

# A Guide for Health Professionals Working with Aboriginal Peoples

## ABORIGINAL HEALTH RESOURCES

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 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 Organization

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*The most important evidence of Indian influence on American medicine is seen in the fact that more than two hundred indigenous drugs which were used by one or more Indian tribes have been official in "The Pharmacopeia of the United States of America" for varying periods since the first edition appeared in 1820, or in "National Formulary" since it began in 1880. So complete, in fact, was the aboriginal knowledge of their native flora that Indian usage can be demonstrated for all but a bare half dozen, at most, of our indigenous vegetable drugs. In a surprising number of instances, moreover, the aboriginal uses of these drugs corresponded with those approved in the "Dispensary of the United States". If the Indian medicine man eventually disappears, he will nevertheless have left to mankind an important store of remedies and curing methods . . .*

– Vogel<sup>1</sup>

*The process of healing must be based on our traditional spiritual values of respect, pride, dignity, sharing, hospitality and mutual aid . . . Self-reliance begins with the individual, then is built by the family, then by the community, and finally, by our relations with other nations.*

– Chief Jean-Charles Pietacho and Sylvie Basile, Mingan First Nation community<sup>2</sup>

#### **RECOMMENDATION D1**

### **Aboriginal communities and health professionals working with Aboriginal peoples should support the creation of community-directed health programs and services for Aboriginal peoples.**

Any discussion of health services for Aboriginal peoples in Canada should be prefaced by recognition that, prior to European contact, Aboriginal communities in what is now Canada already had regionally specific, locally controlled, culturally appropriate systems of health care in place, many of them quite sophisticated. These indigenous health care systems and the cultures upon which they were built were damaged by European colonization (sections A, \* C2-4\*\*).

Returning control of health services for Aboriginal peoples back to Aboriginal communities is in keeping with the principles of self-government discussed in Section A8.\*\*\* During the RCAP hearings, presenters clearly and repeatedly articulated a desire for resumption of community-directed authority over health services:<sup>3</sup> a transfer of control subsequently advocated by the RCAP commissioners.<sup>2</sup> The Canadian Medical Association (CMA) also supported Aboriginal control of health and social services in its submission to RCAP.<sup>4</sup> Article 23 of the UN Draft Declaration on the Rights of Indigenous Peoples affirms the right of indigenous

peoples "to determine and develop all health and housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions."<sup>5</sup> In addition to arguments based on community preference and the inherent right to self-government, there is evidence in the literature that increased Aboriginal control over and participation in policy development, implementation, and evaluation has led to improved socioeconomic outcomes.<sup>6</sup>

The desire for self-determination of health services is often linked to a desire to renew traditional values and healing practices. When the First Nations and Inuit Regional Health Survey (FNIRHS) posed the question "Do you think a return to traditional ways is a good idea for promoting community wellness?" over 80 percent of respondents replied yes.<sup>7</sup> At the National Aboriginal Information and Research Conference held in Ottawa in 1998, a holistic viewpoint, self-responsibility for health and healing, and the importance of putting the individual in the context of family and community were identified as key to traditional ways and community wellness. Participants also articulated a need for diverse and community specific services in response to the diversity and regional variation among Aboriginal communities in Canada.<sup>7</sup> The themes of holism (see section B1)<sup>†</sup> and the need for diverse services parallel RCAP recommendations.<sup>2,8</sup>

At the same time, any new framework of health services for Aboriginal peoples based on the principle of self-determination must be guided by a principle of equity of health and social outcomes.<sup>2,8</sup> This document has already detailed the disproportionate burden of health problems facing Aboriginal peoples (B2-3),<sup>††</sup> the geographic, social, and historical context of these health problems (A4-6),<sup>†††</sup> and the shortcomings of mainstream systems (C2-4).<sup>\*\*</sup> RCAP details potential "community-based centres to develop and deliver integrated health and social services:" an idea repeatedly expressed at RCAP public hearings across the country.<sup>2</sup> Implementation would involve transformation of current nursing stations and health facilities into "integrated hubs of health and social services." Additionally, some communities, such as rural Metis settlements and small towns with substantial Aboriginal populations which currently have no Aboriginal specific services, would require new resources. The principle of equity described in the RCAP report also includes correction of the current systemic inequalities of services between First Nations, Metis, and Inuit.<sup>8</sup>

The RCAP report recognizes that new models of holistic, community-directed health programming will have little chance of success unless they are accompanied by community infrastructure programs to deal with problems of housing, employment, education, clean water, and waste management. Since this process needs to be appropriately resourced, RCAP has advocated

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

\*\* J Soc Obstet Gynaecol Can 2001;23(2):157-67.

