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A Guide for Health Professionals Working with Aboriginal Peoples: Cross Cultural Understanding

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SUPPORTING ORGANIZATIONS

Assembly of First Nations

Canadian Institute of Child Health

Canadian Paediatric Society

College of Family Physicians of Canada

Congress of Aboriginal Peoples

Federation of Medical Women of Canada

Inuit Tapirisat of Canada

Metis National Council

National Indian and Inuit Community Health Representatives Organization

Pauktuutit Inuit Women's Organization

“I believe you understand what you think I said, but I’m not sure you realize that what you heard is not what I meant ...”

– anonymous, from blackboard in Weagamow Lake
Band Office¹

“Cross-cultural communication can be seen as a solution to providing quality health care as opposed to a ‘problem.’”²

RECOMMENDATION C1

Relationships between Aboriginal peoples and their care providers should be based on a foundation of mutual respect

Respect is the cornerstone of many Aboriginal philosophies. It is part of a code of ethics that some Aboriginal writers feel represents the “most important ... teachings that are universal to all tribes.” It is one of the “Seven Grandfather Teachings” referred to by Algonquin peoples and is a “core value” of Inuit culture.³ It can be defined as “to feel or show honour or esteem for someone or something; to consider the well-being of, or to treat someone or something with deference or courtesy.”⁴ Among the Inuit, the ethic of respect may include “respect for the land, for our elders, for each other.”³

Indeed, respect is a universal principle, likely found in all human groups. Clearly, racist and prejudiced attitudes are universally disrespectful. Most health professionals would readily acknowledge that mutual respect is key to the clinical encounter. Many are working hard to challenge the stereotypical images of Aboriginal peoples which unfortunately still appear in movies, new age literature, sports team logos, and our children’s history texts. In addition to challenging attitudinal and structural racism, however, it is important to recognize that although respect is a universal concept, some of the behaviours which generate or manifest respect are culturally specific.

Given the importance of respect both to Aboriginal philosophies and the health care encounter, the health professional should consider this concept, and its appropriate expression in an Aboriginal context. The Aboriginal psychiatrist Clare Brant sees “non interference” as one method by which an Aboriginal person may show respect for another’s independence. Defining the term as “a behavioural norm of North American Native tribes that promotes positive interpersonal relations by discouraging coercion of any kind, be it physical, verbal, or psychological,”⁵ Brant contrasts non interference with western European society where “the (white) man who remarks that he plans to buy a pear tree may anticipate that someone will immediately suggest that he buy a peach tree instead. If he remarks that he is shopping for a new car, someone will be happy to tell him exactly what kind of car he ought to buy.”⁶

Understanding the contrast between these two philosophies, one can begin to understand how the instructions of the well meaning health professional may be interpreted differently by a person of Aboriginal descent than by the professional giving those instructions. For example, a health professional who suggests to a diabetic client a strict diet, reinforcing this instruction with the possibility of diabetic complications should the diet not be followed,

may be effective if the client is of western European descent, but viewed as disrespectful and interfering if the client is an Aboriginal person who adheres to the ethic of non interference.

RECOMMENDATION C2

Health professionals should recognize that the current health care system presents many gaps and barriers for Aboriginal individuals and communities seeking health care

RECOMMENDATION C3

Health professionals should work proactively with Aboriginal individuals and communities to address these gaps and barriers

Barriers facing Aboriginal individuals seeking health care may not be apparent to the health professional in the cross-cultural context. Existing identified barriers may be categorized as: attitudinal, values and beliefs, structural, socioeconomic, and language and communication.

Attitudinal barriers include racism and prejudice. Prejudice can be defined as incorrect assumptions or stereotypes about an individual based on their racial or ethnic background, while racism includes prejudicial behaviour occurring within a context of power inequities. While intentional, overt racism is usually obvious to all parties involved and does not merit much discussion, more subtle racism may occur without conscious intent, and is therefore defined by those who experience it.

