Understanding the Broader Context: The Health of the Urban Native Canadian

Prodan-Bhalla, N.

Abstract

The average life expectancy for a Native male is 66, and for a non-Native male, 76. It is undisputed that the health of the Native Canadian is poor, yet substantial inequalities remain. One of the reasons these inequalities remain is the shallow, limited understanding of the poor health of the urban Native Canadian which, in turn, leads to quick fixes and temporary solutions.

The purpose of the following paper is to give nursing leaders an accurate description of the poor health status of the urban Native Canadian, as well as a description of the perpetuating events leading up to their current situation. Once this is understood, the nursing profession can work with urban Native Canadians towards sustainable, long-term solutions.

The following paper provides an overview of the historical oppression of Native Canadians, a discussion on the effects of marginalization and the subsequent adaptation process, an overview of the current health status of the urban Native Canadian and a practical assessment tool. The paper concludes with practical suggestions and directions for the future.

Introduction

It is an undisputed fact that Native Canadians suffer from a disproportionate amount of illness within our society as compared to non-Native Canadians. Illnesses such as diabetes, infectious diseases, and cardiac disease are all more prevalent among Native Canadians than among Non-Native Canadians (Tsookney, 1996). The poor health of Native Canadians has been studied extensively over the last few decades, yet this substantial disparity remains. Perhaps the poor health of Natives is due to their poverty, or maybe to their lack of education or employment. A more likely cause is a combination of many factors. Native Canadians hold a unique position within our society; they are our founding peoples and at the same time, a disfavored and conquered people. Their oppressive history combined with their current impoverishment results in a multitude of problems which are not simply defined nor solved. Urban Native Canadians, those who have left reservations for the city, are perhaps the most marked example of this phenomenon.

The following paper will attempt to clarify the problems of the urban Native Canadian within the historical context from which they come. For the purposes of this paper, the term ‘Native’ is used in a global sense to include Inuit, Metis, status and non-status Natives. While diverse, their historical experiences and poor health status are similar. An overview of the history of Native Canadians will be followed by a report on the current health status of urban Native Canadians. Davidstunt and Giger’s (1996) Transcultural Assessment Model will then be used to discuss nursing implications. The purpose of the paper is to provide nurses with accurate information and understanding about the current health status of urban Native Canadians. A practical assessment tool for nurses to utilize while working with Native Canadians will also be provided. With this understanding and practical tool, nurses can work together with urban Natives to improve their health status.

History of Native Canadians

Native Canadians of the 1600s experienced the economic boom of the fur trade (Waldrum, Harring, & Young, 1997). Initially, the trading was good for the Natives; they received cooking utensils and building supplies in trade with the Europeans for furs (Waldrum et al.). However, as animals became more scarce and fur hats went out of fashion, the market began to decline and the status of the Natives started to fall substantially (Waldrum et al.). In conjunction with this, alcohol and guns replaced the cooking utensils and the traditional way of life for Native Canadians began to change. Both the fall of the market and the introduction of guns and alcohol created dependency, and set the stage for future problems.

In 1763, the British wrote the Royal Proclamation which stated that the crown had to buy land from the Natives for settlements (Waldrum et al., 1997). This was a positive move for the Natives, as they recognized they owned the land (Waldrum et al.). However, dependency had already been established at this point and many Natives started to rely on guns for hunting. As a consequence land was bought, in many cases, under unfair circumstances. In 1867, Canada became a country under the British North America Act (BNA). As the Europeans encroached upon Native land, treaties were signed which gave Native lands away to the Europeans for guns and alcohol, or in one case for the Plains Cree in Alberta, for the promise of health care, known today as the Medicine Chest clause (Waldrum et al.). The BNA was also responsible for the introduction of reservations (Waldrum et al.). Many times, treaties were signed which forced the Natives to relocate.

