

Perspectives

THE HEALING OF FIRST NATIONS: DOMINANCE OR HEALTH?

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Abstract

The historical development of health issues in the Aboriginal community and the implications for First Nations program delivery and health educators is explored from a First Nations perspective. The health education of First Nations people has historically occurred in a field of contradictions and competing interests. In the re-negotiation of the field it is incumbent on Aboriginal and non-Aboriginal health educators to understand the historical emergence of health issues in the context of relationships between colonial forces and Aboriginal people. The re-negotiation of these relationships to restore Aboriginal peoples to correct relationships with the land, each other, and the colonizer may be understood as part of the work of healing. The devolution of federal health programming to First Nations and provincial organizations provides opportunities for new approaches. As adult educators providing these services we must ask ourselves: Are we participating in dominance or health education?

Résumé

Cet article retrace, du point de vue des peuples des Premières Nations, l'évolution des soins de santé dans l'histoire autochtone, ainsi que sa portée sur la formation des intervenants et la nature des programmes actuels. Le contexte historique de l'éducation aux soins de santé est caractérisé par la confusion et l'affrontement d'intérêts divergents. Il est important pour les intervenants autochtones et non-autochtones de comprendre l'émergence de leur discipline dans le contexte de la négociation entre peuples aborigènes et forces colonisatrices. En renégociant cette relation, les peuples aborigènes pourront retrouver un équilibre avec la nature et avec leurs semblables, et reconnaître le rôle du colonisateur dans le processus de guérison. Le transfert des programmes fédéraux vers les administrations autochtones et provinciales permet d'entrevoir un changement favorable. Dans ce contexte, les éducateurs d'adultes doivent déterminer à quel principe ils se vouent: à l'éducation aux soins de santé, ou au maintien de la relation de domination?

In this article, the terms Aboriginal(s), First Nations, Native, and Indian will be used interchangeably to emphasize the multidimensionality of the group of people under discussion.

Canada is a country populated by many ethnic groups who know little about their country's original inhabitants: First Nations people. Part of what they know is that Native people and their communities have "health" problems that frequently make the six o'clock news and the front page of the daily newspaper. Regrettably,

the "common sense" with which such public displays are understood is based on assumptions which obscure the historical differences between the dominant Eurocentric and First Nations notions of, and the means to achieve, health or well being. Such unexamined assumptions are often the foundation on which adult programming for First Nations is constructed. Health education and promotion is a burgeoning industry in First Nations communities across Canada as a means to community development. The need for more and respectful participation with First Nations in their quest for health by professionals such as social service and health educators are recommended by the *Royal Commission on Aboriginal Peoples* (Government of Canada, 1996).

When European colonizers began living side by side with the Aboriginal inhabitants of what was to become Canada, the notions of each group about governance, education, physical and spiritual well being existed as two parallel and non-interacting streams of being. The Aboriginal people encoded this concept of living side by side in the seventeenth century in the "Wampum Belt" to commemorate the co-occupation of land by First Nations and Europeans with different ways of life (Scozzari, 1997). But colonial rule became increasingly centralized and as colonizers engulfed the Aboriginal people from east to west so were the cultural notions of First Nations also engulfed over a period of more than 300 years. Now, because of global consciousness about indigenous populations, fiscal restraint, the assertiveness of First Nations, and the devolution of responsibility for health care to First Nations, there is a cacophony of voices defining "health," "health care" and "health education" from within First Nations communities and for the First Nations communities of Canada. Nowhere is this cacophony louder than in the competing claims and contradictions of adult education delivery of health and social programming conducted by or directed toward First Nations. The central purpose of this paper is to present a First Nations perspective on the relationships between traditional concepts of health from the perspectives of First Nations, the creation of dependencies on European medical technology, contemporary turning points in the reclamation of health by First Nations and the implications of the journey to health. Obviously, adult educators are and will increasingly be critical participants in First Nations health and social programming. Understanding the issues from a First Nations perspective can provide a more complete view of social and historical reality in which to found a common discourse for adult educational practice.

As a member of the First Nations community, health program planner and adult educator, I offer my insights into the complexities of the field so that work in this area may be more respectful, progressive, democratic, and health-fulfilling rather than merely training for compliance.

First Nations Perspectives on Health: Balance and Harmony

From most First Nations perspectives, harmony is valued as the desired state of the universe. Balance between nature, others, self and the spirits is believed to promote health. Historically, much First Nations social and ritual activity was mediational, dedicated to the management of relationships between the spiritual and

material dimensions of life. Such mediational activities included shamanistic practices, Salishan winter dances, healing ceremonies, *hamatsa* (Cannibal dance), *Tlookwaana* (Wolf Ritual), sun dancing, and sweat lodge ceremonies (Jelik, 1982; Waldram, et. al., 1995). Harmony can best be understood as an actively mediated synchronicity between the moral, physical, social, psychological, spiritual, legal, and mythological dimensions of a person or group.