As an example, a triage nurse at an urban clinic, identifying an Aboriginal client by his last name and heavy accent, associated the client's slow manner of speech and lengthy pauses for several seconds before answering each of the nurse's questions as possibly indicative of intoxication. The on-call physician, later assessing the client, found that he was not in fact intoxicated, but did have a significant medical problem which merited assessment. The communication style had been the result of the client using English as his second language, while the pause time was appropriate for the client's mother tongue. The nurse had made a prejudiced assumption about the client's speech pattern, based on a shortage of accurate information about language patterns and a stereotyped association of alcohol abuse with Aboriginal people. Because the nurse is in a position of power, this assumption could be classified as an example of racism, despite its being unintentional.

Differences of values and beliefs can leave an individual feeling alienated in a health care setting with which they are not familiar. For example, very little in a busy urban hospital may be familiar to an older Metis woman who lives in a small rural community. Even if she is fluent in English, the communication styles and pace in the urban hospital are very different from her small town, the physical environment is foreign, and medical terminologies, assessments, and technologies are strange and can be intimidating. Culturally, most of the hospital staff will be operating from the perspective of a totally different worldview. All of these factors present a major barrier in this woman's attempt to obtain health care.

Structural barriers presented by health care services to Aboriginal individuals and communities are the direct result of conflicting sets of values and beliefs in the context of

respect and non interference. Brant notes that the principle of non interference was applied to pre-colonial Aboriginal governance and group administration:

Once the leadership had evolved, it would rely on voluntary cooperation for the attainment of group goals, whether with regard to hunting, warfare, or economic decisions.⁵

This cooperative style of administration is in stark contrast to that used historically by the federal government in its contact with Aboriginal peoples, including the involuntary removal of family members from communities to sanatoriums and residential schools. Furthermore, the current western medical approach remains founded on the “expert” health care provider who makes the major decisions regarding the need for diagnostic tests, prescriptions, and other medical resources and then “advises” the patient.

Structural barriers may be the result of the racist or prejudiced attitudes or policies of a group of people or an institution. This type of structural barrier may be termed “systemic racism.” For example, the historic policies of assimilation described in section A5,^{*} including the imposition of the western health care system described above, were based on an assumption by the federal government and religious institutions regarding the superiority of western European land rights, education systems, and health care systems.

Systemic racism, as manifested in the colonization process, has been deadly to Aboriginal peoples worldwide. Outside of an appropriate cultural context, Aboriginal peoples and their behaviours may habitually be misunderstood, misinterpreted, and misjudged. On an individual scale such misinterpretation is psychosocially damaging, as described by Sid Fiddler, an Aboriginal social worker:

The historical institutional racist disruption of Indian culture, combined with subsequent attempts at forced assimilation, broken treaties and unfulfilled promises have also contributed to the general Indian’s distrust of whites. Their personal experiences of racism in residential schools, educational institutions and in the urban and rural towns has reinforced the distrust, subsequent poor relationships, skepticism and reactive racism toward white people. These explain the propensity of Indian/Native clients in general towards not seeking help from the helping professions, including white therapists.⁷

Residential schools, whose generational impact has been discussed in section A5, are a specific example of systemic, or structural, oppression. For the significant number of Aboriginal peoples who are survivors of residential schools, the first experience of authority figures, including health professionals, was in an abusive and intimidating context, creating an attitude of fear and apprehension based on negative past experience, which in turn presents a barrier to future attempts at building relationships with health care providers.

Unfortunately, prejudicial and racist images of Aboriginal peoples are still prevalent in the media and society. It is difficult to avoid internalizing some of these images, especially given the paucity of alternate positive images of Aboriginal peoples in the media. Historically,

^{*}J Soc Obstet Gynaecol Can 2000;22(12):1076–7.

there has been a lack of recognition for Aboriginal initiatives by the dominant society. For example, few North Americans are aware that the first written constitution in what is now North America appeared before Columbus: the Gayaneshagowa or Great Binding Law of the Five Nation Iroquois Confederacy describes democratic ideas including equality and referendum. Some of the American “Founding Fathers,” including Benjamin Franklin, were familiar with this work, and scholars argue that it significantly influenced the American constitution.^{8,9} However, the historic lack of respect afforded Aboriginal initiatives in the colonial context and the ongoing societal and media stereotypes of Aboriginal peoples and cultures present significant systemic barriers to Aboriginal individuals and communities attempting new initiatives, since the systemic assumption may be that such initiatives will not be successful or credible. Even if the new initiative is able to overcome these barriers, its success and credibility will often be judged using a Western European worldview: and should it not measure up, the original, stereotyped assumption regarding the inferiority of Aboriginal initiatives will be perpetuated. Rupert Ross encourages the following preventative measures:

Whenever we find ourselves beginning to draw negative conclusions from what the other has said or done, we must take the time to step back and ask whether those words and acts might be open to different interpretations, whether that other person’s actions may have a different meaning from within his cultural conventions.¹

Other examples of structural barriers would include the geographic distribution of Aboriginal communities in Canada in relation to the geographic distribution of health care resources, the small numbers of Aboriginal health professionals relative to number of Aboriginal individuals requiring service, and jurisdictional confusion between federal, provincial, and regional government in the definition and provision of health services to Aboriginal peoples on- and off-reserve.¹⁰ Forty-eight percent of participants in the First Nations and Inuit Health Survey over the age of 45 years felt that First Nations and Inuit do not have the same level of services as other Canadians. Services cited as most in need of improvement included prevention, education, long-term health services for the elderly, and pediatric health services for children.¹¹

In Section A6,^{**} the following social conditions were cited as impacting adversely on the health status of many Aboriginal individuals and communities: poverty, inadequate housing, unsanitary water supply and waste disposal, low educational achievement, unemployment, alcohol and substance abuse, dependence on social assistance, discrimination within the justice system, and environmental exposures. Each of these issues presents affected individuals and communities with a major barrier to health care. Unfortunately, many of these factors are correlated. Poverty affects the ability to eat nutritious food, fill prescriptions, travel to medical appointments, and participate in recreational activities. It is also linked with inadequate housing, which is in turn linked to diseases of the respiratory tract, spread of infectious diseases, injuries, and violence.¹² In addition to physical health impacts, the adverse socioeconomic conditions facing Aboriginal individuals and

^{**} *J Soc Obstet Gynaecol Can* 2000;22(12):1077–8.

communities also have significant mental, emotional, and spiritual health impacts. Collectively, these adverse conditions are termed “relative deprivation” and have been linked to depression and alcohol and drug abuse.⁷

Language and communication barriers include not only the need for direct translation of what is being said, but also interpretation of the content to include culturally appropriate concepts. These barriers will be further discussed in section C5.

Once health care providers are sensitized to the barriers facing Aboriginal peoples, they can work proactively with individuals and communities to address and eliminate these barriers.

RECOMMENDATION C4

Health professionals should work with Aboriginal individuals and communities to provide culturally appropriate health care

At this point in the discussion, hopefully it is apparent that “traditional Aboriginal (First Nations, Inuit, and Metis) peoples and non-Aboriginal people have differing worldviews.”¹³ The culture of a particular group of people could be defined as their worldview and its expression in language, customs, and arts. Because worldviews are shaped and influenced by environment, culture is a dynamic entity. Ovide Mercredi, former grand chief of the Assembly of First Nations, further delineates the broad scope of culture and the impact of cultural change on health:

One of the reasons we have health problems in our communities is because our culture has been destroyed. So now we have to rebuild it, and that’s going to take a long process. The importance in terms of relations with the medical profession is that instead of resisting the restoration of the Indian culture, you become a partner with us in the restoration. Culture means many things. It means language and arts. It means a way of life, a way in which people deal with human beings in a society. It’s the way in which you raise children. Culture is the way you deal with health in a community, with economic development and spiritual needs.²

The Inuit Tapirisat of Canada also looks to culture as the basis for the future of Inuit in Canada:

Despite the different challenges of the 20th century, Inuit culture continues to be strong and resilient. Our language is one of the very few Aboriginal languages not in danger of extinction. Young Inuit are taught their language in schools and the Inuktitut language can be read, seen, and heard on a wide variety of media across the north and in some part of southern Canada. Our elders are our pillars. Their skills and experience provide an irreplaceable cache of traditional knowledge to be passed on to our youth. With their guidance and wisdom, our culture will endure and enable our future generations to be knowledgeable about who they are and to say with pride—We are Inuit.¹⁴

The need for culturally appropriate approaches to Aboriginal health is overwhelmingly supported by experts in the field and has also been included in recommendations by the First Nations and Inuit Regional Health Survey (FNIRHS),¹¹ the Royal Commission on