In 1876, the Indian Act was introduced and to this day is what governs Native Canadians (York, 1990). Under the Indian Act, “Indians” are defined, thus the terms status and non-status were introduced. Under the Indian Act, Indians are defined as those with Indian blood (DNA), those
married to and children of status Indians (York). Status Na-
atives are those who fall under this definition and are reg-
istered with the Canadian government as being to. Non sta-
tus Natives are simply those who do not fit the definition or
who have lost their status at some point. Up until 1985, 
Native women lost their status if they married a non-Native
and up until the 1930s men lost their status if they wanted to
attend university (Shab & Dubinski, 1992). The Indian Act
implies that everything that was once Native is now the
property of the government and that Natives are now "al-
lowed" to use it (Waldrum et al., 1997). The Indian Act was
a formal way for the government to assimilate Natives into
mainstream Canadian culture (Salojoee, 1998).

The Indian Act also made the Federal government responsible for all aspects of Native life including health (Waldrum et al., 1997). In 1969, the White Paper on Indian Policy was published which recognized the Indian Act was racist, and recommended that it be abolished (Waldrum et al.). This caused an uproar of protests from the Native com-
munity and marked the beginning of strong political activ-
ism (Waldrum et al.). The Natives felt that although oppress-
ive, the Indian Act recognized them as a unique people with special status. With its abolishment, any status they have would disappear (Cardinal, 1969).

In 1982, the Constitution Act amended the BNA and the recognition of "existing aboriginal rights" was added (Waldrum et al., 1997). This statement leaves substantial room for interpretation and many of the land claims before the courts today are a result of its ambiguity. In 1986, the Health Transfer Initiative was implemented to return to Na-
tives the right to govern their own health care (Atkinson, 1996). Currently, the Initiative has been implemented on a small number of reservations on a trial basis.

The early part of the century (1900-1950) saw the introduction of the residential school system (York, 1990). This system was introduced to "civilize" Native Canadians and force assimilation (York). The federal government gave the Protestant and Catholic churches control over the edu-
cation of Natives (York). Within these schools, Native chil-
dren were not allowed to speak their language or follow any of their traditional ways of life (York). Furthermore, it has just recently been discovered that abhorrent acts of physi-
cal and sexual abuse also occurred within the residential schools. The children were often separated from their par-
ents to make the assimilation "easier" on the religious lead-
ers who ran the schools (York). As a result, generations of Native lost their cultural identity, their self-confidence, their language and their families. This has had an enormous im-
 pact on the generation who were forced to attend residential schools and will resonate for many generations to come.

As the residential schools started to fall out of favour the practice of systematically removing Native chil-
dren from their homes began (Waldrum et al., 1997). This allowed the government to continue to assimilate Native
into mainstream Canadian society. In the 1960s and 1970s, thousands of children were taken away from their families and adopted by non-Native families. By the early 1980s, 40-
60% of all children removed from Canadian homes were Na-
tive (Waldrum et al.); this too, resulted in loss of cultural identity and language. This generation of children are now known, within the Native community, as the "lost genera-
tion" (Waldrum et al.).

John Barry (1986) discusses the idea of marginality and defines it as striking out against the larger society while at the same time losing cultural identity. It is characterized by being out of touch with both the larger society as well as with the traditional society (Barry). When it is imposed by the dominant group, as in the case of Native Canadians, the result is ethnocide (Barry).

The residential schools and the mass adoptions are just two examples of forced marginality which occurred in the early and recent part of this century. Loss of cultural identity leads to loss of self-esteem and feelings of self-
worth, resulting in lack of education, unemployment, pov-
erty, and finally both mental and physical illssnesses. Subse-
sequently, it is not surprising that as a result of this marginalization, the Native Canadian of today has both a lower socioeconomic status and poorer health than that of the non-Native Canadian.

John Barry (1986) also discusses the process of adaptation which is of particular relevance to the urban Na-
tive Canadian. Adaptation can allow for a reduction in the conflict and may involve one of three responses which are: adjustment, reaction, and withdrawal (Barry, 1986). In ad-
justment, changes are made that reduce the conflict through making cultural behaviours more similar to the dominant group; assimilation is one kind of adjustment (Barry). In reaction, political activism occurs in retaliation to the poli-
cies implemented by the dominant group and in withdrawal, the adapting group removes themselves from the situation (Barry).

Over the centuries, Native Canadians have experi-
enced all three kinds of adaptation which has contributed极大地 to their identity confusion. Initially, at first contact with the Europeans, Natives were able to combine with their tra-
ditional ways of life and both cultures lived symbiotically.

