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A Guide for Health Professionals Working with Aboriginal Peoples

The Sociocultural Context of Aboriginal Peoples in Canada

This Policy Statement has been reviewed by the Aboriginal Health Issues Committee and approved by Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

PRINCIPAL AUTHOR

Janet Smylie, BA, MD, CCFP, Ottawa, ON

ABORIGINAL HEALTH ISSUES COMMITTEE

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Tracy O'Hearn, Ottawa ON
Kenneth Seethram, MD, FRCSC, Yellowknife, NT

SPECIAL CONTRIBUTORS

Avis Archambault, MA, Phoenix, AZ
Howard Cohen, MD, Ottawa, ON
Margaret Moyston Cummings, BSc, PHN, RN, MSW, Ottawa, ON
Pascale Desautels, MD, Val d'Or, QC
Bernice Downey, RN, Ottawa, ON
Claudette Dumont-Smith, RN, BScN, MPA, Ottawa, ON
Jessie Fiddler, Sioux Lookout, ON
Margaret Horn, MA, Kahnawake, QC
Elaine Johnston, BScN, Cutler, ON
Mae Katt, RN, BScN, MEd, Thunder Bay, ON
Lorraine Kenny, BA, Sioux Lookout, ON
Dorothy LaPlante, RN (EC), BScN, Ottawa ON
Susan Maskill, BSc, Ottawa, ON
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Marie Ross, BA, RN, CGPA(Dip.), Truro, NS
Carol Terry, BA, Sioux Lookout, ON
Vincent F. Tookenay, MD, Russell, ON
Alan Waxman, MD, MPH, Gallup, NM
Cornelia Wieman, MD, FRCPC, Hamilton, ON

SUPPORTING ORGANIZATIONS

Assembly of First Nations
Canadian Institute of Child Health
Canadian Paediatric Society
College of Family Physicians of Canada
Congress of Aboriginal Peoples
Federation of Medical Women of Canada
Inuit Tapirisat of Canada
Metis National Council
National Indian and Inuit Community Health Representatives Organization
Pauktuutit Inuit Women's Association

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"Of all the teachings we receive this one is the most important: Nothing belongs to you of what there is; of what you take, you must share."
– Chief Dan George[1]

RECOMMENDATION A1

Health professionals should have a basic understanding of the appropriate names with which to refer to the various groups of Aboriginal peoples in Canada.

The Constitution Act defines "Aboriginal" as an inclusive term, referring to First Nations, Inuit, and Metis.[2] Aboriginal peoples refer to themselves by their specific tribal affiliation (such as Mi'k-maq, Cree, Innu, Ojibwa) or First Nations, Inuit or Metis. First Nations peoples may also be referred to as Native or "Indian," although the latter term, a misnomer based on an assumption by early European explorers that they had travelled to Asia, can be offensive to some First Nations people, and so its use in this article will be restricted to references from government statistics and documents using this term.

The government classifies First Nations people according to whether or not they are registered under the federal Indian Act. "Status Indians" are registered under the Act and numbered 610,874 in 1996. First Nations people who are not registered under the Act are referred to as "non-status Indians."[3] First Nations people may also be classified as "treaty" or "non-treaty," with a "treaty" Indian's ancestry being traceable to First Nations people who signed treaties in Canada. "Treaty" lists or "band" lists are maintained by First Nations communities. The terms "treaty" and "status" are not interchangeable. A person might be registered at the Department of Indian Affairs and Northern Development as having "status" per the Indian Act, but might be excluded from the band list at the community level. They would therefore be entitled to some rights according to their "Indian status" but exempt from "treaty" rights administered at the community level.

The Metis are a group of Aboriginal peoples whose ancestry can be traced to the intermarriage of European (mainly French but also Scottish) men and First Nations women in the western provinces during the 17th century.[3] Over the next two centuries, the Metis became a sizeable nation with a distinct language (Michif), culture, and economic role in the buffalo hunt and fur trade. Individuals of mixed Native and non-Native ancestry who are not directly connected to the Metis of the historic northwest may also identify themselves as Metis. Metis have historically been excluded from treaty negotiations and the Indian Act.

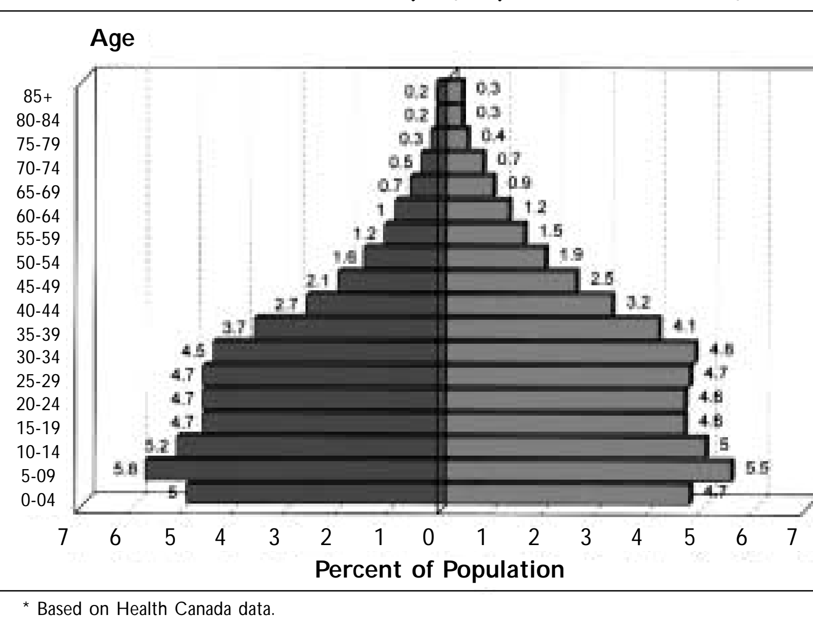
The Inuit traditionally lived above the tree line of what is now Canada, and are part of a larger circumpolar Inuit population that includes Greenland, Alaska, and Russia. "Inuk" refers to an individual Inuit person. The previous term "Eskimo" is actually Algonkian in origin, translating as "eaters of raw meat," and is now generally considered a misnomer. There are now four Inuit regions in Canada: Nunavut, Inuvialuit (western Arctic), Nunavik (northern Quebec), and Nunatsiavut (northern Labrador). Historically, Inuit have registered with the Department of Indian Affairs and Northern Development in order to obtain certain benefits, including health benefits. Excluded from the Indian Act when it was revised in 1951, the Inuit have now settled land claims in three Inuit regions after more than 30 years of negotiation, and an agreement in principle has been reached in Nunatsiavut.