Aboriginal Peoples (RCAP),¹⁵ the Canadian Medical Association in the *Bridging the Gap* document,¹⁶ and the Aboriginal Women's Health Report.¹⁷ The RCAP report recommends profound changes to the current systems of health and social services in Canada to better serve Aboriginal peoples, including reorganization of the existing network of services for Aboriginal peoples into a system of health and healing lodges under Aboriginal control.¹⁵ Recommended changes also include adaption of mainstream services "to accommodate Aboriginal people as clients and as full participants in decision making."¹⁵ This transfer of control to Aboriginal peoples will be further discussed in section D.[†]

Support for culturally appropriate health programs was also a major theme found in the literature review.^{10,18–54} Many of these articles identified the failure of mainstream approaches to particular health problems and the importance of the socio-historic context in fully understanding these problems. The call for culturally appropriate health programming was often tied to the recognition that control of these programs needs to be in the hands of the Aboriginal communities. Brian Postl states that "there is a remarkable linkage between concepts of health promotion and the empowerment of Aboriginal peoples through self-government."⁵⁵ a concept that will be further discussed in sections D1 and D2.

Cervical cancer is one area where the barriers presented by a mainstream approach to screening and support for more culturally appropriate interventions are well documented. It was noted earlier (section B)^{***} that mortality from cervical cancer is markedly increased among First Nations women.^{21,42,56} In a review of band membership lists and the BC Cervical Cytology Screening Program registry, Hislop *et al.*⁴² found that Pap smear screening rates were substantially lower among First Nations than among other women in British Columbia. After holding community meetings to identify facilitators and barriers in urban screening program, the group found that women's knowledge regarding Pap smears was limited mainly to how the test was performed clinically. Little was known about the purpose of the test. Other barriers included psychological and physical discomfort, safety issues, and past abuse. The group then collaborated with a "community advisory committee" to develop specific interventions including a poster, pamphlet, articles in First Nations community newspapers, and special screening clinics.

At eight Aboriginal health clinics in California, Hodge²¹ ran a series of 16 "talking circles" in order to better identify barriers to and increase knowledge levels regarding cervical cancer screening. Results of the focus groups "confirmed reports of less frequent use of cancer prevention measures among American Indians and that cultural barriers have contributed to underutilization of medical care." Furthermore, "focus group members placed a high value on cultural sensitivity in the patient-provider relationship. Showing respect, kindness, and understanding of American Indian ways were identified as important features."²¹

In a small survey⁵⁷ in Kuujuaq, Nunuvik, it was found that 34 percent of Inuit women older than 45 years had never had a Pap test. Knowledge regarding cervical cancer prevention and screening was very limited: many women thought Pap testing was a test for sexually

[†]Will appear in March *JOGC*.

^{***}*J Soc Obstet Gynaecol Can* 2001;23(1):54–68.

transmitted diseases. The most common reasons cited for never having had a Pap test were “was not offered” and “not interested.” Other reasons included “afraid,” “didn’t know why she should have one,” and “never go to the clinic.” The survey resulted in an educational brochure and inspired cross-cultural education workshops at the Society of Obstetricians and Gynaecologists of Canada (SOGC).

Two studies attempted to measure the success of more culturally appropriate interventions on cervical screening rates among Aboriginal women. Dignan *et al.*⁴³ conducted a randomized, controlled trial of a culturally appropriate education program among Cherokee women in North Carolina over a period of five years. Women who received the education program had a greater knowledge about cervical cancer prevention and were more likely to have had a Pap test. Calam *et al.*²⁰ found a 15 percent increase in cervical cancer screening after the initiation of a community outreach program in the communities of Haida Gwaii, Queen Charlotte Islands, British Columbia. However, 52 percent of the women identified as overdue for cervical screening still did not participate in the specially designed clinics even after being visited by community health representatives, indicating additional barriers that need to be identified and addressed.

Some health care domains, such as birth, sexuality, and death, bear particular cultural significance in all cultures and hence require particular attention in the cross-cultural setting. The fact that cervical cancer screening is a sexual health issue contributes to the heightened need for culturally sensitive programming. Inuit communities have experienced the transition from traditional midwifery to medicalized births in hospitals away from home (section A4),[†] the negative impact of which is noted by Pauktuutit (the national Inuit Women’s Organization):

The loss of family and community control over childbirth, imposed by a paternalistic and alien government, is a major factor in the breakdown of Inuit families and the social dislocation that Inuit experience today.³

Culturally appropriate health care in this situation requires respect for the choice of community based childbirth; and may also challenge the worldview of medically trained health professionals who are concerned with access to medical technologies and medico-legal liabilities. An example of a culturally responsive maternity program that addresses some of these challenges will be described in Section D1.