\*\*\* J Soc Obstet Gynaecol Can 2000;22(12):1080.

† J Soc Obstet Gynaecol Can 2001;23(1):55-6.

†† J Soc Obstet Gynaecol Can 2001;23(1):56-66.

††† J Soc Obstet Gynaecol Can 2000;22(12):1074-8.

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that self-government be accompanied by a fair redistribution of lands and resources and that Aboriginal governments have access to the same sources of revenues by which federal, provincial, and municipal governments currently self-resource, such as taxes, investments, public corporation revenues, and lotteries.<sup>2</sup>

Community ownership of health services also requires appropriate human resource development, as noted by John O'Neil:

The commission has recognised that the key to successful self-determination in the health field for indigenous people is the emergence of appropriately trained individuals and parallel institutions capable of designing, implementing and administering an indigenous people's health system. This focus is a departure from the current "transfer" policy, in which existing programs and services have simply been transferred to indigenous communities or organisations which must then either contract with external agencies or individuals for expertise or struggle with limited experience to meet community health needs.<sup>8</sup>

The requirements for Aboriginal individuals trained in health care services present a dual challenge. Firstly, there are very few practising Aboriginal health professionals. Secondly, the needs of the transformed system will require individuals with an understanding of both traditional health and healing practices and mainstream approaches. The need to encourage the education of Aboriginal health care professionals will be further discussed in section D3.

Historically, health services for Aboriginal peoples have been provided by federal and provincial governments. In this model, government officers responsible for program planning and delivery are directly responsible to their ministers, who in turn are responsible to parliament and the law; but are only indirectly accountable to the Aboriginal communities they serve. Politically, many of the concerns regarding accountability in this system pertain to fiscal matters.<sup>6</sup> Community-directed health programming for Aboriginal peoples requires the creation of mechanisms of local accountability. In order to avoid the problems of indirect accountability associated with governmental programs, new accountability processes will need to assess a broad scope of accountability measures, strive for genuine and comprehensive community involvement, and be compatible with local culture and value systems. In keeping with the circular models of health discussed throughout this document, new models of accountability may be ongoing or cyclical. The information gathered from community-based program assessments could be periodically fed back into responsive and effective local programs. Community-directed research will be further discussed in section D2.

Individuals and organizations working on the design, implementation, and administration of self-determined health services at the community level will benefit from the newly established

Organization for the Advancement of Aboriginal Peoples' Health. This national Aboriginal-designed and controlled organization is dedicated to improving the health of all Aboriginal peoples. Its mandate is to develop policy, research guidelines, and traditional healing resources. It will work in partnership with existing programs that promote Aboriginal health and accommodate three individual centres of Inuit, Metis, and First Nations health.

The maternity program at the Inuulitsivik Health Centre in Puvungnituk, Quebec is a good example of a transition towards community-directed health programming for Aboriginal peoples. The maternity program was initiated in 1986 by a local Inuit women's group in response to dissatisfaction with federal policy changes that required all Inuit women to travel away from their communities to southern hospitals for childbirth. Working in cooperation with a local family physician and the provincially funded local health centre, a midwife was hired and local Inuit women were selected by the community and trained via a mentorship program as community midwives. These community midwives are now important community leaders and health advocates. Women in the community now have informed choice regarding delivery location. A perinatal committee comprised of community midwives, non-Inuit midwives, and physicians reviews individual charts at 32 weeks gestational age and makes recommendations to local women regarding the location of birth. Local births are attended by a community midwife and a registered midwife or physician. The community midwives, community liaison, and local health centre board of directors offer ongoing accountability to the community. In addition, statistics regarding cultural satisfaction and perinatal outcomes are monitored in partnership with various academic institutions. Since the initiation of the local birth program, perinatal outcomes have improved to levels that are better than the Quebec average and care is more culturally appropriate.<sup>9,†</sup>

This program models some of the strategies and challenges that may be involved in the transfer of control of health services back to Aboriginal communities. In response to community requests, the government returned control over the location of childbirth back to the community members. Community members worked with a team of health care providers to create a community-directed childbirth program that built on the ancestral system of traditional community midwives. The new system is in keeping with local value systems and prioritizes the role of family, culture, education, and prevention. It integrates modern medical practices where appropriate, useful, and compatible with the community-directed paradigm. Local community accountability is ensured through a variety of mechanisms. Outcomes, both in terms of culturally appropriate care and perinatal morbidity and mortality, have improved with the new system.