In the United States, Aboriginal peoples are commonly referred to as "Native Americans," with other regionally specific American terms including "Native Hawaiian" and "Alaska Native" referring to all Aboriginal peoples indigenous to what is now Hawaii and Alaska respectively. The common term "American Indian" refers to those Native Americans living in what is now the mainland United States, not including Alaska. Several American organizations, both Aboriginal and non-Aboriginal, continue to use the term "Indian," including the Association of American Indian Physicians and the Indian Health Service.

RECOMMENDATION A2

Health professionals should have a basic understanding of the current sociodemographics of Aboriginal peoples in Canada.

FIGURE 1
STATUS INDIAN POPULATION (593,050) BY AGE AND SEX, 1995*



* Based on Health Canada data.

TABLE 1

LINGUISTIC GROUPINGS AND LANGUAGES OF ABORIGINAL PEOPLES IN CANADA

Group	Languages	Group	Languages
ALGONKIAN	Abenaki Blackfoot Cree Delaware Malecite Mi'kmaq Montagnaia Ojibwa Potawatomi	**KUTENAIAN**	Kutenal
		SALISHAN	Bella Coola Comox Halkomeiem Lilooet Oakanagan Sechelt Shuswap Squamish Straits Thompson
ATHAPASKAN	Beaver Carrier Chilcotin Dogrib Han Hare Kaska Kutchin Sarcee Sekani Slave Tagish Tahitan Tuchone	**SIOUAN**	Dakota
		TLINGIT	Inland Tlingit
		TSIMSHIAN	Coast Tsimshian Nass-Gitksan
		WAKASHAN	Haista Heiltshuk Kwakiuti Nootka
HAIDAN	Haida	**INUIT**	Inuktitut
IROQUOIAN	Cayuga Mohawk Oneida Onendaga Seneca Tuscarora		

* Adapted from a chart obtained from Dr. Vincent Tookenay, former President of Native Physicians in Canada.

In the 1996 Census, 1,101,960 people reported Aboriginal ancestry (3.9% of total Canadian population), with 799,010 (2.8%) identifying themselves as Aboriginal persons.[4] Of these, 867,225 individuals reported "North American Indian" ancestry, 220,740 individuals reported Metis ancestry, and 49,845 individuals reported Inuit ancestry. By identity, the numbers were 210,055 for Metis, 41,085 for Inuit, and 535,075 for North American Indian. A follow-up survey of the 1991 census[4] indicated that approximately two thirds of individuals reporting Aboriginal ancestry will identify themselves as Aboriginal.*

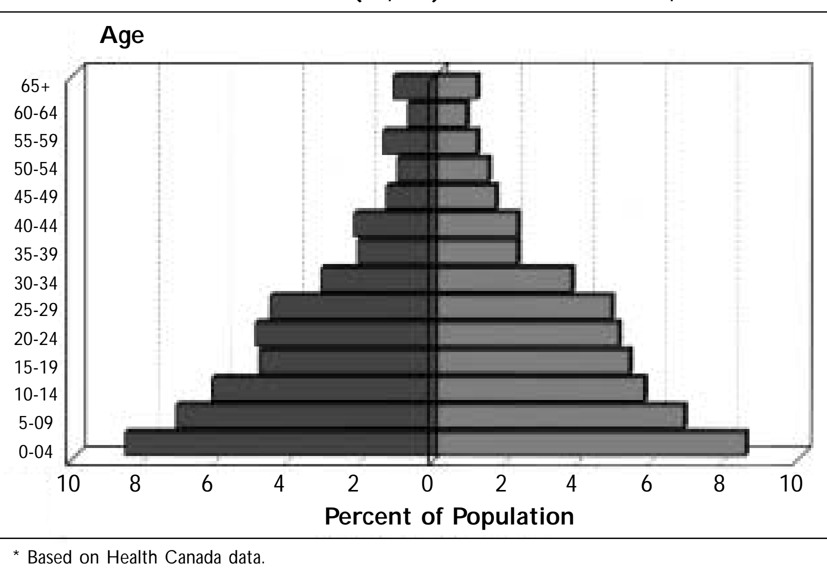
Census data is likely to underestimate the numbers of Aboriginal peoples for several reasons. In the 1996 Census, 77 reserves with an estimated total population of 44,000 people were incompletely enumerated, and therefore not included in any census counts.[4] Among "registered" Indians and members of a First Nation, 19,220 did not report identity.[4] In addition, some would not reveal Aboriginal ancestry or identity to a non-Aboriginal enumerator. Aboriginal peoples tend to move more often and make up a significant proportion of homeless people, making chronic undercounting more likely. Finally, some individuals of Aboriginal ancestry may have chosen the category "Canadian" rather than specifying Aboriginal ancestry.

Although there is little information on the health status of individuals who report Aboriginal ancestry versus those who report Aboriginal identity, it could be postulated that the risk for some health problems with a genetic component, such as diabetes, might be increased in those with Aboriginal ancestry, whether or not self-identified as Aboriginal. The limited health statistics on Metis people suggest that disease prevalence does not necessarily decrease for persons of mixed Aboriginal and European heritage compared to the total Aboriginal population.[5] However, as a result of historic, systemic, and attitudinal inequities, many individuals with significant Aboriginal ancestry may not openly self-identify as Aboriginal. Hence, despite the recent shift of census statistics to identity-based questions, ancestry questions may be the most relevant for the health professional while being less threatening for some clients.

