of defects labelled ‘fetal alcohol syndrome’. A minority of researchers have suggested that other factors, including maternal malnutrition, may be the cause. However, the most recent research demonstrates clearly that alcohol has independent effects on the fetus, and prenatal alcohol exposure is now thought to be the leading cause of birth defects and intellectual disability in North America. See “Fetal Alcohol Syndrome”, *Alcohol Alert* 13/PH297 (July 1991) (Washington: National Institute on Alcohol Abuse and Alcoholism, U.S. Department of Health and Human Services); and Kenneth Lyons Jones, *Smith’s Recognizable Patterns of Human Malformation*, 4th edition (Toronto: W.B. Saunders Co., 1988).

63 Van Bibber, “FAS Among Aboriginal Communities in Canada” (cited in note 61). See also Mary Jane Ashley, “Alcohol-Related Birth Defects”, in *Aboriginal Substance Use: Research Issues*, ed. Diane McKenzie (Ottawa: Canadian Centre on Substance Abuse, 1992), pp. 69-73. We note that small sample sizes in the studies of FAS and FAE in Aboriginal communities make generalizations tentative at best.

64 House of Commons, Report of the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women, *Foetal Alcohol Syndrome: A Preventable Tragedy* (Ottawa: June 1992).

65 Van Bibber, "FAS Among Aboriginal Communities in Canada" (cited in note 61).

66 For further discussion of the particular needs of women in combatting addiction, see testimony before the Commission by Jackie Adams of Urban Native Women of the First Nations, RCAP transcripts, Port Alberni, British Columbia, 20 May 1992; Charlotte Ross of La Ronge Native Women's Council, RCAP transcripts, La Ronge, Saskatchewan, 28 May 1992; Catherine Brooks, Executive Director of Anduhyaun, RCAP transcripts, Toronto, Ontario, 26 June 1992; Della Maguire of the Micmac Native Friendship Centre, RCAP transcripts, Halifax, Nova Scotia, 4 November 1992; and Nancy van Heest of Urban Images for First Nations, RCAP transcripts, Vancouver, British Columbia, 2 June 1993.

67 Standing Committee on Health and Welfare, *Foetal Alcohol Syndrome* (cited in note 64), pp. 27-28.

68 Van Bibber, "FAS Among Aboriginal Communities in Canada" (cited in note 61).

69 See public testimony given by Betsy Jackson and Lorraine Stick of the Alcohol Related Birth Defects Committee, RCAP transcripts, Whitehorse, Yukon, 18 November 1992; Della Maguire of the Micmac Native Friendship Centre, RCAP transcripts, Halifax, Nova Scotia, 4 November 1992; Joyce Goodstriker of the Blood Tribe Education Board, RCAP transcripts, Calgary, Alberta, 26 May 1993; Marlene Thio-Watts of the Northern Family Health Society, RCAP transcripts, Prince George, British Columbia, 1 June 1993; Marie Baker, Aboriginal Women's Council, RCAP transcripts, Vancouver, British Columbia, 2 June 1993; and Ian Hinksman, President, B.C. Aboriginal Network on Disability Society, RCAP transcripts, Vancouver, British Columbia, 4 June 1993. See also Van Bibber, "FAS Among Aboriginal Communities in Canada" (cited in note 61).

70 In some places, the policy came some time later. In northern Quebec, it was not until the 1970s that evacuation of pregnant women to hospitals in Moose Factory or Montreal became routine. In the Northwest Territories, the policy did

not come into effect until the late 1970s. Christopher Fletcher, “The Innuulisivik Maternity Centre: Issues Around the Return of Midwifery and Birth to Povungnituk, Quebec”, research study prepared for RCAP (1994).

71 For details of traditional birthing practices and their role in family and community solidarity, see Lesley Paulette, “Midwifery in the North”, research study prepared for RCAP (1995); Laura Calm Wind and Carol Terry on behalf of Equay Wuk (Women’s Group), *Nishnawbe-Aski Nation Traditional Midwifery Practices* paper presented to the Ministry of Health of Ontario concerning the exemption of Aboriginal traditional midwives from the *Regulated Health Professions Act, 1991* (Sioux Lookout, Ontario: August 1993); Rose Dufour, *Femmes et enfantement æ sagesse dans la culture Inuit* (Quebec City: Éditions Papyrus, 1988); and the testimony of Dr. Bernard Saladin D’Anglure of the department of anthropology, Laval University, RCAP transcripts, Wendake, Quebec, 17 November 1992.

72 Fletcher, “The Innuulisivik Maternity Centre” (cited in note 70). Lesley Paulette, in her research study “Midwifery in the North” (cited in note 71), told us, “Elders have suggested that in the days when families gave birth together in the traditional way, the bonds between family members were stronger than they are today. In particular, men seem to have had a different kind of appreciation for their wives and a closer relationship with their children”.

73 Vicki Van Wagner, Ontario Interim Regulatory Council on Midwifery, RCAP transcripts, Toronto, 2 November 1992. See also Paulette, “Midwifery in the North”; and Sarah Robinson, “The Role of the Midwife: Opportunities and Constraints”, in Iain Chalmers, Murray Enkin and Marc J.N.C. Keirse, eds., *Effective Care in Pregnancy and Childbirth* (Toronto: Oxford University Press, 1989).

74 See Ginette Carignan, *Pregnancies and Births Among the Inuit Population of Hudson Bay, 1989-91* (Quebec City: Community Health Department, Laval University Hospital Centre, 1993); and François Meyer and Diane Bélanger, *Évaluation des soins et services en périnatalité, Hudson et Ungava : Volet épidémiologie æ Grossesses et naissances dans deux populations inuit du Nouveau-Québec* (Quebec City: Community Health Department, Laval University, 1991).

75 Nunavik comprises 14 communities in all. Eight are served by the primary care hospital in Povungnituk and six are served by a similar facility in Kuujjuaq. There is no similar maternity care program in Kuujjuaq.

76 Fletcher, “The Innuulisivik Maternity Centre” (cited in note 70). See also the testimony of Ineaq Korgak of the Baffin Regional Health Board, (RCAP transcripts, Iqaluit, Northwest Territories, 26 May 1992; Ipeelee Kilabuk of the Health Committee, RCAP transcripts, Pangnirtung, Northwest Territories, 28 May 1992; Martha Greig, Vice-President of Pauktuutit, RCAP transcripts, Ottawa, Ontario, 2 November 1993; and Rose Dufour, Laval University Hospital Centre, Wendake, Quebec, 18 November 1992.

77 This analysis is most closely associated with Thomas McKeown, *The Origins of Human Disease* (Oxford: Basil Blackwell, 1988); *The Modern Rise of Population* (London: Edward Arnold, 1976); and *The Role of Medicine: Dream, Mirage or Nemesis?* (Princeton: Princeton University Press, 1979).

78 John F. Marchand, “Tribal Epidemics in the Yukon”, *Journal of the American Medical Association* 123/16 (1943), pp. 1019-1020.

79 A.F.W. Peart and F.P. Nagler, “Measles in the Canadian Arctic, 1952”, *Canadian Journal of Public Health* 45 (1952), p. 146.

80 Ales Hrdlicka, *Physiological and Medical Observations Among the Indians of Southwestern United States and Mexico*, Bulletin 34 (Washington, D.C.: Smithsonian Institution, Bureau of American Ethnology, 1908); and David A. Stewart, “The Red Man and the White Plague”, *Canadian Medical Association Journal* 35 (1936), pp. 674-676.

81 G.C. Brink, *Across the Years: Tuberculosis in Ontario* (Willowdale, Ontario: Ontario Tuberculosis Association, 1965).

82 Tuberculosis killed 24 per cent of the children who attended residential schools in western Canada during the 15-year period investigated by the government’s own medical superintendent (western region), Dr. Peter Bryce. See P.H. Bryce, *The Story of a National Crime: An Appeal for Justice to the Indians of Canada* (Ottawa: James Hope & Sons, 1922). For more discussion of the history and impact of residential schooling on Aboriginal people, see Volume 1, Chapter 10, and John S. Milloy, “Suffer the Little Children: The Aboriginal Residential School System, 1830-1992”, research study prepared for RCAP (1996).

83 Kathryn Wilkins, “Tuberculosis Incidence in Canada in 1992”, *Health*

Reports 6/2 (1994), Statistics Canada Catalogue No. 82-003, pp. 301-309.

84 Young, *The Health of Native Americans* (cited in note 42), p. 63.

85 Young, *The Health of Native Americans,* pp. 56-57.

86 The work of Imrie and Newhouse suggests that the incidence of sexually transmitted diseases among Aboriginal people is relatively high. Robert Imrie and David Newhouse, "Aboriginal People and HIV/AIDS in Canada", research study prepared for RCAP (1994). See also the testimony of Glen Ross of the Cree Nation Tribal Health Centre RCAP transcripts, The Pas, Manitoba, 20 May 1992; and Maggie Saunders, RCAP transcripts, Yellowknife, Northwest Territories, 10 December 1992.