Many Native nations had rich traditional pharmacopoeia consisting of preparations made from herbs, plants, animals, and minerals from within the local territory or obtained in trade. While the "medicine chests" of Aboriginal peoples across Canada varied in scope and formalization, thousands of years of adaptation provided a knowledge base that covered the basic necessities. Couched in cultural belief systems of interconnectedness, food complexes provided adaptive healthful diets; herbal knowledge supplied help when something went amiss: analgesics, emetics, diuretics, vitamins; taboos permitted the mediation between the spiritual and material. Taboos help culturally minded Aboriginal people to remember that all material things have spiritual origin. Taboos, like prescriptive norms in other cultures, keep social and object relationships vital through observance and acknowledgment. Consequently, some First Nations people today still distinguish European from indigenous diseases. European medicine is required for post contact diseases. For familiar, pre-contact conditions, traditional medicines are preferred (Waldram, et. al., 1995).

Contemporary First Nations perspectives on health still involve spiritual and material dimensions (Keitlah, 1995). An academic, anthropological perspective on health (Good, 1994; Hahn, 1995) recognizes the culturally embedded nature of both sickness and cure in a manner that concurs with the perspectives of First Nations. However, the position of most non-First Nations organizations and individuals reflects the dominant, mainstream materialist thinking of Eurocentric medical and social science. The biomedical position is itself a coherent cultural system that organizes the vast complex of the health care system (Good, 1994; Hahn, 1995). The material perspective of medical science and the spiritual perspective of health of First Nations have historically hindered a coherent discourse on health, healing or harmony. The disparity between the assumptions of the cultures of First Nations and the culture of the medical establishment amplify the cacophony.

Most First Nations still desire "harmony" despite their abysmal historical, cultural, and epidemiological health record in the Canadian state (Waldram, Herring & Young, 1995). This record is writ large by the lowest socioeconomic indicators of health and born of the burden of the historical construction of First Nations by Canadian society. An historical construction which relegated Aboriginal populations to reserves organized by Eurocentric social standards and values. A Eurocentric value system which became a wedge to separate the Aboriginal body from the cultures that had perpetuated it for millennia. An historical construction that denied biological, social and linguistic adaptations of the Aboriginal population evolved in a richly diverse geography over 11 to 60 millennia (Waldram, et. al., 1995). A construction that denied the complexity and diversity of the First Nations of Canada.

Denied was the flexible social organization of the northern hunters (e.g., Cree) who ranged over large territories in small groups, maintaining tribal identities through bilateral kinship systems with annual gatherings of the tribal groups (i.e., stagings such as summer Sun Dances, powwows). Denied were the rich matrilineal societies of the eastern horticulturalists (e.g., Six Nations Confederacy tribes) who occupied tracts of arable land and whose political organization provided democratic models for emerging nation states. Denied were the diverse economic strategies of the west coast fishers and sea mammal hunters (e.g., Nuu-chah-nulth) lived on open ocean sites in summer and in sheltered harbors in winter organized through potlatches rich through patrilineal, matrilineal, and bilineal kinship systems. Denied was the complex and delicate balance of the social economies of the northern whalers and sea mammal hunters who thrived by differentiating the "white" of snow conditions. Colonial administrations denied Native people diverse and flexible social organizations based on complex spiritualities that were key to material survival and well being.

European Arrival: Contradictions and Conflicting Interests

First Nations people were not always dependent on Europeans for health care or definitions of well being. As early as the 1600's, Aboriginals viewed missionaries as sorcerers when mass infant baptisms resulted in epidemics in which most infants died. Missionaries used their medical expertise to persuade Natives of the superiority of their belief system, to challenge native healers to healing duels (Waldram, et. al., 1995), Christianizing the people, and as a tool to lure children into residential schools (Miller, 1996). Fur traders and whalers maintained the loyal participation of Natives as economic allies with Europeans, using the powerful bargaining tools of medical technology, pharmacology and surgery (Waldram, et. al., 1995). The Hudson Bay Company looked after the medical interests of its Aboriginal trappers as late as the 1930s by consulting with the medical establishment and providing vitamins, antiseptic, and milk powder (Waldram, et. al., 1995). In the face of epidemics that Europeans brought with them to Canada, European interests such as trade, fur trapping, whaling, missionizing, and settling were facilitated by the "medicine chest" used as the bargaining tool. European encroachment on traditional territories became encroachment into that space between the bodies of First Nations people and the territories which they historically, linguistically and spiritually embodied. The encroachment colonized the well being of First Nations. Aboriginal health care dependencies were the cost that First Nations paid in order to achieve European interests.