The Aboriginal population of Canada identified by the 1996 Census is much younger than the general Canadian population, with an average age of 25.5 years compared to 35.4 in the general population. Children under 15 account for 38 percent of all Aboriginal peoples, compared with 20 percent of the general population.[4] Half of all Aboriginal peoples in Canada are under the age of 24 years.[6]

FIGURE 2

INUIT POPULATION (36,215) BY AGE AND SEX, 1991*

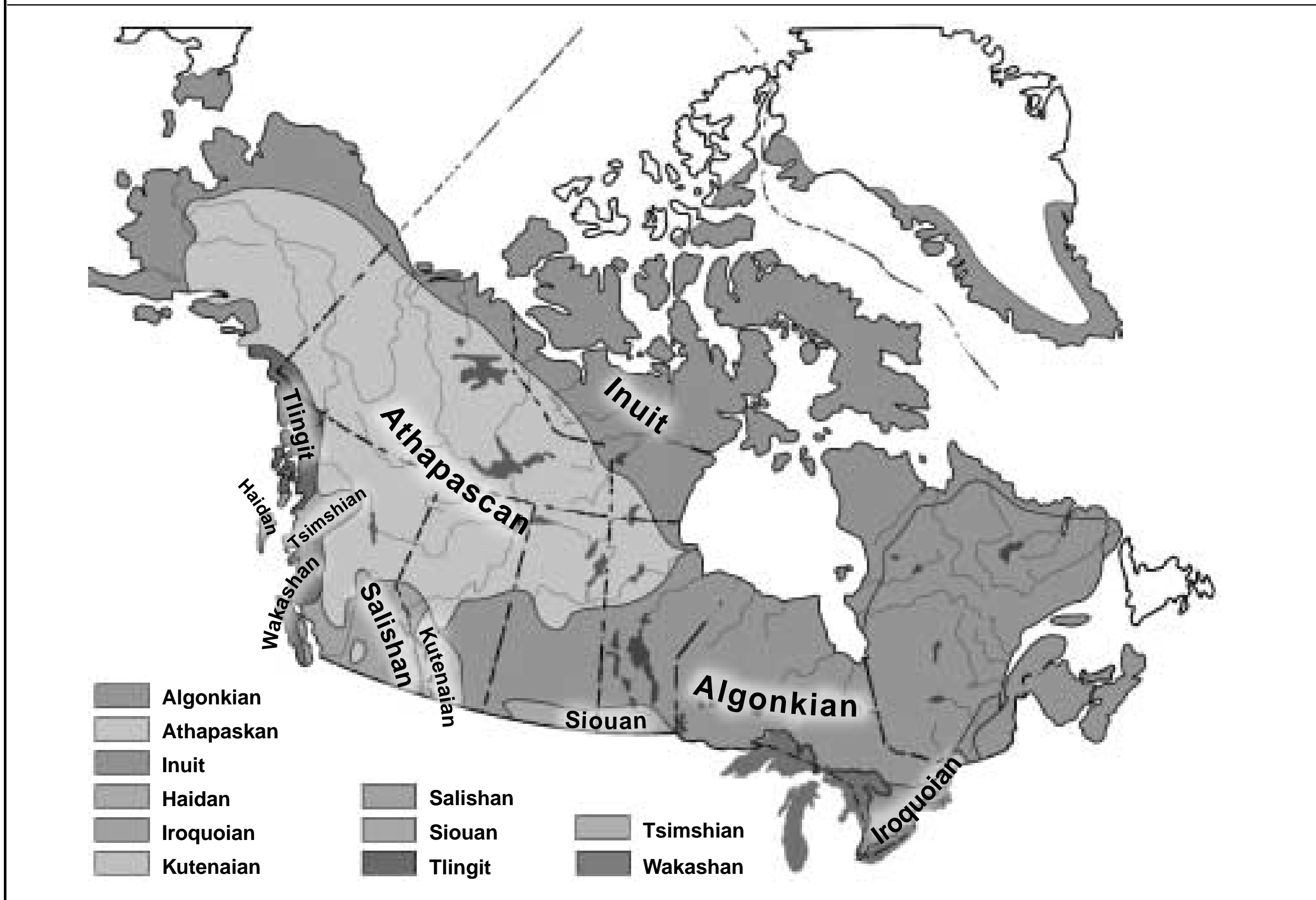


* Based on Health Canada data.

* Ancestry questions pertain to the cultural or ethnic group(s) of a person's ancestors, while identity refers to whether or not that person considers him- or herself a part of that group.

FIGURE 3

TRADITIONAL LAND BASE OF ABORIGINAL PEOPLES IN CANADA ACCORDING TO LANGUAGE GROUP



Aboriginal children under the age of 15 are more likely than non-Aboriginal children to live in single parent families (32% vs. 16%). In urban areas, over half of Aboriginal children under 15 live in single parent families.[4]

There is also a trend towards increasing urbanization of Aboriginal peoples in Canada, with 70.9 percent of all Aboriginal peoples identified by the 1996 Census living off-reserve.[6] One out of five Aboriginal peoples live in seven of Canada's 25 metropolitan census areas (Winnipeg, Edmonton, Vancouver, Saskatoon, Toronto, Calgary, and Regina).[4]

The majority of Inuit identified by the 1996 Census live in and around 55 communities in the Arctic and sub-Arctic regions of Canada, most of which are remote and isolated. A small but increasing number of Inuit live in urban centres in southern Canada. Like the First Nations, the Inuit population is also a very young population compared to the general Canadian population (Figure 2). The birth rate of Inuit women (3.4) is the highest of all Aboriginal populations and is twice as high as the Canadian average (1.7). In some northern regions, the proportion of persons under 30 years is as high as 60 percent.[7]

Most Metis identified by the 1991 Census live in the prairie provinces, although there are also significant populations in Ontario, British Columbia, and the Northwest Territories. Sixty-five percent of Metis live in urban areas, compared to 77 percent of the general Canadian population. Even in those largest urban centres with the highest numbers (Winnipeg, Edmonton, and Saskatoon), the Metis represent a small percentage of the total urban population (2.5-3.7%). Approximately half of the Metis population lives in villages, hamlets, and rural communities concentrated in a band just above the "fertile belt" in the Canadian prairies, as well as in areas of Northern Ontario, the interior of British Columbia, and the Northwest Territories south of Great Slave Lake. In these areas, the Metis may make up a very significant part of the total population, and in some instances define the community as Metis. In keeping with the age profiles of other Aboriginal groups, the Metis also have a young population: 37.8 percent of those of Metis identity were 14 years of age or under.[8]

RECOMMENDATION A3

Health professionals should familiarize themselves with the traditional geographic territories and language groups of Aboriginal peoples.