Death is another area where cultural values and protocols may require particular sensitivity. As in childbirth, the cultural values of Aboriginal peoples may be in conflict with the policies and procedures of the mainstream health care system. Also as in childbirth, specific traditions vary considerably between different Aboriginal peoples. Generally, it may be important to have family and community members present at the time of death, for death to occur in the community if possible, for the body to be returned to the home community if death did occur outside of the community, and for family members to be directly involved in the preparation of the body after death.

[†]J Soc Obstet Gynaecol Can 2000;22(12):1074–6.

There may also be strict protocols regarding the handling of the dead body. In one example, an Aboriginal child with a severe congenital illness died during a medical procedure in a tertiary care hospital several hundred kilometres away from the family's home community. The family was aware that the procedure involved some risk to the child. Due to the circumstance of death, the coroner requested an autopsy; however, the cultural protocol of the family was that only family members should handle the body after death. The family, who had initially felt quite comfortable with the care the child had received, also felt that the request for autopsy was an indication that something had gone wrong during the procedure. Fearful of legal recourse if they refused, they reluctantly allowed the autopsy. The hospital staff were shocked when a family member waited at the door of the morgue to personally receive the body after the autopsy and carry it out of the hospital. The family was deeply disturbed by the condition of the body after the autopsy.

In such situations, extreme cultural sensitivity is warranted. Consultation of an Aboriginal health advocate should be considered. There are no simple solutions to the above scenario, but respectful, patient, and nonjudgmental communication is essential.

RECOMMENDATION C5

Aboriginal peoples should receive treatment in their own languages, whenever possible

RECOMMENDATION C6

Health care programs and institutions providing service to significant numbers of Aboriginal peoples should have cultural interpreters and Aboriginal health advocates on staff

The 1996 Census⁵⁸ revealed that for individuals reporting Aboriginal identity, just over one in four reported an Aboriginal language as a mother tongue. The large majority of individuals reporting an Aboriginal mother tongue used this language at home. Aboriginal languages with large mother tongue populations, including the Inuktitut, Algonkian, and Athapaskan language families, had the highest rates of home use. Aboriginal languages with smaller mother tongue populations were less likely to be passed on to future generations at home, and were therefore at risk.⁵⁸ Little information was available on the levels of comprehension of non-Aboriginal languages, although one would assume that communities with high rates of home language use would have significant numbers of individuals for whom communication in English or French would present a major obstacle. Even those communities with fewer speakers of the traditional language may have some community members who require translation, especially among the elderly population.

If Aboriginal peoples are to be "full participants in decision making," services need to be available in Aboriginal languages. Recognition and support for Aboriginal languages is linked to recognition and affirmation of the inherent rights of Aboriginal self-government. Aboriginal leaders have paralleled this linkage to the efforts of francophone Quebecers to attain the recognition of Quebec as a distinct society by the federal government.⁵⁹ As a result of francophone efforts, the majority of federal services are now available in French. Unfortunately, the same cannot be said regarding the availability of services in Aboriginal languages.

The availability of language specific services has an obvious impact on the provision of health services to Aboriginal individuals and communities. Medical interpreters need to be highly skilled in their knowledge of medical concepts and terminology as well as in their ability to interpret culturally specific values and beliefs. Although family members are often asked to act as interpreters when a medical interpreter is not available, this is inappropriate and unethical. The family member may not be able to translate the medical terminology or culturally specific concepts, and may also have a vested interest or opinion in the matter being discussed and therefore possibly edit the translation according to their own personal opinions. Also, asking a family member to interpret may make the patient reluctant or uncomfortable about sharing personal yet vital information, especially with regard to violence and sexual abuse. Finally, serving as a translator also interferes with the ability of that family member to support the ill person and to process their own feelings regarding the illness.