The British parliament transferred responsibility for Indians to the new federal government with the British North America Act in 1867 (Waldram, et. al., 1995). Leaders of Indian nations saw the need for the "medicine chest clause" in the treaties as insurance against European plagues. Indian leaders believed that they had successfully negotiated health care equivalent to that available to colonists. Today's leaders believe this care to be in compensation for the use of the land by colonizers as part of the treaty rights which the government signed. The government and the courts meanwhile maintain that the right to comprehensive medical ser-

vices does not exist as a treaty right. Government interests of the day had not been sensitized to genocide by plague as the Indian leaders had. Government documents carry the weight in official history and in the courts. Documentation of negotiations of Treaties 1 to 11 tell a story of Native leaders persistently arguing for availability of medical treatment and food for the survival needs of their people into the future. The federal government had given such assurances with the caveat that interpretation of the terms of such provision would be at the discretion of the government agent (Waldram, et. al., 1995).

The federal government is responsible for the public health of First Nations people under the Indian Act (Shawana, et. al, 1995). Colonial administrators interpreted this law from their own perspectives according to the prevailing public mood. Although Native people resisted individually and occasionally in more organized ways, the administrators had powerful legislative control over the social and economic conditions of the lives of "their" Indians from cradle to grave. Time and again these administrators have been shown to have acted in ethnocentric ignorance in which they misunderstood the pleas of Native leaders, depriving Indians of the basic necessities of health (Miller, 1996; Shawana, et. al, 1995).

The Subjugation of Aboriginal Health

The colonization of Aboriginals in Canada was promoted through a centralized administrative structure based on laws developed and promoted through structural and policy initiatives. These included state-supported assaults on First Nations spirituality, culture, social organization, governance and economic activity. Missionization encouraged an abstraction and formal institutionalization of spirituality via Christianization. Historical, social and political organizations of First Nations societies and governments were suppressed, for example, through anti-potlatch laws. Mandatory school attendance interfered with political production and reproduction through marriage systems and winter feasting. Legislatively defined and bureaucratically controlled reservation systems with token local governments curtailed traditional territorial occupation and use. Legislatively defined membership categorically based on non-Native values confused issues of social membership. Schooling was externally controlled through the mechanism of residential schools, in which the state and church attempted to capture and remake both the formal and informal social life of children (Adams, 1995; Duran & Duran, 1995; Miller, 1996). Such initiatives were promoted by the Canadian colonial government in the gap between the socio-economic aspirations of colonizers and survival of Canadian indigenous societies.

These initiatives served to subjugate First Nations by systematically alienating individuals from their history, politics, territory, family, traditions, material culture and spiritual roots. The powerful nature of the state level management of the lives of First Nations people through traders and missionary organizations served to legitimize the aspirations of the colonizers while simultaneously subjecting Aboriginal people through the Indian Act by generalizing and categorizing Ahousaht, Anishinaabi, Dene, Tseshah, Heilsuk, as "Indians." The colonial state

thus worked through its social, religious and economic institutions to legitimate and manage the systematic alienation of the colonized. Anomic depression, a psycho-somatic state wherein an individual is distanced from survival systems of the body manifesting itself in alcoholism and suicide, was identified by Jelik (1982) as a typical outcome of such systematic alienation among the Salish of Vancouver Island.

The health of the colonized is directly linked to the deprivation caused by colonization (Memmi, 1965) as discussed above. The material evidence of pre-contact population and health status is fragmentary and highly inferential. Nevertheless, Waldram, Herring & Young (1995) construct images of pre-contact disease profiles throughout the regions of Canada on the scantiest of evidence (i.e. supported by one or two studies). They suggest the "disease free claim" of First Nations people is not supportable. However, when comparing the pre-contact level of some fungal, bacterial, and parasitic infections relative to the genocidal post-contact pressures of infectious diseases and socio-cultural oppression, their argument is less compelling. The immune systems of indigenous populations had developed no resistance to the European diseases. The advent of the European in North America was a public health disaster for First Nations (Waldram, et. al., 1995).

Contemporary Perspectives

The specter of annihilation is still fresh in the minds of First Nations that reckon their history in the span of generations rather than years. What Euro-Canadians see as the heroic and honorable settling of a land and building of a nation, First Nations see as encroachment and colonization as treaties were broken and promises forgotten. Early on, the chiefs and their spokesmen petitioned the highest authorities to counteract the neglect in the field. Where the colonial government failed, history intervened in the form of international de-colonization which demands the issues of First Nations be revisited. It is in this revisiting we, as Canadians, find the need to work on mutual de-colonization as peoples who share a nation state. The colonizer and the colonized together in co-operation can negotiate a new relationship (Memmi, 1969). The work of the healing of First Nations occurs through the re-negotiation of colonized social, political, economic, physical, and spiritual territories, simultaneously at the individual and community levels. This work of healing occurs in the context of policy through the devolution of health services from the federal government and the evolution of health services in the First Nations communities across Canada.