87 Health Canada, "Information: HIV/AIDS and Aboriginal People in Canada" (Ottawa: 1994), p. 2. More recent figures indicate that as of January 1996 Health Canada was aware of 176 cases of AIDS among Aboriginal people. See Warren Goulding, "Behind the Statistics", *Maclean's,* 15 July 1996.

88 Risk factors for HIV/AIDS among Aboriginal people were discussed in our public hearings by Glen Ross, Cree National Tribal Health Centre, RCAP transcripts, The Pas, Manitoba, 20 May 1992; Linda Day and Frederick Haineault, B.C. First Nations AIDS Society, RCAP transcripts, Vancouver, British Columbia, 2 June 1993; and Maggie Saunders, RCAP transcripts, Yellowknife, Northwest Territories, 10 December 1992.

89 Alan Kennard, vice-president of the Vancouver Native Health Society, warned us that "TB and AIDS [together] could be the deadliest combination to Aboriginal people since smallpox" (RCAP transcripts, Vancouver, British Columbia, 4 June 1993).

90 Imrie and Newhouse, "Aboriginal People and HIV/AIDS in Canada" (cited in note 86). See also the testimony of Joylenne Shade, RCAP transcripts, Lethbridge, Alberta, 25 May 1993; and Cheryl Starr of the Saskatchewan Indian Youth Advisory Committee, Saskatoon, Saskatchewan, 27 October 1992.

91 See the testimony of Linda Day and Frederick Haineault of B.C. First Nations AIDS Society, RCAP transcripts, Vancouver, British Columbia, 2 June 1993; Susan Beaver, RCAP transcripts, Toronto, Ontario, 25 June 1992; and

T’mas Young, Micmac AIDS Task Force, RCAP transcripts, Halifax, Nova Scotia, 4 November 1992.

92 Susan M. Beaver, RCAP transcripts, Toronto, 25 June 1992.

93 Imrie and Newhouse, “Aboriginal People and HIV/AIDS in Canada” (cited in note 86).

94 See, for example, Farkas et al., “Impact of HIV Infection/AIDS on Social Service Agencies Serving Children and Youth in Toronto”, *Canadian Journal of Public Health* 81 (July/August 1990), p. 297.

95 Imrie and Newhouse, “Aboriginal People and HIV/AIDS in Canada” (cited in note 86). See also Alan Kennard, RCAP transcripts, Vancouver, British Columbia, 4 June 1993; and T’mas Young, RCAP transcripts, Halifax, Nova Scotia, 4 November 1992.

96 For discussion of recommended public health responses to HIV/AIDS, see the research study prepared for RCAP by Imrie and Newhouse, “Aboriginal People and HIV/AIDS in Canada” (cited in note 86), and RCAP transcripts of the testimony given by Glen Ross, The Pas, Manitoba, 20 May 1992; Linda Day, Vancouver, British Columbia, 2 June 1993; Maggie Saunders, Yellowknife, Northwest Territories, 10 December 1992; Tom Iron, Wahpeton, Saskatchewan, 26 May 1992; and T’mas Young, Halifax, Nova Scotia, 4 November 1992.

97 Report of the Second International Conference on Diabetes and Native Peoples (Honolulu, Hawaii, 19-21 May 1993). See Alethea Kewayosh, ed., *Sociocultural Approaches in Diabetes Care for Native Peoples* (Ottawa: Assembly of First Nations, 1993).

98 Staff communication, Sue Boyd, manager, Community Access Network, Canadian Diabetes Association, 6 July 1995.

99 See also Paul Brassard, Elizabeth Robinson and Claudette Lavallée, “Prevalence of Diabetes Mellitus Among the James Bay Cree of Northern Quebec”, *Canadian Medical Association Journal* 149/3 (1993), pp. 303-307.

100 Expert Committee of the Canadian Diabetes Advisory Board, “Clinical Practice Guidelines for Treatment of Diabetes Mellitus”, *Canadian Medical*

Association Journal 147/5 (1992), p. 707.

101 *Sociocultural Approaches in Diabetes Care* (cited in note 97).

102 For a detailed discussion see T. Kue Young et al., "Prevalence of Diagnosed Diabetes in Circumpolar Indigenous Populations", *International Journal of Epidemiology* 21/4 (1992), pp. 730-736; and T. Kue Young, Emoke J.E. Szathmary, Susan Evers and Brian Wheatley, "Geographical Distribution of Diabetes Among the Native Population of Canada: A National Survey", *Social Science & Medicine* 31/2 (1990), pp. 129-139.

103 Maureen I. Harris, Wilbur C. Hadden, William C. Knowler and Peter H. Bennett, "Prevalence of Diabetes and Impaired Glucose Tolerance and Plasma Glucose Levels in U.S. Population Aged 24-74 Years", *Diabetes* 36 (April 1987), pp. 523-34.

104 See Donnell Etzweiler "International Concerns about Diabetes and Indigenous Peoples", pp. 13-19, in *Sociocultural Approaches in Diabetes Care* (cited in note 97); and Young, *The Health of Native Americans* (cited in note 42), p. 146.

105 Young, *The Health of Native Americans*, p. 139.

106 Quoted in *Sociocultural Approaches in Diabetes Care* (cited in note 97), pp. 55-56.

107 *Sociocultural Approaches in Diabetes Care* , pp. 5-8, 32-35, 76-79.

108 *Sociocultural Approaches in Diabetes Care*, p. 6, based on research by M. Yvonne Jackson and Brenda A. Broussard, "Cultural Challenges in Nutrition Education Among American Indians", *The Diabetes Educator* 13/1 (1987), pp. 47-50; and L. Tom-Orme, "Diabetes in a Navajo Community: A Qualitative Study of Health/Illness Beliefs and Practices", PH.D. dissertation, University of Utah College of Nursing, 1988.

109 *Sociocultural Approaches in Diabetes Care*, pp. 76-79.

110 Both diabetes prevention programs are described in *Sociocultural Approaches in Diabetes Care*.

111 For further information, see the testimony of Dr. Louis T. Montour of the Kateri Memorial Hospital Centre, RCAP transcripts, Kahnawake, 5 May 1993; Ann C. Macaulay, Nancy Hanusaik and Deborah D. Delisle, “Diabetic Education Program in the Mohawk Community of Kahnawake, Quebec”, *Canadian Family Physician* 34 (July 1988), pp. 1591-1593; Ann C. Macaulay, Louis T. Montour, and Naomi Adelson, “Prevalence of Diabetic and Atherosclerotic Complications Among Mohawk Indians of Kahnawake, PQ”, *Canadian Medical Association Journal* 139 (1988), pp. 221-223.

112 See, for example, RCAP transcripts of the testimony of Isabelle Smith, Saskatoon, Saskatchewan, 27 October 1992; Judi Johnny, Whitehorse, Yukon, 18 November 1992; Gary Tinker, Ile-a-la-Crosse, Saskatchewan, 8 December 1992; Valerie Monague and Leonore Monague, Orillia, Ontario, 12 May 1993; Connie Laurin-Bowie and Bob Walker, Toronto, Ontario, 2 June 1993; James Sanders and Wanda Hamilton of the Canadian National Institute for the Blind, Ottawa, Ontario, 15 November 1993; Doreen Demas, Winnipeg, Manitoba, 17 November 1993; and James “Smokey” Tomkins, Ottawa, Ontario, 17 November 1993.

113 Statistics Canada, *The Daily*, News Release, “Disability and Housing, 1991 Aboriginal Peoples Survey” (25 March 1994). The APS depended on self-reports, which are subjective. However, the APS asked a number of questions designed to confirm or contradict the subject’s perception by revealing behavioural consequences. Questions reflected the World Health Organization’s definition of disability as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.”

114 House of Commons, Special Committee on the Disabled and the Handicapped, *Obstacles: The Third Report* (Ottawa: Supply and Services, 1981).

115 National Aboriginal Network on Disability, “Aboriginal Disability”, brief submitted to RCAP (1993), p. 5. For information about briefs submitted to RCAP, see *A Note About Sources* at the beginning of this volume. See also Volume 4, Chapter 7 for further discussion of urban Aboriginal people with disabilities.

116 David A. Randall, John A. Fornadly and Kevin S. Kennedy, “Management of Recurrent Otitis Media”, *American Family Physician* 45/5 (May 1992), pp. 2117-2123; Rose Dufour, “Prêtez-nous l’oreille! Anthropologie de l’otite

moyenne chez les Inuit", PH.D. dissertation, Quebec City, Laval University (1989).