As the encroachment onto Native lands increased, Natives were forced onto reservations and forced to withdraw. Then, thoughts on Natives changed, the government realized they were unable to support the Native way of life on reserva-
tions (Salojoee, 1998). Thus, the introduction of residential schools and mass Native adoptions into non-Native fami-
lies became government policy. This started the period of assimilation (Salojoee, 1998). Natives were to become non-
Native and give up their traditional ways of life to ease the government's burden of taking care of them.

The White Paper on Indian Policy, published in 1969 initiated the period of activism or reaction from the

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Canadian Natives and has continued to this day (Waldrum et al., 1997). Currently, Natives are still struggling for posi-
tive adaptation mechanisms, however, their complicated his-
tory provides them with significant barriers. Integration is
difficult when their traditions have been taken away from
them and cultural identity has been lost. It is essential that
health care providers have an understanding of both the
history of Native Canadians and their current health prob-
lems to ensure that adequate and effective health care is
provided for Native Canadians.

The Health of Urban Native Canadians

The history of Native Canadians provides a backdrop
to the understanding of the current health status of
today's urban Native Canadian. There are four distinct
groups of aboriginal Canadian; status Natives, non-status
Natives, Inuit and Metis. The four groups are diverse and
are represented by different political organizations across
the country (MacMillan, MacMillan, Offord, & Dingel, 1996).
It is important to distinguish between the four groups as
they all have different cultures, different languages and
different traditions. Even among the same tribes, traditions
vary.

In today's society, an average male Native will die at
the age of 66, while an average non-Native will die at
the age of 76 (York, 1999). By any socioeconomic standard, Na-
tive are the poorest group within Canada (Poutl, 1997). Only
10-20% of Natives finish high-school, while only 50% of
Native housing has sewage or water connections (Salojee, 1997).
Some reservations report a 90-95% unemployment
rate (Salojee). Almost half of Natives have no central
heat, compared with only 5% in the Native-popula-
tion (MacMillan et al., 1996). These poor socioeconomic
variables provide a direct link to their poor health.

The rates of diseases like diabetes, tuberculosis, and
end-stage renal disease are all found more often among
Native Canadians (MacMillan et al., 1996). Diabetes is found
in 6% of Native Canadians 15 years and older-when compared
with 2% among non-Natives (McMillan et al.). Tuberculosis is
found in 161 per 100,000 Native Canadians and in only 16 per
100,000 non-Native Canadians (McMillan et al.). More as-
tonishing is that in Tanzania, a developing country in Af-
rica, only 50-100 per 100,000 have tuberculosis (York, 1990).
Mental health illnesses are also more prevalent. The suicide
rate among men aged 15-24 is seven times greater among
Natives than non-Natives (MacMillan et al.).

Urban Natives have the same poverty, health and
social issues as Natives who live on reserves, however it
is compounded by the stress of being in an urban environ-
ment. Shah (1988) states that the major self-identified prob-
lems of the urban Native are unemployment, limited educa-
tion, poor housing conditions, alcohol abuse, lack of cul-
tural awareness and discrimination. All of these factors con-
tribute to unhealthy environments and lifestyles which lead
quite rapidly to both physical and mental illnesses.

The majority of Canadians think of Natives as liv-
 ing on reservations far away from the cities. While this
was once the case, more and more Native Canadians are immi-
grating into the cities. Currently, 45% of Native Canadians
live in cities which is expected to become over 50% by the
year 2016 (Royal Commission on Aboriginal Peoples
(RCAP), 1996). As many Natives live in Winnipeg as in all
of the Northwest Territories (RCAP). Because urban Na-
tives are not on reservations, they receive less resources
than Natives who are. The federal government tries to pass
on their responsibilities outlined in the Indian Act to provin-
cial and municipal governments, and, as a result, urban Na-
tives are often missed. Resources such as funding for edu-
cation, access to housing, and drug benefits are often not
supplied by either government. This is due partly to logis-
tics and partly due to the belief that Natives "don't belong" in
cities; they "belong" on reservations. This attitude has
often made the plight of the urban Native much worse than
that of the Native who continues to live on the reservation
with family, support and a better sense of cultural aware-
ness.