Negotiations for De-colonization

Since the eighteenth century, First Nations delegations have attempted to articulate their needs and treaty rights by appealing to the Queen of England, the League of Nations, the United Nations, the federal and provincial legislatures without success (McFarlane, 1993). In response to pressure by Native leaders and international social movements to "choose a new path," the Liberal government of Pierre Trudeau commissioned the "White Paper" (Government of Canada, 1969) through Jean Chrétien, the Minister of Indian Affairs. The "White Paper" proposed the colo-

nial slate be wiped clean. First Nations people would become "ordinary" citizens of Canada. With hurried and superficial consultation, the "White Paper" was to herald a "post-colonial era" in Canada with the stroke of a pen. Meanwhile, across the border, Americans were ushering in their "post-colonial era" by pursuing a "termination policy" against their Indian populations by buying reservation lands. The logic seemed to be, if the institutions of colonial oppression such as residential schools, reservations, medical services for Indians, and the Indian Act were legislatively removed de-colonization would be a *fait accompli*. The American example provided Canadian legislators with a model and a hope for an expedient solution.

Canadian First Nations leadership saw the developments across the border and took a stand in the face of termination. The federal government could not legislate away the social and economic gap in development that Canadian Indians experienced. Young Canadian First Nations people found a voice in the popular movements of the 1960s as part of the international de-colonization movement. The solutions would not be quick nor easy. Harold Cardinal and George Manuel traveled internationally and across Canada to bring back ideas about new relationships (McFarlane, 1993). The Jay Treaty (1795), recognizing the lack of national boundaries for Aboriginals, permitted Canadian Indians to live, work, be educated, and politicized in the United States. Some of the American de-colonizing influences were the "Peace Movement" manifested in anti-racist, anti-Vietnam War, and anti-nuclear weapons and the "Civil Rights Movement" proclaiming equality for all. International telecommunications created a "global village" which permitted American Indian leadership to warn Canadian First Nations of the genocidal bureaucratic agenda of the American termination process. Buffy St. Marie, a Native activist, popularized the issues of the day with her songs. "Now that the Buffalo is Gone" (Saint-Marie, 1965) lamented the genocidal pressures on the Native community. The "Universal Soldier" (Saint-Marie, 1965) lamented genocide over all time in response to the American war in Vietnam. It was time for First Nations to take a stand in Canada.

The Indian Association of Alberta and the National Indian Brotherhood of Canada responded to the Liberal agenda of Trudeau with the "Red Paper" (National Indian Brotherhood, 1969). The "Red Paper" claimed the right of Aboriginals of Canada to be recognized as First Nations people, a unique people with unique aspirations in a modern world. For Canadian and American Indians, the catch was that their internal colonization was in countries that perpetrated the myth of "justice and freedom for all." There had been no colonial uprising in Canada, only the Front de Liberation du Quebec (FLQ) crisis. Canada was a colonial nation in a "post colonial era" being pressured to dismantle the internal colonization of First Nations and Québécois. For Canada, the dialectic between the "White Paper" and "Red Paper" had crystallized the international movement of modernization ideology and de-colonization. This was the opening act by Canada and her First Nations on the world stage.

The discourse between Canadian First Nations and non-First Nations about the healing of First Nations individuals and communities is a confusing cacophony.

Beneath the surface of the discourse are dynamics between Aboriginal and state organizations such as at the Royal Commission on Aboriginal Peoples' National Round Table on Health and Social Issues. Lynes (1995) discerned a stalemate between legitimate governmental administrative priorities and the cultural commitments of First Nations. In this stalemate, "talk" occurs without discernible progress or solutions. Goodwill seems to evaporate in the gap between the concept of holistic health and machinations of bureaucracy. This evaporation of goodwill seems to be associated with the paradox created by the proposal of First Nations to administer health care through First Nations cultural vehicles. In the short run, public administrative demands for reporting will undermine First Nations efforts to manage health care culturally with the use, for example of traditional healers, herbalists, home health care and home birthing. Traditional medical and health care knowledge and practices are under documented and thus still suspect in the eyes of a non-Native public. Lynes (1995) maintains that public tolerance that could become political seems not to favor First Nations people finding solutions in their own cultures (Lynes, 1995).

The Work of Healing

The work of healing began in the early 1970s between a dominant federal government and resistant First Nations. Although the social and economic determinants of Aboriginal health were known to the government at this time, there was little progress in the talks between officials and urban natives who were neediest because they were outside the boundaries of the "protection" of the Indian Act. Ryan (1978) documents four years of protracted wrangling when funding was approved by the Department of Indian Affairs and Northern Development but never expended, when policy changes were approved but never implemented. This withholding of the necessities for survival and health culminated in the ritual suicide of Nelson Small Legs Jr., even as the Berger Commission held hearings in Calgary looking for solutions to Native problems.