117 J.D. Baxter, "What Have We Learned About Otitis Media and Hearing Loss by Studying the Native Peoples of Canada?", *Journal of Otolaryngology* 19/6 (1990), pp. 386-388; and Peter D. Eimas and James F. Kavanagh, "Otitis Media, Hearing Loss, and Child Development: A NICHD Conference Summary", *Public Health Reports* 101/3 (May-June 1986), pp. 289-293.

118 Jan Allison Moore, "Delivery of Audiologic Service and Prevalence of Hearing Loss in the Western Canadian Arctic", in *Circumpolar Health 90* (cited in note 29), pp. 630-633.

119 See "Tips from Other Journals", *American Family Physician* 49/7 (1994), p. 1654.

120 Healthy Inuit Babies Working Group, *Community Programs for Healthy Inuit Babies: Guidelines* (Ottawa: Pauktuutit, 1994); and Bernice L. Muir, *Health Status of Canadian Indians and Inuit: 1990* (Ottawa: Health and Welfare, 1991).

121 Healthy Inuit Babies Working Group, *Community Programs.*

122 David W. McCullough, "Chronic Otitis Media in the Keewatin Area of the Northwest Territories", *Journal of Otolaryngology* 19/6 (1990), pp. 389-390.

123 James Baxter, "An Overview of Twenty Years of Observations Concerning Etiology, Prevalence, and Evolution of Otitis Media and Hearing Loss Among the Inuit in the Eastern Canadian Arctic", in *Circumpolar Health 90* (cited in note 29), pp. 616-619; Baxter, "What have we learned?" (cited in note 117), pp. 386-388.

124 Baxter "An Overview" (cited in note 123); Baxter, "What have we learned?" (cited in note 117).

125 In relation to audiology and otolaryngology, the special services normally involved in identifying and treating otitis media, Salloum and Crysdale have documented the problems of securing reliable services in Sioux Lookout. Sharon Salloum and William S. Crysdale, "Ear Care for a Canadian Native Population", *Journal of Otolaryngology* 19/6 (1990), pp. 379-382.

126 House of Commons, Special Committee on the Disabled, *Obstacles* (cited in note 114); House of Commons, Special Committee on the Disabled and the Handicapped, *Follow-up Report, Native Population*: Fourth Report (Ottawa: Supply and Services, 1981).

127 House of Commons, Standing Committee on Human Rights and the Status of Disabled Persons, *Completing the Circle: A Report on Aboriginal People with Disabilities,* Fourth Report (Ottawa: 1993).

128 See, for example, the testimony of Mary Lou Fox, RCAP transcripts, Sudbury, Ontario, 31 May 1992; Louise Chippeway, RCAP transcripts, Roseau River, Manitoba, 8 December 1992; and Darlene Kelly, RCAP transcripts, Vancouver, British Columbia, 2 June 1993. See also Fernande Lacasse, "La conception de la santé chez les Indiens montagnais", *Recherches amérindiennes au Québec*, XII/1 (1982), pp. 25-28.

129 See, for example, RCAP, *Choosing Life* (cited in note 48); *Bridging the Cultural Divide: A Report on Aboriginal People and Criminal Justice in Canada* (Ottawa: Supply and Services, 1996); and Chapter 2 in this volume.

130 These are not aberrant figures. In the 1986-1988 period, injury also appeared as a leading cause of death in statistics gathered by the federal government. Health and Welfare Canada, *Aboriginal Health in Canada* (Ottawa: Supply and Services, 1992), p. 30.

131 According to the Canada Safety Council, the significant decrease in motor vehicle fatalities achieved during the last 20 years in Canada as a whole has not been equalled in the Aboriginal population. Canada Safety Council, "Submission to the Royal Commission on Aboriginal Peoples" (1993), p. 3. See also the testimony of the Canada Safety Council, given by Émile-J. Thérien, president, and Ethel Archard, manager of marketing and production, RCAP transcripts, November 1993.

132 See, for example, the 10-step model described by William Haddon, Jr., in "Advances in the Epidemiology of Injuries as a Basis for Public Policy", *Public Health Reports* 95/5 (1980), pp. 411-421. One of its applications to Aboriginal risk was explored by B. Friesen. See "Haddon's Strategy for Prevention: Application to Native House Fires", in *Circumpolar Health 84: Proceedings of the Sixth International Symposium on Circumpolar Health*, ed. Robert Fortuine (Seattle: University of Washington Press, 1985), pp. 105-110.

133 Telephone communication, Dr. Gordon Trueblood, Epidemiology and Community Health Specialties, Medical Services Branch, Health Canada, Ottawa, 20 July 1995.

134 The project is in its pilot phase. Written communication, Dr. Gordon Trueblood, Epidemiology and Community Health Specialties, Medical Services Branch, Health Canada, Ottawa, June 1995.

135 Fermented beverages were used, mostly for spiritual and ceremonial purposes, by some southern Aboriginal peoples but apparently by none who lived north of the 49th parallel. Lurid stories of Aboriginal drunkenness abound in the historical literature on the fur trade, but it is important to acknowledge that many Aboriginal people abstained from drinking; many opposed the consumption of alcohol by others, and many welcomed the arrival of the Northwest Mounted Police as a defence against the whisky traders from the United States. Furthermore, little alcohol was consumed except on visits to trading posts, where European traders encouraged its use and joined in its consumption. Waldram et al., *Aboriginal Health in Canada* (cited in note 18), pp. 137-140.

136 Alcohol is the addictive substance presenting the greatest number of problems to Aboriginal people and communities in Canada. However, solvent and inhalant use is inflicting grave damage to young people in some places, particularly in northern and isolated communities, where it is has been observed in children as young as six years old (Laurence Kirmayer et al., “Emerging Trends in Research on Mental Health Among Canadian Aboriginal Peoples”, research study prepared for RCAP, 1994). The ext reme toxicity of solvents and inhalants means that permanent injury to the brain and other organs may occur, even during a short period of use. The federal health minister has announced funding for six solvent abuse treatment centres for First Nations and Inuit (Donald Macdonald, “Aboriginals gain six treatment centres”, *The [Ottawa] Citizen*, 12 May 1995, p. A10).

Less visible action has been taken in relation to the very high rates of tobacco use among Aboriginal people. According to Thomas Stephens, well over half (57 per cent) of Canada’s Aboriginal adults are smokers (Thomas Stephens, *Smoking Among Aboriginal People in Canada 1991* [Ottawa: Supply and Services, 1994]). Most (62 per cent of smokers) consume 11 to 25 cigarettes per day. More Inuit than First Nations or Métis people smoke, in a ratio of about three to two. Tobacco is generally understood by non-Aboriginal Canadians to

be a highly addictive substance with a wide range of ill health implications. This public health message should be communicated more effectively to Aboriginal people. Santé Québec, *A Health Profile of the Inuit*, Report of the Santé Québec Health Survey Among the Inuit of Nunavik, 1992, Volume 1: Health Determining Factors, ed. Mireille Jetté (Montreal: Santé Québec, 1994).

137 Testimony of Jacques LeCavalier, Chief Executive Officer, Canadian Centre on Substance Abuse, RCAP transcripts, Ottawa, Ontario, 2 November 1993.

138 Most data describing substance abuse in Canada (and elsewhere) is self-report data. Telephone communication, Dr. R. Smart, Head of Social Epidemiology, Addiction Research Foundation of Ontario, Ottawa, 14 July 1995.

139 Yukon Government, *Yukon Alcohol and Drug Survey*, Volume 1: Technical Report (Whitehorse: Yukon Government Executive Council Office, Bureau of Statistics, 1991).

140 Santé Québec, *A Health Profile of the Cree*, Report of the Santé Québec Health Survey of the James Bay Cree, ed. Carole Daveluy et al. (Montreal: Santé Québec, 1994). See also Johanne Laverdure and Claudette Lavallée, *User Profile and Description of Mental Health Services Provided to the James Bay Cree* (Montreal: Montreal General Hospital, Department of Community Health, 1989).

141 See J. David Kinzie et al., “Psychiatric Epidemiology of an Indian Village: A 19-Year Replication Study”, *Journal of Nervous and Mental Disease* 180/1 (1992), pp. 33-39.

142 The prevalence of medically defined psychiatric disorders among Aboriginal people is impossible to establish with confidence because of the reluctance of many Aboriginal people to seek help from mainstream services for such conditions, the varied professional definitions of what ‘counts’ as a mental illness when people do seek help, and the rarity of aggregated records analysis. When records have been examined, they have shown two common conditions in the distress patterns of Aboriginal people: depression or suicidal thoughts and behaviour, and alcohol and drug abuse. In most studies, the co-incidence of more than one condition and of related social problems is high. For further discussion, see Laurence J. Kirmayer et al., “Emerging Trends in

Research" (cited in note 136); and Steering Committee on Native Mental Health, *Agenda for First Nations and Inuit Mental Health* (Ottawa: Health and Welfare Canada, 1991).