The Aboriginal peoples in Canada embody approximately 50

culturally diverse groups, the roots of which are found in distinct languages and land bases. Table I outlines the 11 major linguistic groups and the 50 distinct languages, while Figure 3 shows the traditional land bases of the First Nations and Inuit peoples according to linguistic group. The traditional homeland of the Metis was the western prairie.

It is important to appreciate the significance of traditional lands to Aboriginal individuals and communities. The Aboriginal concept of land and the relationship of humans to the land is very different from the western European perspective. Traditionally, most Aboriginal peoples did not have a sense of "land ownership" in the western European sense, but rather perceived a responsibility to "take care of" or maintain certain tracts of land that may have been inhabited for thousands of years by their ancestors. Since these tracts of land and the plants and animals found there were the basis for survival, the geography of these traditional lands determined daily behaviours, linking traditional Aboriginal customs and cultures to these traditional lands:

> Native people have a reverence for and attachment to their land, even to the few acres left after the pillage of the forests and plains by the dominant culture. Natives are products and extensions of this land and the vestiges of Native ethics and rules of behaviour, which continue to promote group unity and survival on Native lands, will not easily or soon be relinquished, even if the consequence of persistence in the old forms of behaviour is to be removed from competitiveness and success in the dominant non Native culture.[9]

The Inuit also have a strong connection to the land, and also to the sea:

> Our people are by tradition a people of the land. Our culture is strongly tied to the land and so are our people and our communities. Inuit have always recognized the fragility of the world they inhabited and the traditional Inuit way has been to live in harmony with the land that feeds and sustains us.[7]

These linkages remain strong in many Inuit communities:

> Inuit continue to keep a close relationship with the land and sea. Virtually every family depends upon our land and sea mammal resources for vital needs such as food and clothing. Many families look forward to the time when they can go out on the land for extended periods and live much like our ancestors.[10]

RECOMMENDATION A4

Health professionals should have a basic understanding of the disruptive impact of colonization on the health and well-being of Aboriginal peoples.

While a detailed summary of the history of Aboriginal and European relations over the past 500 years is beyond the scope of this document, health professionals need to have some sense of this history for several reasons:

- It has had a major, ongoing impact on the physical, mental, emotional, and spiritual health and well-being of Aboriginal peoples in Canada
- It impacts on current relationships of Aboriginal peoples with their health care providers and with the mainstream health care system (which grew out of the colonial system)
- Policies and attitudes which perpetuate this history still exist today

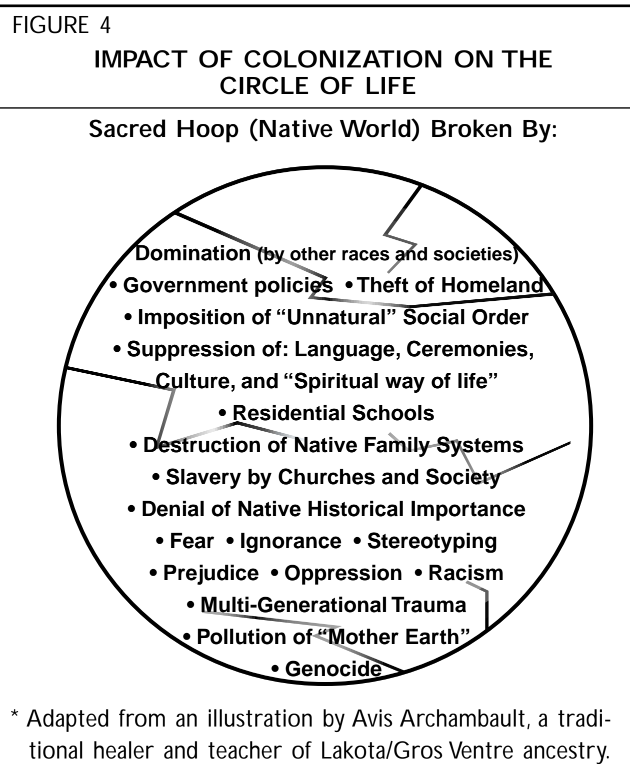
The reality of Aboriginal existence for many First Nations and Metis has been described as the "Circle of Life" or the "Sacred Hoop." This concept could be loosely described as a continuum of age-related roles and physical, mental, emotional, and spiritual well-being: which is congruent with the cycles of nature (see section B1). Prior to colonization, Aboriginal communities in the Americas were diverse and thriving. Shaped by the environment and available technologies, they ranged from the large cities of the Cherokee confederacy, Maya, and Inca peoples to the smaller mobile groups of plains and northern peoples.

Figure 4 illustrates how colonization completely disrupted this "Circle of Life." Early European colonization of the Americas brought epidemics of disease and included massacres, war, and slavery.

The "Sacred Hoop" and "Circle of Life" concepts are not applicable to the Inuit, who have their own rich and unique cultural heritage. Although Inuit did suffer from many of the oppressions listed in Figure 4, a more appropriate metaphor might be the impact of these events on traditional Inuit community events such as the sharing and eating together of traditional or "country" foods.