Ryan (1978) recounts the persecution of Nelson Small Legs Jr. by the Canadian authorities for his role in attempting to secure health and social services for the thousands of Native Canadians who had migrated to urban Alberta centers. Ryan was one of a group of University of Alberta academics who participated with urban organizers to develop support services through the Calgary Urban Treaty Indian Alliance (CUTIA). The regulative regime of the federal Department of Indian Affairs (DIAND), the government of Alberta, the RCMP, the regional DIAND and the municipal government stonewalled the efforts of a small band of activists to secure the basic necessities of life for urban Natives: there was no goodwill nor political will.

The activists sought change through the bureaucracy. Harold Cardinal, who had been instrumental in the "Red Paper" response, could not overcome the resistance of the bureaucracy. Nelson Small Legs Jr. protested in the only way he felt he would be heard, after years of sit-ins, conferences, talks with government officials, orga-

nizing with the American Indian Movement (AIM)—he shot himself. His suicide note to the press said:

I give up my life in protest to the present conditions concerning Indian people... I also give my life in hopes of a full-scale investigation into the dept. of Indian Affairs corruption...and divide and conquer tactics present on each reservation...For 100 years Indian people have suffered. Must they suffer another 100 years? My suicide should open the eyes of non-Indians into how much we've suffered (Ryan, 1978, p.85).

Ryan (1978) expressed the hope that she will not be there when the grief and pain turns inward into self destruction or outward into anger or revenge for "Indians have nothing to lose except their lives. Nelson's problem was that he knew it sooner than the rest of us" (p.86).

Clearly, First Nations needed a discourse on health, social, and economic issues beyond sit-ins, standoffs, and ritual suicide. The discourse became more complex as First Nations people voiced their needs and demanded their rights. A legal argument was an appropriate opening gambit because the federal government is responsible for the public health of First Nations people (Shawana, et. al.,1995). The standoff with CUTIA was an example of the first stumbling steps in the very public re-negotiating of a historical relationship. The first steps were grounded in the articulation of needs by Aboriginals outside the strict interpretation of the jurisdiction of the Indian Act. These voices were supported by Native and non-Native academics in a search for justice and healing. The Department of Indian and Northern Affairs was moved from the inside by First Nations people who could hear the needs of their brothers in the streets. The media focused on the potential for violence and the illegitimacy of the claims. Nelson Small Legs Jr. possibly provided the only symbol that could cut through the rhetoric to claim that space between the spirit in which the treaties were signed by Native leaders and the letter of the law by which non-Natives administered them.

Devolution of Federal Health Services

Despite political stonewalling in the early 1970's, recent federal governments, motivated by economic restraint, have found the political will to devolve health care education and services to First Nations communities . As part of the policy to promote self government, the devolution of health care service delivery is occurring almost as fast as contracts can be signed. Health Canada funds such devolution from the national treasury and therefore maintains the right to set standards while shifting control (i.e., form of service delivery) to communities through contribution agreements negotiated to meet the needs, aspirations, and capacities of local communities (Health Canada, 1997). However, devolution of service delivery comes complete with standards and criteria developed in the existing system that will be difficult to meet in a decentralized system (Lynes, 1995).

The comprehensive strategy to move federal responsibility for the delivery of health services to the local community includes some of the following initiatives:

medical service levels including nursing in health centers, expanded community role of the nurse, responsibility for public health, staffing and administration of out-post hospitals to be maintained. Capacities to maintain and promote health are to be developed in rural and urban Aboriginal populations through programs such as *Community Action Pack*, the work of community health representatives, prenatal nutrition programs, and child care initiatives. Research about pressing Aboriginal health issues such as diabetes, drug and alcohol, gambling, cervical cancer, etc. is promoted through partnerships between academic institutions and local communities so there can be mutual learning. Such projects promote the participation by First Nations individuals in health careers. The strategy further promotes environmental health initiatives through grants to organizations and funds the development of health information systems to permit interfaces between First Nations communities and other governmental agencies. This process has been entrusted to ameliorate some of the pitfalls such as compromised standards and criteria that arise when informal social networks take over the responsibility of governance (Lynes, 1995).

Consequently, the greatest challenge for First Nations and tribal councils is the development of capacities to accommodate the change and yet to retain the value of First Nations people, traditions, and culture. First Nations people living off-reserve are considered wholly the responsibility of the province, but they also want services consistent with their values, culture and traditions. In British Columbia, the Aboriginal Health Council (AHC), was formed to meet some of these programming challenges through participatory action. The AHC focus on off reserve populations is facilitated through friendship centers and non-profit organizations, and through the development of capacity for health service delivery in First Nations communities. Partnerships and networking with community and governmental organizations are promoted at every level of health care to encourage capacity building through linkages.

Issues of health and healing are integrally related to human rights, racism (Fiddler, 1989), justice (Harrison, et. al., 1997) and land (Atleo, 1990). The treaty table in British Columbia has become the place to negotiate the first contract between the governments of Canada, British Columbia and First Nations.