143 Until 1982, the program was called the National Native Alcohol Abuse Program (NNAAP).

144 Young and Smith, *Involvement of Canadian Native Communities* (cited in note 26), p. 15.

145 In our public hearings, the Commission was addressed by scores of people concerned about addictions. Those who spoke from direct program experience included Maggie Hodgson of the Nechi Institute on Alcohol and Drug Education; Patrick Shirt, Deanna J. Greyeyes and Wilson Okeymaw, all of the National Native Association of Treatment Directors; Henoch Obed and Robin Dupuis of the Labrador Rehabilitation Centre's Alcohol and Drug Abuse Program; Apenam Pone, Innu Alcohol Program; Andrea Currie, Stepping Stone Street Outreach Program; Gordon King and Marie Francis, MicMac Native Friendship Centre; Donald Horne, Kahnawake Shakotii'takehnhas Community Services; Tommy Keesick and Roy Assen, Grassy Narrows First Nation Solvent Abuse Program; Winston McKay, Metis Addictions Corporation of Saskatchewan; Joyce Racette, Metis Addictions Council of Saskatchewan; Donald Favel, Northwest Drug and Alcohol Abuse Centre; John Loftus, Action North Recovery Centre; Matthew McGinnis, Calgary Alpha House; and Tom George, Drug and Alcohol Counsellor, Stoney Creek Band.

146 Recently, some analysts have considered the possibility that Aboriginal people may suffer from 'post-traumatic stress disorder' as a result of long-term exposure to violence and the risk of sudden death, as well as multiple loss of family members, ways of life, lands and cultures. Kirmayer and his colleagues have pointed out that this possibility is appealing scientifically because it yields a single explanation for a diverse set of phenomena; clinically, because it leads to a strategy of disclosing, reliving and transforming traumatic memories; and morally, because it shifts the blame from self to others. Kirmayer et al., "Emerging Trends in Research" (cited in note 136). It is not clear how effective the technique of psychological 'purging' by means of personal and collective narrative is in resolving the social and emotional ill health experienced by Aboriginal people today, but we were informed by leading Aboriginal caregivers that they have found the approach useful.

147 Kirmayer et al., "Emerging Trends in Research" (cited in note 136).

148 Steering Committee on Native Mental Health, *Agenda for First Nations and Inuit Mental Health* (cited in note 142).

149 Steering Committee on Native Mental Health, *Agenda For First Nations and Inuit Mental Health*, p. 6.

150 See Michèle Therrien, “Corps sain, corps malade chez les Inuit, une tension entre l’intérieur et l’extérieur æ Entretiens avec Taamusi Qumaq”, *Recherches amérindiennes au Québec* XXV/1 (1995), pp. 71-84.

151 Kirmayer et al., “Emerging Trends in Research” (cited in note 136); and staff communication, Dr. Stephen Hodgins, head of the department of public health, Nunavik regional board of health and social services, 25 July 1995.

152 See, for example, Douglas Black et al., *Inequalities in Health: The Black Report* (New York: Penguin Books, 1982); George Davey-Smith, Mel Bartley and David Blane, “The Black Report on Socioeconomic Inequalities in Health 10 Years On”, *British Medical Journal* 301 (1990), pp. 373-377; and Clyde Hertzman, “Where are the Differences Which Make a Difference?”, Canadian Institute for Advanced Research, Population Health Working Paper No. 8 (Toronto: CIAR, 1990).

153 Hertzman, “Where are the Differences?”, p. 5.

154 Russell Wilkins and Owen B. Adams, *Healthfulness of Life: A Unified View of Mortality, Institutionalization, and Non-Institutionalized Disability in Canada* (Montreal: Institute for Research on Public Policy, 1985).

155 British Columbia, *A Report on the Health of British Columbians: Provincial Health Officer’s Annual Report, 1992* (Victoria: Ministry of Health and Ministry Responsible for Seniors, 1993), p. 25.

156 Federal, Provincial and Territorial Advisory Committee on Population Health, “Strategies for Population Health: Investing in the Health of Canadians”, paper prepared for the meeting of Ministers of Health, Halifax, 14-15 September 1994, p.
14.

157 Human Resource Development, *Improving Social Security in Canada:*

Income Security for Children, A Supplementary Paper (Ottawa: Supply and Services, 1994); and CICH, *The Health of Canada's Children* (cited in note 53); Gail Aitken and Andy Mitchell, "The Relationship between Poverty and Child Health: Long-Range Implications", *Canadian Review of Social Policy* 35 (Spring 1995), pp. 19-36.

158 R. Shillington, "Estimates of the Extent of Child Poverty: Census 1986" (cited in Aitken and Mitchell, "The Relationship between Poverty and Child Health").

159 Sharon Kirsh, *Unemployment: Its Impact on Body and Soul* (Ottawa: Canadian Mental Health Association, 1992).

160 The Honda Foundation, *Prosperity, Health and Well-being*, Proceedings of the 11th Honda Foundation Discoveries Symposium, 16-18 October 1993 (Toronto: The Canadian Institute for Advanced Research).

161 At least as recipients of social assistance experience it, there is no single system of social assistance in Canada. Provinces and territories have their own policies and guidelines, which are in turn open to regional and local interpretation. In some provinces, municipal governments are responsible for establishing and administering programs. The result is that there are, in effect, hundreds of welfare systems in Canada. National Council of Welfare, *Welfare Incomes 1993* (Ottawa: Supply and Services, 1994).

Social assistance to Aboriginal people is administered by different levels of governments depending on the 'status' of the recipients, that is, whether they are registered or non-registered Indian people living on- or off-reserve, Inuit living in or outside the Northwest Territories, or Métis people. For more details on the administration of social welfare programs, see Volume 2, Chapter 5, and Volume 4, Chapter 6. See also Allan Moscovitch and Andrew Webster, "Social Assistance and Aboriginal People: A Discussion Paper Prepared for the Royal Commission on Aboriginal Peoples" (1995).

162 Moscovitch and Webster, "Social Assistance and Aboriginal People".

163 National Council of Welfare, *Welfare Incomes 1993* (cited in note 161).

164 National Council of Welfare, *Welfare Incomes 1993*.

165 CICH, *The Health of Canada's Children* (cited in note 53).

166 National Council of Welfare, *Welfare Incomes 1993* (cited in note 161), p. ii.

167 CICH, *The Health of Canada's Children* (cited in note 53), p. 113.

168 Representatives of the National Anti-Poverty Organization described the need for a productive place in society as a general human drive and pointed out that the western nations and their restructuring economies are, at present, unable to provide that opportunity to growing numbers of their citizens. See RCAP transcripts, testimony of Lynne Toupin, Executive Director, National Anti-Poverty Organization, Ottawa, Ontario, 16 November 1993.

169 World Bank, *World Development Report 1992: Development and the Environment* (New York: Oxford University Press, 1992).

170 Canadian International Development Agency, *Water, Sanitation and Development: Water and Sanitation Sector*, Development Issues Paper (Ottawa: Supply and Services, 1988).

171 On a world scale, diarrheal diseases that result from contaminated water kill about two million children and cause about 900 million episodes of illness each year. See *World Development Report 1992* (cited in note 169). More recent figures suggest that one billion people lack access to an adequate supply of water and 1.7 billion do not have adequate sanitation facilities. (See Ismail Serageldin, *Water Supply, Sanitation, and Environmental Sustainability: The Financing Challenge* (Washington, D.C.: World Bank, 1994), p. 1.

172 Mani Shan Andrew brief submitted to RCAP (1992). Ms. Andrew described herself as a 26-year-old Naskapi Mushuau woman living in Davis Inlet, Labrador, a mother of five, and a member of the Innu Nation and the Innu Skueuts Committee.

173 DIAND Technical Services, *Community Water and Sewage System Profiles 1994 (Preliminary Report)* (Ottawa: DIAND, February 1995). The figures in the report refer to 'community systems' only. Individual household systems (wells, pails, septic fields, privies) are known to have problems too.

174 DIAND Technical Services, Community Water and Sewage System

Profiles, p. 4.

175 DIAND Technical Services, *Community Water and Sewage System Profiles*, p. 7.

176 CIDA, *Water, Sanitation and Development* (cited in note 170).

177 World Health Organization, *Improving Environmental Health Conditions in Low-Income Settlements: A Community-Based Approach to Identifying Needs and Priorities* (Geneva: UNEP & wHO, 1987).

178 The number of fires on reserves poses a serious health and safety problem. The average number increased from 174 in the period from 1970 to 1979 to 295 in the period from 1980 to 1989. Property damage was estimated at about $12 million during the 1980-89 period (measured in 1989 dollars). Young and his colleagues have estimated that the mortality rate from house fires among Aboriginal people is six to 10 times higher than for other Canadians. T. Kue Young et al., *The Health Effects of Housing and Community Infrastructure on Canadian Indian Reserves* (Ottawa: Supply and Services, 1991), p. 60.

