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

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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 (Tookenay, 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 disenfranchised 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. Davidhizar and Giger's (1998) 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, Herring, & 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 it 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 Natives are those who fall under this definition and are registered with the Canadian government as being so. Non-status 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 (Shah & Dubeski, 1993). The Indian Act implies that everything that was once Native is now the property of the government and that Natives are now "allowed" to use it (Waldrum et al., 1997). The Indian Act was a formal way for the government to assimilate Natives into mainstream Canadian culture (Saloojee, 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 community and marked the beginning of strong political activism (Waldrum et al.). The Natives felt that although oppressive, 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 Natives 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 education of Natives (York). Within these schools, Native children 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 physical and sexual abuse also occurred within the residential schools. The children were often separated from their parents to make the assimilation "easier" on the religious leaders who ran the schools (York). As a result, generations of Natives lost their cultural identity, their self-confidence, their language and their families. This has had an enormous impact 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 children from their homes began (Waldrum et al., 1997). This allowed the government to continue to assimilate Natives 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 Native (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 generation" (York, 1990).

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, poverty, and finally both mental and physical illnesses. Subsequently, 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 Native 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 adjustment, 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 policies implemented by the dominant group and in withdrawal, the adapting group removes themselves from the situation (Barry).

Over the centuries, Native Canadians have experienced all three kinds of adaptation which has contributed greatly to their identity confusion. Initially, at first contact with the Europeans, Natives were able to continue with their traditional 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 reservations (Saloojee, 1998). Thus, the introduction of residential schools and mass Native adoptions into non-Native families became government policy. This started the period of assimilation (Saloojee, 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

Canadian Natives and has continued to this day (Waldrum et al., 1997). Currently, Natives are still struggling for positive adaptation mechanisms, however, their complicated history 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 problems 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 Canadians; 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, & Dingle, 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, 1990). By any socioeconomic standard, Natives are the poorest group within Canada (Postl, 1997). Only 10-20% of Natives finish high-school, while only 50% of Native housing has sewage or water connections (Saloojee, 1997). Some reservations report a 90-95% unemployment rate (Saloojee). Almost half of Native homes have no central heating, compared with only 5% in the non-Native population (MacMillan et al., 1996). These poor socioeconomic variables provides 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 compared with 2% among non-Natives (MacMillan et al.). Tuberculosis is found in 161 per 100,000 Native Canadians and in only 16 per 100,000 non-Native Canadians (MacMillan et al.). More astonishing is that in Tanzania, a developing country in Africa, only 50-100 per 100,000 have tuberculosis (York, 1990). Mental health illnesses are also more prevalent. The suicide rate among men aged 15-25 is seven times greater among Natives than non-Natives (MacMillan et al.).

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

The majority of Canadians think of Natives as living on reservations far away from the cities. While this was once the case, more and more Native Canadians are immigrating 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 Natives 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 provincial and municipal governments, and, as a result, urban Natives are often missed. Resources such as funding for education, access to housing, and drug benefits are often not supplied by either government. This is due partly to logistics 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 awareness.

Among urban Natives, the unemployment rate is two and a half times greater among Natives than non-Natives (Shah & Dubeski, 1993). Only 4% have a university education compared with 13% of the non-Native population (Shah & Dubeski). In 1996, The Royal Commission on Aboriginal Peoples (RCAP) found that 60% of Native households 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 reasons. They have little education, resulting in lower socioeconomic status and poor housing and the elderly often live alone, further isolating them from social activities and family. Adolescents are also easily influenced and readily join gangs, smoke and become addicted to drugs and alcohol to feel a sense of belonging (Shah & Dubeski).

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 accurately addresses many of the key components affecting the health of the Native Canadian. They state that understanding the patient as a culturally unique individual, while ensuring that practice occurs within culturally sensitive environments will allow for culturally diverse nursing care (Davidhizar & Giger).

Within culturally diverse nursing care, Davidhizar and Giger (1998) have identified six elements which contribute 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 so heavily to their poor 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 astute 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 hers. 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, 1998; Jackson, & Ward, 1999). 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 adoptions 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 (Waldrum 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 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, 1998). Traditionally, Natives live for the present. If an opportunity comes up to hunt, they will hunt instead of keep 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 behaviours initiated.

Unfortunately, as a result of systematic oppression, Native Canadians do not often have a sense of control. Natives lost all of their control with colonialization 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 uncorrelated, resulting in an unwillingness to influence behaviours (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 behaviours (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 both 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 in place and the poor socioeconomic status of Native Canadians begin 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.

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References

Atkinson, V. (1996). An overview of rights to health care for aboriginal Canadians. Unpublished manuscript.

Barry, J. (1986). Refugee mental health in resettlement countries. Kingston, ON: Hemisphere Press.

Cardinal, H. (1969). The Unjust Society. Edmonton, AB: Hurtig.

Davidhizar, R., & Giger, J. (1998). Canadian Transcultural Nursing. St. Louis, MO: Mosby.

Jackson, L., & Ward, J. (1999). Aboriginal health: Why is reconciliation necessary? Medical Journal of Australia, 170, 437-440.

MacMillan, H., MacMillan, A., Offord, D., & Dingle, J. (1996). Aboriginal health. Canadian Medical Association Journal, 155 (11), 1569-1578.

Newbold, K. (1998). Problems in search of solutions: Health and Canadian Aboriginals. Journal of Community Health, 23 (1), 59-73

Postl, B. (1997). It's time for action. Canadian Medical Association Journal, 157 (12), 1655-1656.

Reid, J., & Trompf, P. (Eds.). (1991). The Health of Aboriginal Australia. Sydney, Australia: Harcourt Brace Jovanovich.

Royal Commission on Aboriginal Peoples. (1996). Ministry of Indian Affairs and Northern Development.

Saloojee, A. (1998). Equity, Human Rights and Organizational Change. Toronto: Ryerson Press.

Shah, C. (1988). A National Overview of the Health of Native People Living in Canadian Cities. Paper presented at the Proceedings of the Ninth Symposium on the Prevention of Handicapping Conditions, Edmonton, AB.

Shah, C., & Dubeski, G. (1993). First nations peoples in urban settings: Health issues. In R. Masi, L. Mensah, & K. McLeod (Eds.). Health and cultures: exploring the relationships; policies, professional practice and education (pp. 47-62). Oakville, ON: Mosaic Press.

Spector, R. (1996). Cultural diversity in health and illness (4th ed.). Stamford, CT: Appleton & Lange.

Tookenay, V. (1996). Improving the health status of aboriginal people in Canada: New directions, new responsibilities. Canadian Medical Association Journal, 155 (11), 1581-1583.

Waldrum, J., Herring, A., & Young, T. (1997). Aboriginal Health in Canada. Toronto, ON: University of Toronto Press.

York, G. (1990). The dispossessed: Life and death in Native Canada. Toronto: Little Brown Canada.