In British Columbia, three levels of government are negotiating treaties of which health programming and capacity development are integral (B.C. Treaty Commission, 1997). First Nations are using existing treaties to negotiate a modern interpretation. First Nations are attempting to ensure that the federal government does not also off-load its fiduciary responsibility (Shawana, et. al, 1995). These issues are contentious, protracted, and ongoing. The policy of negotiation demands a complementary process of education for both Natives and non-Natives for which the B. C. Treaty Commission has a mandate.

Evolving Health Services in First Nations Communities

The "Red Paper" (1969) served to establish a perceptual link between First Nations and federal government organizations. Government dependents under the

Indian Act were talking back (McFarlane, 1993). First Nations began to demand programming which brought the best of traditional practices into the present to provide continuities with the past. Programming which reflects First Nations social, technological, and economic visions has become a goal for the devolution of the Medical Services Branch, transfers of health funding and service delivery.

Program development from First Nations perspectives is a first order of healing. The mental, physical, spiritual, moral, and social health of First Nations people can be promoted in an inclusive society that values diversity and multiculturalism. Professionals such as adult educators in every field can be instrumental in promoting an inclusive society.

Up to the present, human service professionals have promoted the social goals and rewards of the dominant culture without understanding the cost to the...identity (and health) of families (and individuals) who would espouse such cultural goals or be assessed by such cultural biases (Atleo, 1988:22).

Using the culture of the dominant society as a means to broker health services is no longer viable. Working with First Nations communities demands a perspective that recognizes the social and spiritual dimensions of First Nations people. To participate with First Nations communities in maintaining value coherence through a program of diversity of value expression requires health educators to be aware of the role of competing socio-cultural perspectives.

The work of healing takes place in treatment centers and community programs where the effects of colonization are exposed and deconstructed. Publicized tragedies such as Davis Inlet can only be understood from a justice perspective in which poverty and social disorganization are remedied so that healing can begin (Harrison, et. al., 1995). Counseling programs are proposed to train First Nations professionals to assist in this monumental task (Peavy, 1993) to counteract colonization that is often expressed as racism by the colonizer and self abuse by the colonized.

The psycho-social effects of racism (relative deprivation, socio-cultural disintegration, anomic depression and alcohol and drug abuse) have taken their toll on the health of First Nations people (Fiddler, 1989). Yet, First Nations survivors are motivated to fight back, often drawing from the strength and method of tradition. Youth develop their own framework to combat suicide that fells more than 5,000 of their peers annually (Nishawbe-Aski, 1996). Aboriginal professionals lend voice to First Nations people by asking them what they need to heal (Ing, 1991; McCormick, 1994). First Nations people identify what they need to promote their empowerment, cleansing, balance, discipline and belonging. First Nations develop their own social service and health program curriculum. The control of health care and education needs to follow the vision of the "Red Paper" to assure the vertical integration of First Nations values and philosophy.

Implications for Adult Educational Practice

There are many challenges in the First Nations healing process. Treatment programs for sexual abuse or residential school trauma may on one hand deal with psycho-emotional trauma that blocks social development and on the other hand create dependencies on expensive facilitators (Atleo, 1995). Health Canada consultation suggests that First Nations communities prefer self-help, self-maintenance alternatives. Individuals and families that use treatment facilities have a high rate of recidivism because the programs provide experiences but do not pass on the conceptual framework and assumptions that can provide self maintenance from the perspective of the trainer/facilitator (Atleo, 1995). For First Nations people, the issue of control centers on the use of their own cultural frameworks. Within these cultural frameworks, conceptual tools for self-management and self-maintenance can provide a socially integrative model of healing for balance and self-transcendence in which they can be agents of their own healing (McCormick, 1994).

Social issues can become confusing and difficult when powerful non-Native perspectives enter First Nations communities. For example, the residential school legacy has been difficult to deal with for First Nations Christians (Stellingwerff, 1997; Strom, 1997; St. Norbert Foundation, 1997; Thorpe, 1997). First Nations individuals may have been harmed by the residential school experience and yet espouse Christianity. From a First Nations perspective, public education that demands Aboriginals comply with non-Native social timing and behavior to fulfill non-Native ideological goals may be seen to be just as oppressive as residential schooling (Ing, 1995; Nuu-chah-nulth Tribal Council, 1995). It should not be surprising that First Nations individuals and communities may process social issues in ways that are counter-intuitive to non-Natives. It is a demonstration of a different frame of reference that needs to be acknowledged and understood.

First Nations individuals who train as professionals in programs with non-Native frames of reference, upon returning to the community, are likely to approach issues from a Western orientation that distorts the cultural fabric and traditional sensibilities. Such individuals may initially cause more harm than good. For example, approaches to family violence may provide opportunities for victim shaming/blaming (see Adams, 1996; Ha-shilth-sa, 1995) or to work out personal problems. Usually in a matter of months the community reclaims its member and there is a productive partnership with the professional. Some organizations may use the needs of the First Nations community to promote their own agendas. For example, the Four Worlds Development Corporation promotes indigenous development on a global scale (Lane, 1995) creating a pan-indigenous perspective that diminishes the diversity and complexity of Aboriginal community development needs. Programming approaches to family violence from an individualistic western orientation can rend the fabric of extended families leaving gaps in the social safety net that limited health care budgets cannot fill. Most of these services are delivered as adult educational programs. These examples provide some indication why it becomes critical for health educators/facilitators working with First Nations issues to understand clearly where they stand, when, why and how.