179 Young et al., *Health Effects of Housing*.

180 Young et al., *Health Effects of Housing*.

181 Ted Rosenberg et al., “The Relationship of the Incidence of Shigellosis to Crowded Housing, Lack of Running Water and Inadequate Sewage Disposal”, report prepared for the Department of Health and Welfare, Medical Services Branch, Manitoba Region, completed in 1995 [unpublished]. The same study notes that, in the period for which records were studied, 81 per cent of the cases of hepatitis A were First Nations people.

182 Trevor Hancock, “The Future of Public Health in Canada: Developing Healthy Communities”, *Canadian Journal of Public Health*, 79/6 (November/December 1988), p. 416.

183 This voluminous literature stretches back to the classic study by Rachel Carson, *Silent Spring* (Cambridge, Mass.: Riverside Press, 1962). More recently it has included World Commission on Environment and Development, *Our Common Future* (Oxford: Oxford University Press, 1987); World Health

Organization, *Potential Health Effects of Climatic Change: Report of a wHO Task Group* (Geneva: World Health Organization, 1990); John M. Last, "Global Environment, Health and Health Services", in Maxcy, Rosenau and Last, eds., *Public Health and Preventive Medicine* (Norwalk, Conn.: Appleton and Lange, 1992), p. 677; Daniel Stokols, "Establishing and Maintaining Healthy Environments: Towards a Social Ecology of Health Promotion", *American Psychologist* 47/1 (January 1992), p. 6; and Price Waterhouse, *Canada Health Monitor: Highlights Report, Survey 6* (Toronto: Price Waterhouse, 1992).

184 Ontario, Premier's Council on Health, Well-Being and Social Justice, *Our Environment, Our Health*: *Healthy Ecosystems, Healthy Communities, Healthy Workplaces* (Toronto: Queen's Printer for Ontario, 1993).

185 Given the high degree of urbanization of Aboriginal people in recent years, such a land-based lifestyle is no longer the norm, though it might be the choice of more Aboriginal people if fish and game were still plentiful and uncontaminated.

186 Charles Dumont and Tom Kosatsky, "Évolution de l'exposition au mercure chez les trappeurs cris de la Baie James", in *Les enseignements de la phase 1 du Complexe La Grande*, ed. Nicole Chartrand and Normand Thérien (Montreal: Hydro-Québec, 1992), pp. 79-90.

187 Unwarranted fears about contaminated fish and game in some Aboriginal communities may be steering people away from traditional foods that are safe and nourishing toward fatty foods, junk foods and other products of little nutritional value.

188 For one example, see Ellen Bielawski, "The Desecration of Nánúlá Kúé: Impact of the Taltson Hydroelectric Development on Dene Sonline", research study prepared for RCAP (1993).

189 This point of view is increasingly acknowledged by researchers. See in particular Georges E. Sioui, *For an Amérindian Autohistory: An Essay on the Foundations of a Social Ethic*, trans. Sheila Fischman (Montreal: McGill-Queen's Press, 1992). For a discussion of this and related issues, see Kirmayer et al., "Emerging Trends in Research" (cited in note 136), pp. 59-62, as well as Volume 4, Chapter 6 of this report.

190 See, for example, Pierre Trudel, "La Compagnie de construction crie prise

à partie par un Cri", *Recherches amérindiennes au Québec* XXV/1 (1995), pp. 95-96.

191 Canadian Wildlife Federation, "Submission to the Royal Commission on Aboriginal Peoples" (1993), p. 2.

192 Ingestion of methylmercury to a blood concentration of more than 100 parts per billion is considered unsafe for human health. At higher concentrations, mercury poisoning can lead to Minamata disease, named after the community in Japan where 1,800 people suffered brain and nerve damage, and some ultimately died, from the effects of methylmercury. See Leonard T. Kurland, Stanley N. Faro, and Howard Siedler, "Minamata Disease: The Outbreak of a Neurological Disorder in Minamata, Japan, and its Relationship to the Ingestion of Seafood Contaminated by Mercuric Compounds", *World Neurology* 1/5 (1960), pp. 370-395. The ill health effects of mercury have been recognized at least since the time of the historian Pliny, who lived in the first century A.D. The phrase 'mad as a hatter' refers to the disastrous ill health effects on hat-makers from using mercury to improve the felting quality of wool and fur, up to and during the nineteenth century. See Warner Troyer, *No Safe Place* (Toronto: Clarke, Irwin & Co., 1977).

193 Dr. Stephen Levin of the Occupational Medical Clinic at Mount Sinai Hospital in Toronto has explained some of the difficulties faced by epidemiologists trying to establish the links between exposure to environmental contamination and later human health effects. Stephen Levin, "Akwesasne Environment: The Limits of Science", *Northeast Indian Quarterly* (Fall 1988), pp. 30-34.

194 Harriet Kuhnlein, "Global Nutrition and the Holistic Environment of Indigenous Peoples", in RCAP, *Path to Healing: Report of the National Round Table on Aboriginal Health and Social Issues* (Ottawa: Supply and Services, 1993), pp. 251-263.

195 James B. Waldram, "Hydroelectric Development and Dietary Delocalization in Northern Manitoba, Canada", *Human Organization* 44/1 (1985), pp. 41-49.

196 Shkilnyk, *A Poison Stronger Than Love* (cited in note 192); Sean McCutcheon, *Electric Rivers: The Story of the James Bay Project* (Montreal: Black Rose Books, 1991); Waldram, "Hydroelectric Development"; and Larry

Krotz, “Dammed and Diverted”, *Canadian Geographic* III/1 (February/March 1991), pp. 36-44. A few studies report little change in diet as a result of industrial projects. See, for example, Robert M. Bone, “Country Food Consumption During the Norman Wells Project, 1982-1985”, *Polar Record* 25/154 (1989), pp. 235-238; and Charles W. Hobart, “Impacts of Industrial Employment on Hunting and Trapping among Canadian Inuit”, in Milton M.R. Freeman, ed., *Proceedings: First International Symposium on Renewable Resources and the Economy of the North* (Ottawa: Association of Canadian Universities for Northern Studies, 1981).

197 Waldram, “Hydroelectric Development”.

198 Dave Stieb and Katherine Davies, *Health Effects of Development in the Hudson Bay/James Bay Region* (Ottawa: Canadian Arctic Resources Committee, 1993); David DesBrisay, “The Impact of Major Resource Development Projects on Aboriginal Communities: A Review of the Literature”, research study prepared for RCAP (1994); and Thomas R. Berger, *Northern Frontier, Northern Homeland: The Report of the Mackenzie Valley Pipeline Inquiry,* Volumes I and II (Ottawa: Supply and Services, 1977), p. 204.

199 Kuhnlein, “Global Nutrition” (cited in note 194), p. 259.

200 Stephanie Pfirman, Kathleen Crane and Peter deFur, “Arctic Contaminant Distribution”, *Northern Perspectives* 21/4 (Winter 1993-94), pp. 8-15.

201 Matthew Coon-Come, Grand Chief of the Cree Nation of Quebec, “Speech to the New York State Legislative Hearings”, New York City, 30 September 1991

202 Peter Usher, “Socio-Economic Effects of Elevated Mercury Levels in Fish in Sub-Arctic Native Communities”, paper presented to the conference on Contaminants in the Marine Environment of Nunavik, Montreal, 12-14 September 1990.

203 B. Wheatley, “A New Approach to Assessing the Effects of Environmental Contaminants on Aboriginal Peoples”, paper presented to the 9th International Congress on Circumpolar Health, Reykjavik, Iceland, 1993.

204 Berger, *Northern Frontier, Northern Homeland* (cited in note 198), p. 155-157.

205 Usher, *Socio-Economic Effects of Elevated Mercury Levels* (cited in note 202); Shkilnyk, *A Poison Stronger than Love* (cited in note 192).

206 Geoffrey York, *The Dispossessed: Life and Death in Native Canada* (Toronto: Lester & Orpen Dennys, 1989).

207 DesBrisay, *The Impact of Major Development Projects on Aboriginal Communities* (cited in note 198); Sylvie Vincent, "Consulting the Population: Definition and Methodological Questions", trans. Harriet Wichin (Montreal: Great Whale Review Support Office, 1994).

208 The five-year allocation of funding for water quality enhancement on reserves under the Green Plan (1989) was the first foray into formal programming.

209 Some ideas were conveyed to us in testimony. See RCAP transcripts for the following testimony: Joan Scottie, Rankin Inlet, Northwest Territories, 19 November 1992; Reg Whiten, Fort St. John, British Columbia, 19 November 1992; Jane Tennyson, Timmins, Ontario, 5 November 1992; Henry Lickers, Akwesasne, Ontario, 4 May 1993; Bob Moore, Brantford, Ontario, 13 May 1993; and Chief Clarence T. Jules, Ottawa, Ontario, 5 November 1993.