According to some historians, the first years of contact in what

FIGURE 4
IMPACT OF COLONIZATION ON THE CIRCLE OF LIFE



* Adapted from an illustration by Avis Archambault, a traditional healer and teacher of Lakota/Gros Ventre ancestry.

is now Canada included fragile but relatively peaceful relations. The Royal Proclamation of 1763 called for negotiated settlement of land transactions through treaty or purchase. Transactions included barter, trade, and military alliances.[11] Unfortunately, governmental approach quickly shifted from negotiations to share land to a unilateral policy of assimilation intended to "remove Aboriginal people from their homelands … suppress Aboriginal nations and their governments … undermine Aboriginal cultures … and stifle Aboriginal identity."[11] The Indian Acts of 1876, 1880, 1884, and later outlawed Aboriginal ceremonies such as the sundance and potlatch, gave the Indian agent authority over the food, goods, and travel available to on-reserve Aboriginal peoples, and supported the abduction of Aboriginal children to residential schools where language and culture were actively suppressed. Starvation, violence, infectious diseases, cultural suppression and imposed religious practices, family and community disruption and relocation, and physical, emotional, and sexual abuse were common realities for Aboriginal peoples in Canada during these chaotic times. The traditional healers in Aboriginal communities had never seen diseases such as smallpox and poliomyelitis, which wiped out many families and some communities. The population in the area of what is now Canada, estimated at 500,000 people prior to European contact, was reduced to 102,000 by 1871.[11]

Regrettably, there have been many opportunities to document the devastating impacts of European colonization worldwide. The result is a clear and long lasting pattern of illness and disease over time:

> All peoples of the world who undergo colonization tend to experience three stages of health and illness patterns as they become more urbanized and industrialized. The first stage is marked by famine, high rates of infectious disease, and high death rates, especially among infants and children. The second is marked by declining rates of infectious disease and rapid population growth. The third stage is marked by the rise of chronic and degenerative diseases. Canadian Aboriginal people seem to be between the second and third stages, as despite the extension of medical and social services in some form to every Aboriginal community, Aboriginal people still experience unacceptable rates of illness and distress.[12]

The history of the current health care system for Aboriginal peoples has its roots in the colonial system. Traditional healing methods were banned as "witchcraft" and access to medicinal plants was denied as part of the legislation associated with the early Indian Acts. The first western health care came in the form of semi-professionally trained Royal Canadian Mounted Police (RCMP) and missionaries: the same missionaries and RCMP that were removing children to residential schools.

Some of the first physicians arrived with the Indian agents and offered medical assistance to First Nations communities conditionally upon the signing of treaties by those same communities. In 1930, the first on-reserve nursing station was opened. Seventeen regional "Indian" hospitals were built by the federal government, initially in an attempt to control the epidemic of infectious diseases associated with colonization, such as smallpox, measles, tuberculosis, and poliomyelitis. Aboriginal children and adults who screened positive for tuberculosis were removed from their communities, often without proper explanation or consent, and placed in these regional hospitals. By 1950 there were 33 nursing stations, 65 health centres, and 18 small hospitals run by the federal government to provide health care for Aboriginal peoples.[12,13]

In 1962, the Medical Services Branch of Health and Welfare Canada was created with the mandate to provide services to treaty Indian and Inuit peoples. In the late 1960's, several universities became involved in the provision of direct primary and consultant services to rural and remote Aboriginal communities in collaboration with Medical Services Branch. Many of these programmes were based out of the same small "Indian" hospitals which had previously been opened in response to infectious diseases such as tuberculosis.[12,13]

Journalist Geoffrey York argues that oppressive policies and attitudes toward Aboriginal peoples survived well into the twentieth century, and in fact still exist today:

> Strangely, most Canadians are better acquainted with the history of native people in the eighteenth and nineteenth century than they are with the unsavoury realities of recent years. Canadians know that the early settlers and governments took land from the Indians, but it is easy to feel detached from those events of long ago. It is more difficult to deny responsibility for the misguided policies of the twentieth century. And so the ugly events of recent history are buried behind a wall of illusion—the illusion that progressive thinking and improved attitudes have brought fair treatment to Canada's native people … Hundreds of native communities are still enduring the malignant effect of institutions that seem benign to non-native Canadians: the churches, religious boarding schools, provincial and federal schools, child welfare agencies, courts, government departments, hydro corporations, and resource developers. The social conditions on modern-day reserves are a legacy of the decisions and policies of the most powerful institutions of the nineteenth and twentieth century. Many of those policies—and the attitudes that shaped them—still exist today.[14]

Examples of systemic oppression that continued into the twentieth century are residential schools, relocation, and the "Sixties Scoop."

Approximately 100 residential schools operated in Canada from 1849 to 1983. Indian Act legislation in 1920 made school attendance compulsory for all First Nations children between the ages of seven and 15. The residential school experience is described in the following excerpt from the First Nations and Inuit Survey Report:

> In some areas as many as five separate generations of children

were removed from their homes, families, culture, and language … At the schools children's long hair was cut off and school uniforms issued … many of the children endured long years of isolation and loneliness … Children entered a strange new world in residential boarding schools … Scores of children died from disease; others were emotionally and spiritually destroyed by the harsh discipline and living conditions. Children were referred to as 'inmates.' Survivors report being hungry all the time. In some cases, children were separated from their siblings, tortured for speaking their mother tongue, forbidden to honour their traditions. Grievous sexual abuse also occurred in some schools, but other outstanding issues include physical abuse and poor quality of education.[15]

Inuit children were not spared the residential school experience. Mary Carpenter summarizes her experience of residential school:

> After a lifetime of beating, going hungry, standing in a corridor on one leg, and walking in the snow with no shoes for speaking Inuvialuktun, and having a heavy stinging paste rubbed on my face, which they did to stop us from expressing our Eskimo custom of raising our eyebrows for 'yes' and wrinkling our nose for 'no,' I soon lost the ability to speak my mother tongue. When a language dies, the world it was generated from is broken down too.[16]

The traumatic impact of residential schools on the individual is described in the same article:

> Former students have expressed the pain and confusion of not fitting in either world, of being caught between two cultures—the white culture of the residential schools and their Inuit culture. This chasm within has caused various illnesses of the soul, leading to depression, hopelessness and destructive behaviours such as alcoholism, drug addictions, sexual promiscuity or violence, all with their own tragic consequences.[16]

Unfortunately, the impact of residential schools goes far beyond the impact on individual survivors. Cornelia Wieman highlights the enduring aftermath of the residential schools, asserting that:

> In addition to the damage caused to the individual survivors who endured emotional, physical, and sexual abuse, we must consider the long-term, cumulative intergenerational effects on First Nations Communities … including dislocation from one's community, loss of pride and self-respect, loss of identity, language, spirituality, culture, and ability to parent. The roots of this damage and these losses are reflected in the abysmal statistics which reflect levels of family violence, suicide, alcohol and other substance abuse in Aboriginal communities today.[17]

Governmental attempts to relocate Inuit communities began in 1934 when 22 Inuit from Kinngait (Cape Dorset), 18 from Mittimatalik/Tununiq (Pond Inlet), and 12 from Pangnirtuuq (Pangnirtung) were transported to Dundas Harbour. During the 1950's and 60's, many more Inuit families were moved from their traditional living areas and relocated to permanent and centralized settlements. Relocation sites were selected by government officials and did not take into account the fact that permanent villages were not part of the Inuit experience. Furthermore, the hunting conditions of the new sites were often suboptimal, interfering with the traditional food supply:[18]

> Although the intentions were to have Inuit gain better access to government services this movement initiated a period of social, cultural, and economic upheaval for the Inuit. Within the space of a few years, many of us had left a life that was based on an intimate reliance on the resources of the land and sea and stepped into a different way of living.[10]

In the 1950's, as the result of amendments to the Indian Act, the provinces were guaranteed federal funding for each Aboriginal child apprehended by child protection agencies: resulting in a ballooning of the number of First Nations children who were taken into care and made legal wards. This accelerated removal of Aboriginal children from their homes is known as the "Sixties Scoop." The percentage of apprehended children who were of Aboriginal ancestry jumped from one percent in 1959 to between 30 and 40 percent in the 1960's. Aboriginal children continue to make up a disproportionate percentage of the children who are apprehended from their homes by social service agencies. Many of the parents of these children are themselves survivors of residential schools.[17]

Corporations involved in hydroelectric power and resource development are also cited by York as modern examples of modern institutions which have a disruptive impact on Aboriginal communities.[14] Reviewing the health status of native peoples in the Hudson Bay/James Bay region in relation to hydroelectric and other forms of development in the region, Stieb and Davies conclude that the increased prevalence of formerly infrequent chronic diseases, injuries, poisoning, and violence appear to be linked to these environmental changes and the accompanying social, economic, and cultural changes.[19]

RECOMMENDATION A5

Health professionals should recognize that the current sociodemographic challenges facing many Aboriginal individuals and communities have a significant impact on health status.

The dramatic improvements in health outcomes (such as life expectancy, maternal and child morbidity and mortality) experienced by the general Canadian population over the past 200 years have been achieved mostly by the increase in economic prosperity brought about by the industrial revolution, which in turn resulted in improved food supply, safe housing, clean water supply, adequate systems for waste disposal, and decreased birth rates. Modern health care systems have had a small impact compared to these changes.[20] Other social factors that have been accepted as determinants of health outcomes include employment,

education level, and certain environmental exposures.

In contrast, many Aboriginal individuals and communities continue to experience social conditions that impact adversely upon health status, including: poverty, inadequate housing, unsanitary water supply and waste disposal, low educational achievement, unemployment, family violence, alcohol and substance abuse, dependence on social assistance, discrimination within the justice system, and environmental exposures.[11,13] The prevalence and trends of some of these problems are outlined below.

- **Income:** according to the 1996 Census, 43.6 percent of Aboriginal peoples were identified as being in a "low-income" household compared to 19.2 percent of the non-Aboriginal population.[4] According to the 1991 Census, the average annual income for Aboriginal peoples in Canada in 1990 was 70 percent of the annual income for non-Aboriginal Canadians. On-reserve, the average annual income was 43 percent that of non-Aboriginal Canadians.[21] Average annual income for Metis was 67 percent of the annual income for the general Canadian population in 1991.[8] In Nunavut, in 1996, the average annual income for Inuit was 44 percent of the average annual income for non-Inuit.[7]

- **Food security:** according to the Aboriginal People's Survey in 1991, 8.3 percent of all Aboriginal respondents over 15 years of age reported food availability as a problem during the year before the survey. Breakdown rates were: 12.7 percent for Inuit, 8.5 percent for off-reserve "Indian" people, 7.7 percent for on-reserve "Indian" people, and 7.5 percent for Metis people.[22] In many isolated and northern Aboriginal communities, nutritious food is difficult and costly to attain: a nutritious food basket for a family of four that costs $125 in Ottawa, costs $209 in Salluit, Nunavik and $260 in Arctic Bay, Nunavut.[7]

- **Unemployment:** participation in the labour force is lower and the unemployment rate is higher for Aboriginal peoples compared to non-Aboriginal Canadians. In 1991, the unemployment rate for Aboriginal peoples was 19.4 percent compared to ten percent for non-Aboriginal Canadians. The unemployment rate for on-reserve First Nations people was 31 percent.[23] Inuit and Metis communities suffer from similar lack of employment. The overall unemployment rate in Nunavut in 1999 was 21 percent, compared to less than nine percent for Canada. Unemployment rates for Inuit only are generally much higher. Many Inuit are still dependent on a mixed economy, combining both wage income and traditional harvesting pursuits for food and clothing.[7] In 1991, the unemployment rate for Metis averaged 21.7 percent.[8]

- **Education:** in 1991, 49 percent of the Aboriginal population in Canada had at least high school education, compared to 62 percent of the non-Aboriginal population. In the same year, 31 percent of First Nations persons living on-reserve and 45 percent of Metis had at least high school education. In 1996, 41 percent of Inuit women and 35 percent of Inuit men had at least high school education, while 35 percent of Inuit women and 32 percent of Inuit men had less than grade nine education.[7] Levels of post secondary education and retention rates for on-reserve schools have improved for the past 20 years. In 1968, approximately 800 Aboriginal persons were known to have post secondary education, increasing to over 150,000 Aboriginal persons in 1991. Retention rates for on-reserve schools improved from 13 percent in 1969 to 75 percent in 1995-96.[23] The First Nations and Inuit Regional Health Survey found that education level was inversely related to self-reported history of chronic disease.[15]

- **Housing:** Sixty-five percent of on-reserve housing was judged to be substandard by the Canadian Mortgage and Housing Corportion in 1996. Although the prevalence of water delivery systems and sewage disposal had increased dramatically over the past ten years, 25 percent of on-reserve houses lacked an operational bathroom in 1996. Thirty-one percent of First Nations people living on-reserve in 1996 lived in crowded homes: housing densities ranged from 3.7 to six persons per home, with the highest densities in Quebec, Manitoba, Saskatchewan, and Alberta.[21,24] Poor housing had also been found to be a factor in ill health among the Metis.[26] Overcrowded and substandard housing is also a major problem for the Inuit living in the North. As the result of increased building and fuel costs, 90 percent of Inuit families in the North rely on social housing. In some communities, the waiting period for housing is several years, and families are overcrowded in small houses lacking adequate insulation, heating, plumbing, and sewers.[7]

Health professionals need to be aware that health status is unlikely to improve significantly unless the roots of these sociodemographic issues are addressed.