Community health educators become caught between two groups with completely different health traditions (i.e., Euro-Canadian and First Nations). The confusion and alienation this can create is considerable. The contexts in which issues are patterned may vary tremendously from one community to another. Communities may be highly resistant to the social and political agendas of the larger society. In this complex cross cultural field it is vital for practitioners to use sound theory and practice in which they can be sensitive to the issues of the internal colonization of their clients (Clarke, in press).

I have attempted to highlight the complexities of health programming that is mainly delivered to First Nations through adult education. In my overview I have attempted to provide more of a First Nations perspective to balance other public perspectives (e.g., Lynes, 1995). Traditional perspectives of health in the First Nations communities come from different traditions than that of the majority society. These different traditions deserve to be valued and respected in health programming planning because they provide the cultural logic for health practices. Research is required to demonstrate to the non-Native public and professionals the values, beliefs, and practices that can form the foundation of more valid and motivational health programming in First Nations communities. Understanding the contexts which create dependencies on Western medical technology is critical to health promotion that aids First Nations in reclaiming their own historical practices.

The treaty process can lead us into a place where meaning and power can be shared to where the relationships between First Nations and the people of Canada and British Columbia can be healed. Validating the perspectives of individuals with different bio-social histories as equals requires critical, reflexive, self conscious adult educators who understand their own position, biases, and distortions so that such dimensions of "self" do not further subjugate First Nations people. First Nations healing may provide an entry point into a democratic movement that values diversity. Such a movement may be a counterpoint to the postmodern discourse that fails to find value or the social motivation which valuing promotes.

Such a utopian vision, one that values diversity and democracy between Canadians, Aboriginal and non-Aboriginal, is held in the background as the inevitable work of the foreground continues to forge a common vision of "health" for First Nations communities. Nested within a common vision of health are the pragmatics of a healing process which requires a critical consciousness that is the stock in trade of adult educators. Critical consciousness has been the background for cooperation and negotiation in the modern treaty process. This consciousness permits the negotiators for First Nations to translate the social institutional sensibilities, structures, practices and principles into a Euro-Canadian discourse and then a legal discourse. Most First Nations negotiators are unschooled in the philosophical implications of such a process. There have been some attempts to "educate" government negotiators into the discourse of First Nations but ultimately the meaning making discourse is Euro-Canadian. The colonization of First Nations was, to the greatest extent, an attempt to normalize First Nations peoples into the image of the

European. The modern treaty process is a social movement through which First Nations people can negotiate their way into Canadian society. Adult educators can facilitate respectful activities in this arena.

References

- Adams, D. W. (1995). *Education for extinction: American Indians and the boarding school experience, 1875-1928*. Lawrence, KS: University of Kansas Press.
- Adams, J. (Ed.) (1996). *Family values project: Final report*. Port Alberni, BC: Nuu-chah-nulth Tribal Council & Nuu-chah-nulth Human Community Services.
- Atleo, M. R. (1995). *Report on workshop by Jane Middleton-Moz, Ph. D.: Effects of residential school trauma on individual, family and community for the Chief and Council of the Ahousaht First Nation, Nuu-chah-nulth Tribal Council, & Ahousaht Community and Human Service Workers*. Unpublished manuscript, Ahousaht Holistic Society, Ahousaht, BC.
- Atleo, M. R. (1990). *Unofficial minutes from the Ahousaht First Nation Membership Assembly on Justice: January, 1990*. Unpublished manuscript. Nanaimo, BC.
- Atleo, M. R. (1988). Studying Canadian indigenous families: A special case of ethnicity in a multicultural nation. In J. M. Hilton (Ed.), *Papers of the western region home management and family economics educators*, 5, Pp. 35-43. Reno, NV: Department of Human Resources and Family Studies, University of Nevada.
- Clarke, H. F. (in press). *Research in nursing and cultural diversity: Working with First Nations people*. Canadian Journal of Nursing Research.
- Duran, E. & Duran, B. (1995). *Native American post colonial psychology*. New York: State University of New York Press.
- Government of Canada (1996). *Final report of the royal commission on aboriginal peoples*. Ottawa, ON: Queen's Printer. Available <http://www.indigenous.bc.ca/rcap/rcap.html>.
- Government of Canada (1969). *Statement of the Government of Canada on Indian policy, a.k.a., "White Paper"*. Presented by the Minister of Indian Affairs and Northern Development. Ottawa, ON: Queen's Printer.
- Good, B. J. (1994). *Medicine, rationality, and experience: An anthropological perspective*. New York: Cambridge University Press.
- Hahn, R. A. (1996). *Sickness and healing: An anthropological perspective*. New Haven, CT: Yale University Press.
- Harrison, A., Meric, M., & Dixon, A. (1995). *Justice and healing in Sheshatshit and Davis Inlet: A report by Peace Brigades International*. Available: <http://www.igc.apc.org/pbi/nap95-02.html>.
- Ha-Shilth-Sa (1996). *Nuu-chah-nulth Family Values Project Update*. December 18, p. 18., Port Alberni, BC.
- Health Canada (1997). *Pathways to First Nations Control: Transfer programs, self-government, integrated community-based*. Available: <http://www.hwc.ca/datamsb/dataont/public-html/msb/ont/msbprogs>, February 18, 1997.
- Ing, N. R. (1991). The effects of residential schools on Native child-rearing practices. *Canadian Journal of Native Education*, 18 (Supplement), 65-118.
- Jay, J. (1895). *Jay treaty: Treaty of amity, commerce and navigation between His Britannic Majesty and the United States of America*. Philadelphia, Penn: Neale and Kammerer Publishers. Available: <http://earlyamerica.com/earlyamerica/milestones/jaytreaty/index.html>.
- Keitlah, W. (Ed.) (1995). *The sayings of our first people: Wawaac'akuk yaqwii?itq quu?as*. Penticton, BC: Theytus Books.
- Lane, Jr., P. (1995). *Four worlds institute for human and community development*. Available: <http://www.nucleus.com/4worlds>. April 3, 1997.