210 Robert Moore, Program Manager, Six Nations of the Grand River Forestry Program Project, RCAP transcripts, Brantford, Ontario, 13 May 1993.

211 Henry Lickers, Director, Department of the Environment, Mohawk Council of Akwesasne, RCAP transcripts, Akwesasne, Ontario, 4 May 1993.

212 Albert Saddleman, Canadian Indian Water Rights Commission of B.C., RCAP transcripts, Kelowna, British Columbia, 16 June 1993.

213 Peter Stevens, Eskasoni First Nation Community, RCAP transcripts, Eskasoni, Nova Scotia, 7 May 1992.

214 Joan Feather, *Social Health in Northern Saskatchewan: Discussion Papers for Working Group on Social Health* (Saskatoon: University of Saskatchewan Northern Medical Services, 1991), pp. 1-2.

215 Barbara Barnes, director of the National Association of Cultural Education

Centres, told us that although there is no ‘pan-Indian’ culture, there is a commonality of values and philosophical outlook shared by First Nations people from across the country (RCAP transcripts, Orillia, Ontario, 4 May 1993). Lesley Malloch drew a similar conclusion from her research (Lesley Malloch, “Indian Medicine, Indian Health: Study Between Red and White Medicine”, *Canadian Woman Studies* 10/2 & 3 (1989), p. 10). Neither of them assumed the inclusion of Métis people or Inuit. In Volume 1, Chapter 15, we suggest that life on the land and understandings of spiritual and natural law generate a commonality of world view that is, nevertheless, given diverse expression in different nations and cultures.

216 Criticism of the ‘lifestyle choice’ analysis has been persistent. The themes of the criticism are that much of what is termed individual choice is in fact a result of social and economic factors and not easily changed as a matter of individual will, and that this analysis shifts responsibility from the public health system to the individual, which may result in the withdrawal of state services where they are in fact still necessary.

217 Robert G. Evans and Gregory L. Stoddart, “Producing Health, Consuming Health Care”, *Social Science and Medicine* 31/12 (1990), p. 1347.

218 OECD Secretariat, *Health Care Financing Review: Annual Supplement* (Paris: Organization for Economic Cooperation and Development, 1991).

219 Quoted in Lorenz K.Y. Ng, Devra Lee Davis, Ronald W. Manderscheid and Joel Elkes, “Toward a Conceptual Formulation of Health and Well-Being”, in Lorenz K.Y. Ng and Devra Lee Davis, eds., *Strategies for Public Health: Promoting Health and Preventing Disease* (New York: Van Nostrand Reinhold, 1981), p. 46. The Commission is persuaded by the general conclusion, without necessarily endorsing the 90:10 ratio.

220 According to Toshiyuki Furukawa, soap helped bring disease-causing microbes under control, and glass permitted sunshine to enter interior spaces, which also decreased harmful micro-organisms (Toshiyuki Furukawa, “A Transactional Comparison of Life Expectancy”, a paper given at the Honda Foundation Conference on Prosperity, Health and Wellbeing, Toronto, October 1993). For a lengthy discussion, see McKeown, *The Modern Rise of Population* (cited in note 77).

221 Michael C. Wolfson, Geoff Rowe, Jane Gentleman and Monica Tomiak,

"Career Earnings and Death: A Longitudinal Analysis of Older Canadian Men", Analytical Studies Branch, Statistics Canada, 1992; and R. Wilkins, O. Adams and A.M. Brancker, "Changes in Mortality by Income in Urban Canada from 1971 to 1986: Diminishing Absolute Differences, Persistence of Relative Inequality" (Ottawa: Health and Welfare Canada and Statistics Canada, 1991).

222 Furukawa, "A Transactional Comparison" (cited in note 220).

223 M.G. Marmot and George Davey Smith, "Why Are the Japanese Living Longer?", *British Medical Journal* 299/23-30 (July to December 1989), p. 1547.

224 Kirsh, *Unemployment: Its Impact on Body and Soul* (cited in note 159); G. Westcott et al., eds., *Health Policy Implications of Unemployment* (Copenhagen: World Health Organization, 1985); and Lars Iverson et al., "Unemployment and Mortality in Denmark, 1970-80", *British Medical Journal* 295 (10 October 1987), p. 879.

225 Carl D'Arcy, "Unemployment and Health: Data and Implications", *Canadian Journal of Public Health* 77/Supplement 1 (May/June 1986), p. 124.

226 Hans Selye, ed., *Selye's Guide to Stress Research*, Volume 1 (New York: Van Nostrand Reinhold, 1980); and Robert Dantzer and Keith W. Kelley, "Stress and Immunity: An Integrated View of Relationships Between the Brain and the Immune System", *Life Sciences* 44/26 (1989).

227 Other social factors are discussed in the following sources: Michael H. Robinson and Lionel Tiger, eds., *Man and Beast Revisited* (Washington, D.C.: Smithsonian Institution, 1991); Lisa F. Berkman and S. Leonard Syme, "Social Networks, Host Resistance and Mortality: A Nine-Year Follow-up Study of Alameda County Residents", *American Journal of Epidemiology* 109/2 (1979); and James S. House, Karl R. Landis and Debra Umberson, "Social Relationships and Health", *Science* 241/4865 (29 July 1988), p. 540.

228 M.G. Marmot, Geoffrey Rose, M. Shipley and P.J.S. Hamilton, "Employment Grade and Coronary Heart Disease in British Civil Servants", *Journal of Epidemiology and Community Health* 32 (1978), p. 244.

229 Leonard Syme, "The Social Environment and Health", paper presented at the Honda Foundation Conference on Prosperity, Health and Wellbeing (cited in note 160).

230 Gus Thompson, *Mental Health, The Essential Thread* (Edmonton: Alberta Department of Health, Division of Mental Health, 1993), p. 5.

231 Kirmayer and his colleagues discuss a selection of research literature that draws similar conclusions. See Kirmayer et al., “Emerging Trends in Research” (cited in note 136), pp. 66-72.

232 Clyde Hertzman, “The Lifelong Impact of Childhood Experiences: A Population Health Perspective”, a paper presented at the Honda Foundation Conference on Prosperity, Health and Wellbeing (cited in note 160).

233 Daniel P. Keating and J. Fraser Mustard, “Social Economic Factors and Human Development”, in *Family Security in Insecure Times* (Ottawa: National Forum on Family Security, Canadian Council on Social Development, 1993).

234 Task Force on Human Development, *The Learning Society*, CIAR Publication No. 6 (Toronto: Canadian Institute for Advanced Research, 1992).

235 Max Cynader, “Biological Pathways that Contribute to Variations in Health Status: The Role of Early Experience”, a paper presented at the Honda Conference on Prosperity, Health and Wellbeing, Toronto, October 1993.

236 CICH, *The Health of Canada’s Children* (cited in note 53).

237 Thompson, *Mental Health, The Essential Thread* (cited in note 230).

238 W. Dewi Rees and Sylvia G. Lutkins, “Mortality of Bereavement”, *British Medical Journal* 4 (October to December 1967), p. 13.

239 Marcia Barinage, “Can Psychotherapy Delay Cancer Deaths?”, *Science* 246/4929 (27 October 1989), p. 448; and David Spiegel, “Therapeutic Support Groups”, in Bill Moyers, ed., *Healing and the Mind* (Toronto: Doubleday, 1993), pp. 157-176.

240 Thompson, *Mental Health, The Essential Thread* (cited in note 230).

241 Thompson, *Mental Health, The Essential Thread*. For a more detailed discussion of the effects of stress on human health, see John Zawacki, “Stress Reduction”, in Moyers, *Healing and the Mind* (cited in note 239), pp. 145-156.

242 See, for example, Moyers, *Healing and the Mind*, especially section III, “The Mind/Body Connection”.

243 Dantzer and Kelley, “Stress and Immunity” (cited in note 226); Cynader, “Biological Pathways” (cited in note 235).

244 This aspect of convergence was foreseen in the definition of health put forward by the World Health Organization: “a state of complete physical, mental and social well being, not merely the absence of disease or injury”.

245 For a discussion of the paradigm shift that has begun in relation to human health, see Rosemary Proctor, “Challenging the Way We Think about Health”, in *The Path to Healing* (cited in note 194), pp. 49-55.

246 The jurisdictional terrain is complex, and terms of access vary from program to program. Generally speaking, the federal government’s ‘Indian’ and Inuit health and social development programs are not open to Métis people or non-status Indians, and only sometimes open to registered Indians living off-reserve or to Inuit living outside their northern communities.

247 The Commission notes the similar finding of the House of Commons Standing Committee on Health in its report, *Towards Holistic Wellness: The Aboriginal Peoples* (Ottawa: July 1995).