Among urban Natives, the unemployment rate is
two and a half times greater among Natives than non-Na-
tives (Shah & Dubski, 1993). Only 4% have a university
education compared with 13% of the non-Native population
(Shah & Dubski). In 1996, The Royal Commission on Ab-
original Peoples (RCAP) found that 60% of Native house-
holds and 80-90% of households run by single women live
below the poverty line. Elderly and adolescent Natives are
especially at risk of illness in the cities for a number of rea-
sons. They have little education, resulting in lower socio-
economic status and poor housing and the elderly often live
alone, further isolating them from social activities and fam-
ily. Adolescents are also easily influenced and readily join
gangs, smoke and become addicted to drugs and alcohol to
feel a sense of belonging (Shah & Dubski).

Nursing Implications

What does all of this mean for nurses? Because nurses
care for urban Native Canadians, it is imperative that they
understand the history of Native issues and the grave
realities of their poor socioeconomic status and poor health.
Davidhizar and Giger (1998) have developed a Transcultural
Assessment Model which provides a framework that accu-
rately addresses many of the key components affecting the
health of the Native Canadian. They state that understand-
ing the patient as a culturally unique individual, while ensur-
ing that practice occurs within culturally sensitive environ-
ments will allow for culturally diverse nursing care (Davidhizar
& Giger).

Within culturally diverse nursing care, Davidhizar
and Giger (1998) have identified six elements which contribu-
to health and are essential to assess when taking care of
a client: communication, space, social organization, time, environmental control, and biological variations. Only the first five will be used for the following discussion as they are the most relevant to Native Canadians. It should be noted that when applying this framework, it is appropriate for a practical assessment only. It does not allow for both an assessment and an understanding of the broad historical context surrounding Native Canadians which contributes to their physical health status.

Communication

Communication encompasses all human interactions, both verbal and non-verbal. It is the way people interact and share information, feelings and emotions. It is via communication that we understand one another. Today, eleven major Native language families with 58 dialects have been identified (Davidhizar & Giger, 1998). It is important for the nurse to find out which language is spoken for translation purposes. In the urban setting, many Native patients will speak English but this should not be assumed. Nor should both written and verbal understanding of English be assumed. Therefore, a thorough assessment of verbal and written language is needed. Stories are often used to communicate by Natives and nurses should be attuned at listening and understanding messages that are conveyed this way (Davidhizar & Giger).

Understanding non-verbal communication is also essential. Traditionally, among Natives, long silences and gaps in conversation are used for reflection and face-to-face conflict rarely occurs (Davidhizar & Giger, 1998). Native Canadians, especially within dominant society, tend to be quiet and submissive. It is important for nurses to be aware of this and not to misinterpret silence for indifference. Because of the Native Canadian’s history, they are often times mistrustful of the health care system and nurses need to understand and accept this.

Space

Personal space refers to the space around the body which the person claims as his or her. Any violation of this space makes the person uncomfortable and the interaction strained. This phenomenon of space also refers to environmental space (Davidhizar & Giger, 1998). Before European contact, Natives led a nomadic lifestyle surrounded by wildlife and nature. Today’s Natives are no longer able to lead this lifestyle and many authors have stated that this has adversely affected their health (Shah, 1988; Spector, 1996; Newbold, 1996; Jackson & Word, 1990). Nurses need to understand this and provide nature and space to Natives when it is possible.

Social Organization

Social Organization refers to the total social context within which a person interacts (Davidhizar & Giger, 1998). This may include what the patient considers family, their role within the family, and religious values and beliefs. Many Natives, through the acculturation process have become Christians, however, with the residential schools many have strong negative feeling towards the church. Forcing them to assimilate through residential schools and the adoption that took place have changed the definition of family for Native Canadians. Nurses need to realize that the individual experiences of Native Canadians have been different and questions around these issues need to be addressed and understood to ensure effective care.