As one example, a physician at a rural hospital was managing a critically ill patient, who appeared to be delirious and in pain, in the middle of the night. Although the physician required an interpreter to clarify the patient's mental status and the nature of the patient's symptoms, medical interpreters were only available during the daytime at this hospital, despite the fact that several of the inpatients at any time were unilingual in an Aboriginal language. The patient's husband and hospital security staff were called upon to interpret. Clearly both the husband and the staff were uncomfortable with this request. Furthermore, the husband appeared to have his own beliefs regarding the nature of his wife's illness and modified his translation accordingly, while the security staff were very uncomfortable with the critical status of the patient. Neither party could provide adequate translation. The physician's assessment remained incomplete, and the patient's condition continued to deteriorate.

Provision of cultural interpreters and Aboriginal health advocates allows mainstream institutions, such as hospitals, to better meet the needs of Aboriginal clientele.

One positive example is found in the Language Services Department at Stanton Yellowknife Hospital. Recognizing that approximately 55 percent of patients coming to the Stanton Hospital were Aboriginal and that one-third of these people had little or no ability to communicate in English, Stanton Hospital now has 23 medical interpreters, qualified in medical terminology in nine Aboriginal languages and their dialects, to assist the family physicians and specialists in provision of care.⁶⁰ These interpreters cover hospital departments, as well as assisting in the clinics of private physicians. Bouvrette⁶⁰ illustrates that cultural translation is much more than strict language translation by describing the broad scope of duties embraced in the interpreter's role, including: shopping, banking, accommodation, preparation of traditional meals, transportation, and advocacy.

RECOMMENDATION C7

Aboriginal peoples should have access to informed consent regarding their medical treatments

Informed consent is recognized as an ethical and medico-legal necessity of care by provincial governments, medical associations, and medical licensing associations.⁶¹ Since most medical professionals now have standard protocols in place to ensure that informed consent takes place, health care providers might assume that Aboriginal individuals will have access to informed consent just as any other patient. However, in order to ensure that Aboriginal clients have equal access to informed consent, it is important to be sensitive to certain historical, cultural, and language issues.

Historically, it is important to note that many Aboriginal individuals alive today have been subjected to medical procedures without explanation or consent in the past. For example, tuberculosis screening was conducted in several Aboriginal communities for many years as a part of “treaty day.” On this day, community members were given a mandatory chest X-ray prior to receipt of their annual treaty monies, with little or no explanation or choice given regarding the X-ray. Community members suspected to have tuberculosis were subject to mandatory treatment at sanatoriums. At the same time, children were being forcibly removed from families and sent to residential schools.

Many Aboriginal individuals will thus have had an experience of forced compliance with western medical procedures and treatments, rather than informed consent. Since informed consent is a western medico-legal concept, many Aboriginal individuals may not be aware of it unless they have learned about this notion through the media or other sources. Certainly one would not expect the notion or words for “informed consent” to exist in Aboriginal languages.[‡] Further, some Aboriginal individuals, concerned that by directly asking questions they would be showing disrespect, may be reluctant to ask directly for clarification or explanation when the issues surrounding informed consent are raised.

Given these historical, cultural, and language issues, health care providers may need to take some extra time or use the services of a trained cultural interpreter to ensure that appropriate informed consent is accessed by Aboriginal clients.

RECOMMENDATION C8

Health services for Aboriginal peoples should recognize the importance of family and community roles and responsibilities when attempting to service Aboriginal individuals

Family is still the central institution in Aboriginal societies. It is only a generation or two since extended kin networks of parents, grandparents and clan members made up virtually the entire social world for Aboriginal people, providing the framework for most of the business of life. Inside the web of family, norms of sharing and mutual aid provided a social safety net for every individual. Aboriginal

[‡]In some Aboriginal cultures there is already a strong notion of personal or sacred space which is not entered by another without permission.

families, and the cultures and identities they passed on to their children, were severely disrupted by actions of colonial and Canadian governments. Children in particular were targeted time and again in official strategies to control and assimilate Aboriginal people.¹⁵

The concept of family is culturally specific. The western European concept of “nuclear family” is in sharp contrast with Aboriginal perspectives of family, which often include strong relationships with a large network of relatives who would be considered “extended” family in western European terms. Extended family plays an important role in the parenting of children. Aunts, uncles, grandparents, cousins, and older siblings may play a role comparable in significance to the western European “parent.” The community as a whole can be involved in raising a child. In addition, the relative importance of meeting personal needs and responsibilities versus meeting family and community needs and responsibilities may differ. While the notion of “individual rights and freedoms,” which places a strong emphasis on personal success, is the cornerstone of the North American capitalist social structure, the Aboriginal ethics of “non competitiveness” and “sharing” may place family and community success ahead of individual success.