RECOMMENDATION A6

Health professionals should recognize the need to provide health services for Aboriginal peoples as close to home as possible.

A significant proportion of Aboriginal communities are in remote regions, many accessible only by air. According to First Nation and Inuit Health statistics, approximately 20 percent of First Nations communities currently do not have year round road access.[25] Almost all northern Inuit communities are remote and do not have year round road access. Post *et al.*[25] estimated that

nationally, 30 to 50 percent of Aboriginal communities could be described as remote, noting that there is wide regional variation.

With the disruption of traditional systems of health care and the encroachment of federal medical systems, large numbers of individuals began to be evacuated from their communities for medical services, often including birthing services. Given the attachment to and synonymity of geographic land base and culture described in section A3, the non-Aboriginal can begin to understand the disruptive impact of having to remove individuals from rural and remote communities to provide medical services as described by Roda Grey, Health Coordinator at the Inuit Tapirisat of Canada:

> Traditional midwives … had special status within Inuit communities and were respected and acknowledged for their skills … Although they travelled far to obtain the services of the traditional midwife, they were accompanied by family members, and remained within their own culture … Traditional midwives provided prenatal care, counselling on nutrition, physical exercise, and care of the newborn …Once nursing stations were permanently established in Inuit lands, the practice of Inuit traditional midwifery was no longer permitted … Pregnant women near delivery were sent to larger communities … Women were separated from their families and culture during an important life event. The health services dealt with emergency cases and treatment rather than prevention and education. Elders within Inuit communities say that Inuit pregnant women no longer follow traditional health teachings.[27]

Geographic location and culture are used almost synonymously in Grey's description, reflecting the close connection between the two. In further discussion, Grey described how Inuit elders see pregnant women lacking physical exercise and a balanced diet, instead relying on "junk food" and spending large amounts of time watching television since the southern nurses took over their health.

Many Aboriginal individuals are still forced to leave their communities for medical care as the result of geographic isolation. The majority of Inuit still live in remote and isolated communities with the nearest hospital usually hundreds of kilometres away, while major referral centres may be thousands of kilometres away. For example, the distance from Iqaluit to Ottawa, the major tertiary care referral site for Iqualuit, is 2,055 km. In most remote Inuit and First Nations communities there is only a nursing station, staffed by a nurse or community health representative. Physicians and other specialists fly into the community periodically. Many services, including rehabilitation, physiotherapy, chiropractic, and mammography are not commonly available.

Several rural and remote Aboriginal communities are investigating the use of advanced telecommunications equipment, including video linkages between patients and off-location health care specialists. Development of such telehealth resources may assist in the promotion of better health care for Aboriginal peoples in isolated communities.

Health care providers involved in the decision making regarding location of medical care for individuals and community programs need to carefully balance the cultural and biomedical impact of location of service.

RECOMMENDATION A7

Health professionals should have a basic understanding of governmental obligations and policies regarding the health of Aboriginal peoples in Canada.

Section A4 provided a brief overview of the context of relations between Europeans and Aboriginal peoples in what is now Canada over the past 500 years. Current governmental obligations towards Aboriginal peoples regarding land and other benefits, including health care, can be traced back to the treaties negotiated during this time period. Treaties, which are negotiated agreements between the Canadian (previously British) government and Aboriginal communities regarding government compensation of Aboriginal peoples in return for land title, have been employed as a tool for the negotiation of peace and shared land use for several hundred years. Treaty making started as early as the 1600's, when the Two Row Wampum was negotiated between the Mohawk and the Dutch in 1613,[11] and continued well into the twentieth century (Treaty #9 adhesions 1929-30). There are still living witnesses to the signing of some treaties.

Unfortunately, many treaty agreements were not fully honoured by the Europeans. In addition, the underlying meaning of the verbally negotiated treaties was often very different from the final written documents according to the perspective of the Aboriginal leaders involved. Aboriginal leaders had been negotiating treaties among their own nations for hundreds of years prior to European contact. These "nation to nation" treaties were based on verbal oaths, ceremonies, and symbolic visual records such as wampum belts. The treaties with the Europeans were negotiated by Aboriginal leaders from this "nation to nation" perspective. British expectations that the First Nations would also acknowledge the authority of a distant monarch and cede large tracts of land to British control were not explicit in the verbal treaty agreements. Indeed, as noted in section A3, the notion of land ownership was a European concept.

Negotiated agreements regarding land use and compensation continue to be settled between the federal government and Aboriginal communities, with hundreds of outstanding land claims yet to be negotiated. Some Aboriginal communities never officially ceded their traditional lands through the signing of treaties. Others are contesting the historic federal interpretation of treaty agreements. In the area of health care, there has been considerable controversy regarding the extent of governmental obligations towards Aboriginal peoples. Provision of health care services for Aboriginal communities was part of at least some treaty negotiations, as demonstrated by

the "medicine chest clause" of Treaty #6 signed in 1876 between Canada and the Cree of Alberta and Saskatchewan:

> In the event hereafter the Indians … being overtaken by any pestilence, or by a general famine, the Queen … will grant to the Indians assistance … sufficient to relieve them from the calamity that shall have befallen them. A medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians at the direction of such agent.[28]

The "medicine chest clause" has been interpreted by many as evidence that provision of health care services by the federal government is a negotiated treaty right.