† Unfortunately the Quebec government has recently passed legislation requiring all new midwives to successfully complete a three year training program outside Puvungnituk, which is available in French only. This will severely limit the number of potential new Inuit midwives.

The new community-directed system of childbirth is quite distinct from the system of evacuation it replaced. One might argue that the previous system was built on western European values and prioritized access to advanced “scientific” technologies and medico-legal liability. Health care providers who are not from the community might be challenged by this contrast of underlying values.

The Kahnawake Schools Diabetes Prevention Program in Kahnawake, Quebec is another example of a community-directed health program, the roots of which are found in the Diabetic Education program of the Kateri hospital.<sup>††</sup> In the 1980s, several studies were conducted in the community documenting the prevalence of diabetes mellitus and its complications among community members. In response to a community request that further research be directed towards diabetes prevention, the Kahnawake Schools Diabetes Prevention Program was initiated. This participatory research program is conducted in accordance with a code of ethics developed by community members to ensure that the research is in keeping with the values of the community, with results of the ongoing evaluation process fed back into the interventions. It is also an example of community-based, community-directed research, which will be discussed in section D2.<sup>10</sup>

Several Aboriginal health centres have been created in urban areas over the past decade. These centres are typically governed by a board of directors composed of community representatives and funded by a mix of municipal, provincial, and federal monies. Most of these centres provide primary health care services as well as educational, social, and cultural programming. Challenges facing urban Aboriginal health centres include: meeting the diverse cultural needs of urban Aboriginal populations; balancing the resources and responsibilities required of a primary care clinic with other community-identified needs; and creating mechanisms of effective community-directed accountability while remaining accountable to government funders. The diversity of urban Aboriginal communities can make it difficult to identify a consistent set of community-directed values or principles that can be used to guide programming.

The notion of community-directed programming, when tied to the concept of community as geographically bounded, can be particularly challenging to Metis initiatives. As discussed in section A2,<sup>†††</sup> the majority of Metis live in urban areas, where they represent a small percentage of the total population and may be dispersed throughout the city. In addition, membership in national and provincial Metis organizations is voluntary (in contrast to membership in on-reserve First Nations communities). Although Metis organizations can still achieve community-directed programming, this programming must be flexible in its definitions of community, and include mechanisms to overcome

geographic barriers and build community linkages and community participation.

In summary, Aboriginal communities have an inherent right and aspiration to resume control of their own health services. This return to community-based, community-directed models of health services will involve a paradigm shift towards systems that are more consistent with community-based value systems. This does not mean an exact replication of historic arrangements, but rather involves building upon the holistic, culture-based values, knowledge, and resources in a particular community. Once the foundation or ethics of such programs have been established, modern medical approaches can be integrated with more “traditional” programming where appropriate, useful, and relevant: resulting in health services that have greater cultural relevance and are therefore more effective and efficient. Health care professionals need to work in solidarity with Aboriginal communities in order to facilitate the transition towards self-determined health services for Aboriginal peoples.

#### RECOMMENDATION D2

#### **Aboriginal communities and health professionals working with Aboriginal peoples should support the development of community-directed, participatory health research for Aboriginal peoples.**

The majority of available health statistics for Aboriginal peoples, as outlined in Sections B2 and B3,<sup>††</sup> concern Aboriginal peoples living on-reserve or “registered” at the Department of Indian and Northern Affairs Canada and relate to mortality. Thus, much of the available data gives only a very narrow view of health conditions for a limited percentage of the Aboriginal population in Canada. With respect to the rest of the Aboriginal population, one author has stated: “Our understanding of the physical and social health conditions for Metis and other indigenous people living off-reserve, and particularly in cities, is minimal.”<sup>8</sup> There is a critical need for regionally specific information that “accurately reflect(s) the health condition for ALL Aboriginal communities if health services are to be grounded in the real needs of the communities themselves.”<sup>11</sup>

However, “scientific” research methods are based on a western European value system that is quite different than the value system inherent in many Aboriginal communities. For example, the concept of individual ownership of ideas may be foreign to an Aboriginal worldview, where knowledge and ideas may be seen as gifts from a higher power which are not to be owned or sold by individuals, but which may be shared for the benefit of the family and community.