248 One notable Canadian example was the forward-thinking analysis of health and social services done by M. Claude Castonguay and his colleagues in Quebec some 25 years ago. The Castonguay-Nepveu Commission (the commission of inquiry on health and welfare, 1970) called for a holistic, community-based approach to health care, based on an inclusive concept of ‘social health’. Local community health and social service centres were proposed as the principal means of delivering integrated services. Many of the recommendations of the Castonguay-Nepveu Commission report were implemented in Quebec, but the report had little impact on governments outside Quebec.

249 Marcia Nozick, *No Place Like Home: Building Sustainable Communities* (Ottawa: Canadian Council on Social Development, 1992).

250 L. Bird and M. Moore, “The William Charles Health Centre of Montreal

Lake Band: A Case Study of Transfer", in Postl et al., *Circumpolar Health 90* (cited in note 29), pp. 47-53. The authors report that fewer people have required hospitalization in a nearby town since the community health centre was established.

251 Meadow Lake Tribal Council, "Vision of Health and Wellness of the Nine Meadow Lake First Nations People", brief submitted to RCAP (1993).

252 Information provided by Health Canada, Medical Services Branch, Program Transfer, Policy and Planning, March 1996.

253 The Commission normally uses figures from the Aboriginal Peoples Survey [APS]. However, because the coverage of APS does not allow us to identify Aboriginal population numbers in every community, we took 1991 census figures showing Aboriginal ancestry and screened out those who reported more than one ancestry. The single-ancestry respondents should approximate the number of persons who would identify themselves as Aboriginal for purposes of service planning.

254 *Aboriginal Custom Adoption Recognition Act*, S.N.W.T. 1994, c. 26.

255 House of Commons, Standing Committee on Health, *Towards Holistic Wellness* (cited in note 247), p. 59.

256 See also Dianne Longboat, "Pathways to a Dream: Professional Education in the Health Sciences", in *The Path to Healing* (cited in note 194), p. 171; and Rick Krehbiel, RCAP transcripts, Fort St. John, British Columbia, 19 November 1992.

257 See, for example, Federal/Provincial/Territorial/National Aboriginal Organizations Working Group on Aboriginal Health, *Report to the Ministers of Health and National Aboriginal Organizations* (Ottawa: Health Canada, 1993).

258 Canadian Public Health Association [CPHA], "The Training and Recruitment of Aboriginal Public Health Workers", Issues Identification Paper (draft for discussion), Ottawa, 27 August 1993, p. 56.

259 Anne Gilmore, "Canada's Native MDs: Small in Number, Big on Helping their Communities", *Canadian Medical Association Journal* 142/1 (1990), p. 52.

260 Anne-Marie Hodes, Native Health Care Careers Program, Faculty of Medicine, University of Alberta, RCAP transcripts, Edmonton, Alberta, 15 June 1993.

261 Margo Rowan, physician, Canadian Medical Association, RCAP transcripts, Ottawa, Ontario, 17 November 1993.

262 CPHA, “Training and Recruitment” (cited in note 258).

263 Hodes, RCAP transcripts (cited in note 260).

264 The Canadian Public Health Association, for example, recently estimated that there may be 3,000 Aboriginal graduate RNs. See CPHA, “Training and Recruitment” (cited in note 258), p. 33. This wide discrepancy between estimated and identifiable personnel is indicative of the inadequacy of data on Aboriginal human resources.

265 Information provided by the Canadian Nurses Association, 6 January 1995.

266 Louis T. Montour, Kateri Memorial Hospital Centre, RCAP transcripts, Kahnawake, Quebec, 5 May 1993.

267 CPHA, “Training and Recruitment” (cited in note 258).

268 Health Canada, Medical Services Branch, Workload Increase System, May 1993. By January 1996 CHR numbers had risen to 671 and NNADAP workers to 700 (staff communication with MSB, January 1996).

269 See Stewart Clatworthy, Jeremy Hull and Neil Loughran, “Patterns of Employment, Unemployment and Poverty, Part One”, research study prepared for RCAP (1995).

270 Statistics Canada, 1991 Aboriginal Peoples Survey, and 1991 Census, custom tabulations prepared for RCAP.

271 6,445 persons in health occupations, plus 6,980 in social service occupations, equals 13,425 x 0.5 = 6,712.5.

272 Important among these reasons is the isolation often experienced by

Aboriginal and non-Aboriginal health and social service professionals who practise in rural and remote communities. These conditions were described in a brief to RCAP by the Ordre des infirmières et infirmiers du Québec, RCAP transcripts, Montreal, Quebec, 16 November 1993.

273 Quoted in CPHA, “Training and Recruitment” (cited in note 258).

274 Ordre des infirmières et infirmiers du Québec, RCAP transcripts (cited in note 272).

275 See Ipeelee Kilabuk, RCAP transcripts, Pangnirtung, Northwest Territories, 28 May 1992. According to the census, the population of the Baffin Region was 11,385 in 1991. Of this number, approximately 9,100, or 80 per cent, were Inuit.

276 See, for example, RCAP transcripts of testimony from George Gillies, Inuvik Regional Hospital, Inuvik, Northwest Territories, 5 May 1992; Isabelle Impey, Saskatoon, Saskatchewan, 12 May 1993; and Lisa Allgaier, University College of the Caribou, Kamloops, British Columbia, 15 June 1993.

277 Employers may have legitimate concerns that collecting some types of information about their employees could constitute an invasion of privacy or a violation of human rights. At the same time, employers have appropriate means available to measure progress toward employment equity.

278 CPHA, “Training and Recruitment” (cited in note 258).

279 For a detailed discussion of training issues for Aboriginal midwives, see Fletcher, “Innuulisivik Maternity Centre” (cited in note 70).

280 The case for a human resources development plan was also made forcefully in a presentation by the Native Council of Canada (now the Congress of Aboriginal Peoples). See RCAP transcripts, Ottawa, Ontario, 8 June 1993.

281 One small but helpful step in systematically collecting and disseminating information about training opportunities has been taken by the department of Indian affairs, which has prepared an inventory of training opportunities. See Department of Indian and Northern Development [DIAND], “Indian/Inuit Training Opportunities, 1993-1994” (Ottawa: Supply and Services, 1993).

282 Chris Durocher, Canadian Medical Association, RCAP transcripts, Ottawa, Ontario, 17 November 1993.

283 National Working Group on Community Health Representatives Scope of Duties, *Final Report* (Ottawa: Health and Welfare, 1993).

284 There have been many proposals to extend the CHR program to urban centres. We were informed about one such proposal in a presentation by the Calgary Aboriginal Urban Affairs Committee. See Gloria Manitopyes, Native Committee Assistant, Calgary Aboriginal Affairs Committee, RCAP transcripts, Calgary, Alberta, 26 May 1993.

285 John D. O'Neil, and Brian D. Postl, "Community Healing and Aboriginal Self-Government: Is the Circle Closing?", in John H. Hylton, ed., *Aboriginal Self-Government in Canada: Current Trends and Issues* (Saskatoon: Purich, 1994), p.
75.

286 See DIAND, Indian and Eskimo Affairs Program, "National Native Alcohol Abuse Program: Information Manual and Project Guidelines" (Ottawa: 1975).

287 Addiction Research Foundation, *Final Report of the Evaluation of Selected NNADAP Projects* (Ottawa: Health and Welfare, 1989).

288 See Health and Welfare, *Aboriginal Health in Canada* (cited in note 18).

289 Addiction Research Foundation, *Final Report* (cited in note 287).

290 Presenters at the public hearings told us that the current structure of NNADAP has led to a good deal of inflexibility, including a per-bed funding formula for residential treatment that does not recognize the importance of prevention or aftercare. See, for example, National Native Association of Treatment Directors, RCAP transcripts, Calgary, Alberta, 27 May 1993. See also Addiction Research Foundation, *Final Report* (cited in note 287).

291 See Four Worlds Development Project, "Survival Secrets of NNADAP Workers", *Four Worlds Exchange* 2/1, pp. 24-39.

292 See Four Worlds Development Project, "Survival Secrets".

293 See also the presentation by Winston McKay, Metis Addictions Corporation of Saskatchewan, RCAP transcripts, La Ronge, Saskatchewan, 28 May 1992.

294 For further detail, see RCAP, *Bridging the Cultural Divide* (cited in note 129); and Chapter 2 of this volume.

295 The need for Aboriginal mental health workers was highlighted in many presentations made to the Commission. See, for example, Ghislain Beaulé, Quebec Regional Health and Social Services Board, Abitibi-Témiscamingue, RCAP transcripts, Val d'Or, Quebec, 30 November 1992. A comprehensive study of the mental health needs of the Aboriginal people of Quebec has also been completed. See Bella H. Petawabano et al., *Mental Health and Aboriginal People of Quebec* (Boucherville, Quebec: Ga'tan Morin Éditeur, 1994).

296 Penny Ericson, Canadian Association of University Schools of Nursing, RCAP transcripts, Moncton, New Brunswick, 14 June 1993.