As described in section A4, the historic basis of federal health care services for Aboriginal peoples was based more on an assumed authority over Aboriginal nations than a negotiated obligation. This policy of appropriation was formalized by the 1897 Constitution Act, by which the federal government gave itself legislative authority over "Indians and lands reserved for Indians." The Indian Acts of 1876, 1880, and 1884 legislated a federal policy of domination and assimilation, with health services initially lumped together with other "services" for Aboriginal peoples. Between 1867 and 1966, the responsibility for "Indian affairs" migrated between several different federal departments, including the Office of the Secretary of State, Citizenship and Immigration, Mines and Resources, and Northern Affairs and National Resources; until the Department of Indian and Northern Affairs was finally created in 1966. In the interim, the responsibility for health services for "registered" Inuit and "status Indians" had been transferred to Health and Welfare Canada in 1945; until in 1962 the Indian Health Service was merged with six other federal health programmes to form the Medical Services Branch of Health Canada, renamed First Nations and Inuit Health in July 2000.

Since the early Indian Acts, only those Aboriginal peoples registered at the Department of Indian Affairs and Northern Development under the Indian Act and those recognized in treaties have been entitled to certain benefits, including specific health services. These benefits and services thus exclude a significant proportion of the Aboriginal peoples living in Canada. According to the 1996 Census results, "status Indians" and "registered" Inuit account for less than 60 percent of the Aboriginal peoples in Canada: with the remaining Aboriginal population composed of those First Nations individuals who were excluded from treaties or lost their status, Metis, and "unregistered" Inuit. Prior to 1985, "status" First Nations women who married "non-status" men lost their Indian status and the associated benefits. Bill C-31 allowed some of these women and their descendants to be registered or re-registered under the Indian Act, with certain limitations. Thousands of Aboriginal men also lost their status as a condition of their military enrollment. In 1969, the "White Paper" attempted to dismantle the Indian Act altogether, including discontinuation of the special health services for "status Indians" and "registered" Inuit.

The Metis have been historically dismissed by the British and Canadian governments. When European settlers arrived and made claim to their historic lands, the Metis were treated as squatters and pushed off the land. Instead of treaty compensation with land and other benefits, as was being negotiated with the First Nations, Metis received "half-breed script" in compensation for relinquishment of Aboriginal title. Metis claims for a secure land base and political recognition have been continuing for over a century. The Metis are currently excluded from health benefits and programmes available to "status Indians" and "registered Inuit" by First Nations and Inuit Health.

Medical services and special health benefits for "status Indians" and "registered" Inuit have been provided through three governmental structures: the provincial governments (which are reimbursed by the federal government for services provided to "status Indians" and "registered" Inuit); the former Medical Services Branch of Health Canada; and the Department of Indian Affairs and Northern Development. This heterogeneous structure has led to a fairly complicated service delivery system with jurisdictional gaps and overlaps: for example, it is not clear which agency is mandated with the provision of mental health services for Aboriginal peoples.

Some services, such as chiropody, are only available on-reserve. Metis and "non-status Indians" are excluded from these services, and receive no funding for non-insured health benefits such as prescriptions and dental care. Although "registered" Inuit in remote communities may in theory be eligible for additional health services, in practice they are denied access to these entitlements due to the lack of availability of these health care services in their communities.

Presently, First Nations and Inuit Health is divided into two principal components: the Non-Insured Health Benefits Programme (NIHB) and the First Nations and Inuit Health Programmes (FNIHP). The majority of health programmes formerly at the Department of Indian Affairs and Northern Development have been transferred to First Nations and Inuit Health. NIHB is a nationally-based programme providing health benefits to "status Indians" and "registered" Inuit. Benefits included under the programme are pharmaceuticals, medical supplies and equipment, dental services, vision care, medical transportation, and individual mental health counselling. FNIHP are community-based and include community health nursing and the community health representatives. In addition, primary care is provided in northern and isolated communities, often by a nurse or community health representative with physician back-up by telephone or radio. These latter programmes are delivered either by regional offices or by First Nations themselves and include such initiatives as: the National Native Alcohol and Drug Abuse Programme (NNADAP), the Brighter Futures programme, solvent abuse programmes, the First Nations Health Information System, the HIV/AIDS programme, the Canada Prenatal Nutrition Programme (CPNP),

and the Aboriginal Headstart on-reserve.

Current federal policies encourage transferring the management of special health programmes to Aboriginal communities.[12] As of March 1999, 41 percent or 244 eligible First Nations and Inuit communities had signed Health Services Transfer Agreements. An additional 37 percent of eligible First Nations and Inuit communities were involved in transfer via planning or contribution agreements.[29]

RECOMMENDATION A8

Health professionals should recognize the need to support Aboriginal individuals and communities in the process of self-determination.

This recommendation is in keeping with the recognition by the Royal Commission on Aboriginal Peoples that the inherent rights of Aboriginal self-government are recognized and affirmed in section 35(1) of the Constitution Act.[2] The Commission advocated the rebuilding and development of self-governed Aboriginal nations.[11]

While the Royal Commission based its arguments on the inherent right to self-government, Gray cites Australian and Canadian literature on self-determination and indigenous-government relations as containing "an implicit view that from self-determination will flow the development and implementation of effective policy and programmes."[30] He further states that a comprehensive United States review found that "real improvements in the socioeconomic status of indigenous Americans are directly attributable to political changes of the 1970's, leading to increased Indian control over, and participation in, the formulation of Indian policy."[30]

The Canadian Medical Association also supported the self-determination of Aboriginal peoples in social, political, and economic life, recognizing that this improves the health of Aboriginal peoples and their communities. The CMA submission to the Royal Commission on Aboriginal Peoples states that:

> The failure of past and present western institutions to meet the fundamental need of Aboriginal peoples, not least in the area of health, supports the view that Aboriginal peoples can best determine their requirements and solutions to their problems.[13]

The control of health services by Aboriginal peoples will be further explored in Section D.

J Soc Obstet Gynaecol Can 2000;22(12):1070-81

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