<sup>††</sup> The Kateri hospital itself was founded in 1955 when a local Mohawk woman obtained Mohawk council and provincial funding to assume control over a local hospital that had been previously operated by a religious order that went bankrupt.

<sup>†††</sup> J Soc Obstet Gynaecol Can 2000;22(12):1071-3.

<sup>††</sup> J Soc Obstet Gynaecol Can 2001;23(1):56-66.

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Historically, scientists and government officials adopted a “helicopter” style of research in Aboriginal communities: arriving in the community, collecting information, leaving the community, and then publishing the information in government and scientific documents to which the community had little access. This methodology obviously deviates from acceptable customs in most Aboriginal communities, and thus has led to a distrust of scientific research in many individuals and communities, especially if this research is conducted by someone from outside of the community.

The notions of self-determination can also be applied to health research in Aboriginal communities. The First Nations and Inuit Regional Health Survey (FNIRHS), coordinated by a national steering committee made up of regional Aboriginal representatives, is an example of a research project where Aboriginal communities played a directing role. Steering committee members adapted a code of ethics, modelled after that of the Kahnawake Schools Diabetes Prevention Program,<sup>10</sup> to ensure the research process, data management, and information dispersal were conducted in a way that was acceptable to the Aboriginal communities involved. Both quantitative and qualitative information was gathered.<sup>7</sup>

Researchers involved in the FNIRHS have recognized the need for more ongoing studies of this kind. Authors of the section on elder health write:

Clearly the study raises more questions than it answers ... much more detailed research in the form of ongoing longitudinal studies need to be undertaken to obtain a comprehensive understanding of the health concerns for the elder population that will continue to grow and change in the future ... This survey contained no questions concerning alcohol consumption, drug use and abuse, diet and nutrition, exercise or other behavioural factors.<sup>7</sup>

The Canadian Medical Association, in its submission to the Royal Commission on Aboriginal Peoples, also advocated for additional health research involving Aboriginal peoples in research design and data collection and analysis, and which feeds back data to the involved communities.<sup>4</sup>

### **RECOMMENDATION D3**

#### **Aboriginal communities and health professionals working with Aboriginal peoples should encourage the education of Aboriginal health professionals committed to future work in Aboriginal communities.**

Self determination of Aboriginal health services requires trained Aboriginal health care professionals. Opportunities for further education of community members in the area of health care are needed: such training optimally to build on the skills, values, and knowledge base already present in the community. In 1997-98, there were 74 self-identified Aboriginal physicians and 42 self-

identified Aboriginal medical students in Canada.<sup>12</sup> Currently, there are approximately 300 Aboriginal registered nurses who are members of the Aboriginal Nurses Association of Canada, and unofficial estimates number the total number of Aboriginal nurses in Canada at 1000. Using counts of the total number of Canadian physicians and nurses from the Canadian Medical Association in 2000 and the Canadian Nurses Association in 1999, these numbers amount to approximately 0.2 and 0.4 percent of all Canadian physicians and nurses respectively, despite Aboriginal peoples accounting for approximately four percent of the Canadian population. There is also a shortage of Aboriginal people with training in social work, dentistry, physiotherapy and occupational therapy, psychology and mental health work (including addictions), chiropractic, midwifery, and chronic care. Although many communities have trained community health representatives (CHRs), the length and depth of CHR training has varied over the years, and is currently a 30 week program with the goal of producing nursing assistants.<sup>13</sup> The short-term training given to community health representatives and the nurses who provide diagnostic and therapeutic services in rural and remote communities is often not sufficient to provide an equitable level of health service.<sup>14</sup>

The focus on the recruitment and training of Aboriginal health care professionals has perhaps overshadowed the concurrent need for trained health administrators. Health management careers is one area where there is a severe shortage of trained Aboriginal professionals: a need which becomes particularly acute as many communities work towards transfer of health services. Finally, Aboriginal persons trained in traditional healing report a shortage of young people continuing this type of training.