297 There are encouraging signs that non-Aboriginal health and social service professionals are developing a greater interest in Aboriginal knowledge and practices. For example, we were told about two cross-cultural training workshop organized by the Manitoba Division of the Canadian Medical Association that attracted almost 250 people, including physicians and other health care workers. Chris Durocher, Canadian Medical Association, RCAP transcripts, Ottawa, Ontario, 17 November 1993. See also Schuyler Webster, RCAP transcripts, Sudbury, Ontario, 31 May 1993.

298 This concern was addressed in a number of presentations made to the Commission. See, for example, John Sawyer, Ontario Native Education Counselling Association, RCAP transcripts, Toronto, Ontario, 18 November 1993.

299 This description of the Indian and Inuit Health Careers Program is based on information provided to the Commission by Health Canada on 16 March 1995.

300 Progress is being made in some areas. Pathways to Success, for example, is a federal program to promote training for Aboriginal people. Initially it provided very little opportunity for Aboriginal people to influence the structure and design of the programs being provided, their involvement being restricted

largely to administering existing programs. A recent review of the program, however, has recommended a consolidation of several training support programs and a new structure that would recognize the primacy of Aboriginal authority and decision making. See Human Resources Development Canada, “Pathways to Success Strategy” (Ottawa: 1995).

301 A number of presentations to the Commission addressed these issues. See RCAP transcripts for the following: Anne-Marie Hodes, Native Health Care Careers Program, University of Alberta, Edmonton, Alberta, 15 June 1993; Dr. David Skinner and Dr. Chris Durocher, Yukon Medical Association, Teslin, Yukon, 27 May 1992; and Ineaq Korgak, Iqaluit, Northwest Territories, 26 May 1992.

302 Ontario Ministry of Health, *New Directions: Aboriginal Health Policy for Ontario* (Toronto: 1994).

303 Northwest Territories, *Working Together for Community Wellness: A Directions Document* (Yellowknife: Government of the Northwest Territories, 1995).

304 See Alberta, “Strengthening the Circle: What Aboriginal Albertans Say About Their Health” (Edmonton: 1995).

305 The case for more and better qualified interpreters and translators, and the importance of the services they provide, was outlined in a brief presented by the Association des hôpitaux du Québec, RCAP transcripts, Montreal, Quebec, 16 November 1993. Similarly, we received several briefs on the importance of having escorts available to help Aboriginal people obtain needed medical services. We were told that escorts are needed especially for seniors, persons who are not fluent in the language of service providers, and for people from rural and remote areas who must travel to urban centres for treatment. See RCAP transcripts for the following: Tonena McKay, Big Trout Lake First Nation, Big Trout Lake, Ontario, 3 December 1992; Senator Edward Head, Metis Senate of Manitoba, Winnipeg, Manitoba, 21 April 1992; Samaria Reynolds, Winnipeg, Manitoba, 21 April 1992; and Herb Manak, Makkovik, Newfoundland and Labrador, 15 June 1992.

306 See RCAP transcripts for the following presenters: Tom Iron, Vice-Chief, Federation of Saskatchewan Indian Nations, Wahpeton, Saskatchewan, 26 May 1992; Eric Robinson, President, Aboriginal Council of Winnipeg, Winnipeg,

Manitoba, 22 April 1992; Debra Alvisatos, Fredericton Native Friendship Centre, Kingsclear, New Brunswick, 19 May 1992; and Douglas Crosby, Secretariat of the Oblate Conference of Canada, Montreal, Quebec, 25 May 1993.

307 For a detailed discussion of these reasons, see *Report of the Aboriginal Justice Inquiry of Manitoba* (Winnipeg: 1991). See also Corinne Jetté, "The Dynamics of Exclusion: Discrimination and Other Barriers Facing Aboriginal People in the Labour Market", research study prepared for RCAP; and Ontario Native Employment Equity Circle, "Honouring the Difference: A Challenge Paper" (Toronto: ONEEC).

308 Interestingly, however, the Canadian Labour Congress, in its presentation to the Commission, identified several large corporations that had hired significant numbers of additional staff. Very few of them were Aboriginal people. See Dick Martin, Canadian Labour Congress, RCAP transcripts, Ottawa, Ontario, 15 November 1993.

309 See Debbie Luce, Canadian Auto Workers, RCAP transcripts, Toronto, Ontario, 19 November 1993.

310 See Assembly of First Nations, "Reclaiming our Nationhood, Strengthening our Heritage", brief submitted to RCAP (1993), p. 62.

311 *Aboriginal Justice Inquiry of Manitoba* (cited in note 307).

312 See RCAP transcripts for the following presenters: Johnny Naktialuk, Inukjuak, Quebec, 8 June 1992; Wayne Helgason, Director, Ma Mawi Wi Chi Itata Centre Inc., Winnipeg, Manitoba, 23 April 1992; and Ghislain Beaulé, Quebec Regional Health and Social Services Board of Abitibi-Témiscamingue, Val d'Or, Quebec, 30 November 1992. We were also told about similar efforts, although less developed, where Aboriginal participation in the development of a regional health plan was described. See Peter Squires, Chairman, Nisg_a'a Valley Health Board, RCAP transcripts, Terrace, British Columbia, 25 May 1993. See also Dr. Richard Kennedy, Canadian Medical Association, Ottawa, Ontario, 17 November 1993.

313 See Timothy Johns, Centre for Indigenous Nutrition and Environment, McGill University; and Joyce Pickering, Northern Quebec Module, McGill University, Montreal, Quebec, RCAP transcripts, 2 December 1993.

314 See Aboriginal Employment Equity Consultation Group, *Completing the Circle: First Report to the Secretary of the Treasury Board* (Ottawa: Treasury Board, 1992).

315 Rhonda Fiander, Waterford Hospital, St. John's, Newfoundland; and Danny Pottle, St. John's Native Friendship Centre, St. John's, Newfoundland, RCAP transcripts, 22 May 1992.

316 See Iris Allen, Labrador Inuit Health Commission, RCAP transcripts, Nain, Newfoundland and Labrador, 30 November 1992.

317 See Dr. Chris Durocher, Yukon Medical Association, RCAP transcripts, Teslin, Yukon, 26 May 1992.

318 See RCAP transcripts for the following presenters: Huguette Blouin, Association des hôpitaux du Québec, Montreal, Quebec, 16 November 1993; Emmanuel Stip, Montreal, Quebec, 3 December 1993; and Louis Cossette, Corporation professionelle des médecins du Québec, Montreal, Quebec, 19 November 1993.

319 Earlier in the chapter, we discussed the maternity centre in Povungnituk, a leading example of how Aboriginal and non-Aboriginal providers can work together to extend culturally appropriate health services to Aboriginal people. See also Anne Rochon Ford, Interim Regulatory Council on Midwifery, RCAP transcripts, Toronto, Ontario, 2 November 1992; and Martha Greig, Vice-President, Pauktuutit, RCAP transcripts, Ottawa, Ontario, 2 November 1993.

320 See Cheryl Ogram, City of Saskatoon Race Relations Committee, RCAP transcripts, Saskatoon, Saskatchewan, 27 October 1992; and Al Adams, Deputy Mayor, City of Thompson, RCAP transcripts, Thompson, Manitoba, 1 June 1993.

321 See RCAP transcripts for the following presenters: Tom Erasmus, Alberta Mental Health Association, Lac La Biche, Alberta, 9 June 1992; Debra Alvisatos, Fredericton Native Friendship Centre, Kingsclear, New Brunswick, 19 May 1992; Theresa Holizki, Chief Commissioner, Saskatchewan Human Rights Commission, Saskatoon, Saskatchewan, 28 October 1992; and Marlene Thio-Watts, Prince George, British Columbia, 1 June 1993.

322 Lorrie Boissoneau-Armstrong, Phoenix Rising Women's Centre, RCAP

transcripts, Sault Ste. Marie, Ontario, 11 June 1992. Many Aboriginal organizations told us about partnerships with mainstream service agencies to provide cross-cultural training to their non-Aboriginal staff. See, for example, Doug Maracle, RCAP transcripts, Brantford, Ontario, 13 May 1993.

323 See, for example, RCAP transcripts for Dan Highway, Aboriginal Advisory Council, Roseau River, Manitoba, 8 December 1992; Celeste McKay, Aboriginal Women in the Canadian Labour Force, Winnipeg, Manitoba, 17 November 1993; and Denney Grisdale, District No. 70 School Board, Port Alberni, British Columbia, 20 May 1992.

324 The speech delivered by Peter Penashue was published with the following citation: Ben Andrew and Peter Sarsfield, “Innu Health: The Role of Self-Determination”, in Fortuine, ed., *Circumpolar Health 84* (cited in note 132).

325 Meadow Lake Tribal Council and St. John Ambulance, brief submitted to RCAP, (1993), p. 14, Appendix A, p. I.