Social support involves individuals’ abilities to deal with health concerns together (Davidhizar & Giger, 1998). It implies families, friends and neighbours helping and supporting one another. Support from family and friends help people problem solve in times of adversity and allows them to maintain a sense of control over their lives. This is because, with help, one is more likely to achieve success. Among Native Canadians, the family is paramount to their survival. Traditionally, generations of families lived together in one home and the whole community shared resources, exchanged services, traded goods, and worked together on decisions for the community (Waldum et al., 1997). Elders in the community were also important and provided the youth with an oral history of their culture (York, 1990). The urban setting does not allow for this type of social organization to sustain itself, thereby leaving many urban Natives isolated, with a poor sense of culture. Combine this with constant interaction with non-Native society and cultural identity is lost even further. The RCAP (1996) state that sustaining a positive cultural identity is especially important for urban Natives because of their often troubled interactions with the dominant society.

Time

Even though the days pass and time goes on for all of us, our concepts of time vary from culture to culture. Natives tend to be a present-oriented culture which causes many difficulties when they come into contact with the future-oriented mainstream Canadian culture (Davidhizar & Giger, 1990). Traditionally, Natives live for the present. If an opportunity comes up to hunt, they will go instead of keeping a doctor’s appointment which affects their future. They feel that if they can put food on the table today, they should (Davidhizar & Giger). For this reason, appointments are often missed which creates frustration for both the health care professional and the patient. Nurses need to understand this and try to explain, if it is essential for the patient to make an appointment, why that is the case. Trying to frame it in present examples and reminders about the appointment may help. The transition for urban Native from present-orientation to future-orientation is a difficult one to make and health care providers need to understand and accommodate this.
Environmental Control

Environmental control refers to having control over the environment in which one lives (Davidhizar & Giger, 1998). To feel a sense of control, certain elements and resources must be in place. The community must have a sense of control over their surroundings and believe that what they want to adopt is worth adopting. Both financial and emotional resources should be in place to support the empowered behaviors initiated.

Unfortunately, as a result of systematic oppression, Native Canadians lost all of their control with colonization and have never regained it. Without a sense of control, it is natural for Natives to be passive about issues affecting them. This concept is called external locus of control and involves individuals who believe that actions and outcomes are uncontrollable, resulting in an unwillingness to influence behaviors (Barry, 1986). The opposite, internal locus of control, states that individuals who believe that a contingent relationship occurs between their actions and outcomes have feelings of control and therefore act to influence future behaviors (Barry). Significant recent strides towards regaining control over their health care has taken place with the Health Care Transfer Initiative. Nurses need to publicly support this initiative and others like it. Nurses should also work on the internal locus of control on an individual basis and support small accomplishments. Even though Natives may seem passive and indifferent, empowerment should be the goal at all times.

The other issue within self-care is the sense of worth. Natives have been made to feel worthless over the last few centuries and until recently, their way of life was not viewed as something that had worth. This feeling of worthlessness discourages activism and makes one feel that what they have to say is not important, so nothing is said. Nurses can play a big role in boosting self-worth. Some methods include positive reinforcement with patients and their families as well as showing a genuine interest in their culture.

Future Directions

The health of the urban Native Canadian is a complex, multi-layered problem which health care professionals need to work through and understand. The nursing profession needs to develop a model which incorporates a broader framework including all assessment parameters and an understanding of the historical context. This broad framework would not only benefit Native Canadians, but could be used for refugees, recent immigrants, and any patient who has been through a traumatic event. This would allow for a full comprehension of why poor health exists, as well as a practical assessment tool. For the urban Native Canadian, a direct link needs to be made between a loss of cultural identity with all of its consequences and their poor socioeconomic status. When this is done and fully understood, the health care professional can then work on the root of the problem instead of on its consequences which results in only temporary solutions.

Conclusion

To understand the health of Native Canadians today, the marginalization which both their ancestors and they have had to endure must be acknowledged and understood. Once this is understood, the pieces of the puzzle start to fall into place and the poor socioeconomic status of Native Canadians begins to make sense. When assessing and taking care of Native Canadians, it is the responsibility of the nurse to take all of these factors into account. Without this understanding, the care provided will be insensitive, improper and unsafe. Native Canadians are our founding peoples who deserve to be respected and to achieve equality in all aspects of their lives and nursing has the opportunity to help make this a reality.

Author

Natasha Prodan-Rhala, RN, MN/ACNP is an acute care nurse practitioner in Cardiology at Trillium Health Centre, Mississauga ON.

References