- Lynes, D. A. (1995). Cultural spirit and the ethic of bureaucracy: The paradox of cultural administration. *The Canadian Journal of Native Studies*, XV (1), 75-88.
- McCormick, R. M. (1994). *The facilitation of healing for the First Nations people of British Columbia*. Unpublished doctoral dissertation, University of British Columbia, Vancouver, BC.
- McFarlane, P. (1993). *Brotherhood to nationhood: George Manuel and the making of the modern Indian movement*. Toronto, ON: Between the Lines.
- Memmi, A. (1965). *The colonizer and the colonized*. Boston, MA: Beacon Press.
- Miller, J. R. (1996). *Shingwaulk's vision: A history of Native residential schools*. Toronto, ON: University of Toronto Press.
- National Indian Brotherhood (1969). Policy paper. a.k.a., *Red paper*. Presented to the Minister of Indian Affairs and Northern Development. Ottawa, ON: Queen's Printer.
- Nishawbe-Aski Nation Youth Forum on Suicide (1996). *Denial, healing and hope*. Available: <http://www.olin.com/bus/b3/denial.htm>, February 19, 1997.
- Nuu-chah-nulth Tribal Council (1996). *Indian residential schools: The Nuu-chah-nulth experience*. Port Alberni, BC: NTC.
- Peavy, R. (1993). Development of *Aboriginal*-counseling: Brief to Royal Commission on *Aboriginal Peoples*, Thursday, June 3, 1993, Vancouver, B.C., Available: <http://www.est.gov.bc.ca/ated/subroyal/com.htm>, February 19, 1997.
- Ryan, J. (1978). *Wall of words: The betrayal of the urban Indian*. Toronto, ON: Peter Martin Associates.
- Saint-Marie, B. (1965). Now that the buffalo's gone. On *Up where we belong*. [Cassette]. Missassauga, ON: EMI. (1996)
- Saint-Marie, B. (1964). Universal soldier. On *Up where we belong*. [Cassette]. Missassauga, ON: EMI. (1996)
- Scozzari, L. (1997). *The significance of wampum to seventeenth century Native Americans*. <http://neal.ctstateu.edu/history/world-history/>, April 2, 1997.
- Shawana, P., Nose, R., & Taylor, R. (1988). Indian health care: Sociological perspectives in law. *Canadian Journal of Native Education*, 15 (3), 39-65.
- St. Norbert Foundation (1997). *Current activities: The Selkirk healing center*. <http://www.native.org>, February 19, 1997.
- Stellingwerff, J. (1997). *Program listings of the Edmonton Native Healing Centre, one of the native ministries of the Christian Reformed Church*. <http://www.kingsu.ab.ca/%7Ejake/abednat.htm>, February 19, 1997.
- Strom, K. M. (1997). *Native American health resources on the Internet*. <http://www.nucleus.com/4worlds>, February 18, 1997.
- Thorpe, B. (1996). *Letter to: Pastoral charges and special ministries in B.C. Conference, Presbytery Chairs and Secretaries*. United Church of Canada: B.C. Conference. <http://infratec.com/unitedchurch.bc/brian.htm>, February 6, 1996.
- Waldram, J. B., Herring, D. A. & Young, T. K. (1995). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives*. Toronto, ON: University of Toronto Press.