Design, implementation, and ongoing management of community-directed Aboriginal health systems will require a considerable increase, not only in numbers of Aboriginal health care professionals, but also in the amount and depth of training these health care workers receive. Many of them will be required to take leadership positions in the new health systems, where they will be required to integrate mainstream approaches with more traditional health and healing practices. In addition, the nature of their positions may place them in the position of advocating for Aboriginal peoples in mainstream services and acting as role models for their own communities. Since not all Aboriginal health care professionals are interested in working in the area of Aboriginal health or in Aboriginal communities, there is a particular need to train Aboriginal health care professionals committed to ongoing work in Aboriginal communities.

RCAP has suggested “a crash program over the next 10 years to educate and train Aboriginal people to staff and manage health and social services at all levels, in Aboriginal communities and mainstream institutions.”<sup>2</sup> The CMA has also supported the education of Aboriginal health care professionals, both in its recommendations to RCAP and by an annual bursary for Aboriginal medical students.<sup>4</sup>

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## RECOMMENDATION D4

### **Aboriginal communities and health professionals working with Aboriginal peoples should recognize the need for preventative health programming in Aboriginal communities.**

The focus on prevention is embedded in the traditional holistic worldview in which health is conceptualized as a balance or cycle that needs to be maintained, and sickness occurs when things are "out of balance" (section B1<sup>†</sup>). Prevention, or maintenance of this balance, is the responsibility of the individual.<sup>15,16</sup> In addition, there is an ethic of long-term preventative planning in many Aboriginal value systems: whereby decision makers are encouraged to consider the consequences of a decision made today on individuals, families, and communities in generations to come.

"Disease prevention," ranked second of all services listed (after "pediatric services"), was cited by 84 percent of participants in the FNIRHS as a health service in need of improvement. "Medication awareness" and "diabetes awareness" ranked number three and four respectively, with over 82 percent of participants listing these items as health services in need of improvement. Three of the top four services cited as needing improvement by participants in the survey are therefore preventative services.<sup>7</sup>

The scientific literature is in agreement with the need to engage in preventative health programming in Aboriginal communities. As the health problems of Aboriginal peoples in Canada shift away from high rates of infectious diseases and perinatal morbidity towards chronic and degenerative diseases, acute medical interventions will have increasingly less impact, and preventative health programming addressing lifestyle and behavioural risk factors will become increasingly important.<sup>17,18</sup> In its submission to RCAP, the CMA concludes that:

as health care professionals, we must acknowledge that we have entered the "flat of the curve" in our efforts . . . improvements in health are tied to socioeconomic and political agendas. More services alone will not improve the collective morbidity and mortality of Aboriginal peoples . . . We must support empowerment in the broadest health promotion context.<sup>4</sup>

## RESOURCES AND CONTACT LIST

### **Aboriginal Nurses Association of Canada**

**Contact: Bernice Downey, RN, Executive Director**

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### **Aboriginal Youth Network**

Website: <http://ayn.ca>

### **Assembly of First Nations**

**Contact: Elaine Johnston, BScN, Executive Director**

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Ottawa, ON K1Y 7B7  
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### **Canadian Institutes of Health Research, Institute of Aboriginal Peoples' Health**

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### **Congress of Aboriginal Peoples**

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Ottawa, ON K1K 3B1  
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Website: <http://www.abo-peoples.org>

### **First Nations and Inuit Health Branch, Health Canada**

Website: <http://www.hc-sc.gc.ca/msb/index.htm>  
Addresses of Regional Offices are on the web site.

### **Indian and Northern Affairs Canada, Headquarters**

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Phone: (819) 997-0380  
Fax: (819) 953-3017  
Website: <http://www.inac.gc.ca>

### **Inuit Tapirisat of Canada**

510-170 Laurier Avenue W  
Ottawa, ON K1P 5V5  
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Website: <http://www.tapirisat.ca>

<sup>†</sup> J Soc Obstet Gynaecol Can 2001;23(12):55-6.

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## Metis National Council

**Contact: Cliff Gladue, Director of Health**

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Website: [www.sae.ca/mbc](http://www.sae.ca/mbc)

## The National Indian and Inuit Community Health Representatives Organization

**Contact: Margaret Horn, MA, Executive Director**

Box 1019  
Kahnawake, QC J0L 1B0  
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Website: [www.total.net/~niichro](http://www.total.net/~niichro)

## Native Women's Association of Canada

9 Melrose Avenue  
Ottawa, ON K1Y 1T8  
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## Organization for the Advancement of Aboriginal Peoples Health

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## Pauktuutit Inuit Women's Association

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