It is important for the health professional to keep the importance of family and community in mind when working with Aboriginal individuals. For example, health care staff at a mainstream city clinic were surprised when an Aboriginal toddler was allowed to wander around the clinic unsupervised by a parent. The mother’s cultural expectation was that the clinic staff would assist in the supervision of the child, as she was accustomed to this type of parenting support in her home community. The health care provider interested in preventing baby bottle tooth decay needs to be aware that it is not only “mom” and “dad” but also “auntie” and “kokum” who need to be warned about the dangers of a sugar bottle.

The literature review supported the importance of family and community roles and responsibilities in understanding and addressing issues of diabetes, substance abuse, and mental health with Aboriginal individuals.^{36,39,47} In a participatory research project, Boston *et al.*⁴⁷ identified concern about upheaval of traditional family roles among James Bay Cree dealing with diabetes. Traditional status and respect shown towards older family members may be inverted by younger family members who use non-traditional foods and are more knowledgeable about modern approaches to diabetes prevention and treatment. Additionally, family members who have diabetes may be separated and marginalized from the family and community, for example by not being able to join in traditional Cree social activities involving eating.

RECOMMENDATION C9

Health professionals should respect traditional medicines and work with Aboriginal healers to seek ways to integrate traditional and western medicine

This recommendation is linked to recommendation C4, in that “traditional” medicines and healers are a part of culturally appropriate care for many (but not all) Aboriginal peoples. Over 80 percent of respondents answered yes to the FNIRHS question, “Do you think a return to traditional ways is a good idea for promoting community wellness?”¹¹ Although

the meaning of “traditional ways” was not clarified, one might assume that at least for some it would include the use of traditional medicines and healers. The RCAP findings also indicated that Aboriginal peoples valued traditional approaches to health:

Although Aboriginal people have moved far away from the lifestyles of their ancestors, they still see value in the traditions and practices that made them unique—including medical traditions ranging from herbal therapies to forms of psychotherapy. Often, they find that mainstream health services do not understand or fully meet their needs. They want to reexamine practices that were once suppressed or ridiculed for their possible usefulness today.¹⁵

Finally, Article 24 of the UN Draft Declaration on the Rights of Indigenous Peoples also affirms “the right of indigenous people to their traditional medicines and health practices.”⁶²

Respect for traditional medicines and healing is therefore important to many Aboriginal peoples as a cornerstone of culturally appropriate health care. Section A examined the disruptive impact of colonization on traditional Aboriginal cultures.^{††} Many Aboriginal individuals and communities are currently undergoing a process of cultural “rediscovery” in an effort to revitalize and strengthen cultural traditions that have been historically suppressed, a process which can be integral to the health or healing of individuals and communities and which is also linked to development of self-determined health services for Aboriginal peoples (see section D1).

As communities work towards understanding and recovering cultural practices, the meaning of “tradition” and “traditional healers” becomes controversial. The impact of colonization, including residential schools and legislation outlawing traditional cultural practice, means that there are relatively few remaining cultural teachers and traditional healers who have received the customary training, which traditionally began in childhood. The church and other mainstream influences have had a varied impact on the cultural context of Aboriginal individuals and communities. In urban areas, Aboriginal individuals come from a diversity of cultural backgrounds. It is therefore not surprising that in some communities there is uncertainty regarding the definitions and protocols surrounding “traditional healing;” nor is there currently any formal method of monitoring or regulating the qualifications of traditional healers. In some situations, individuals have taken advantage of this by self-proclaiming to be healers or traditional peoples despite questionable qualifications. Aboriginal individuals and communities have recognized the need to further define “tradition” and “traditional healing.”^{11,63} In addition, RCAP identified a “pressing need” for “people who can apply Aboriginal knowledge to current health problems and combine traditional health and healing practices with mainstream approaches.”¹⁵

There are existing examples of health care facilities in which both “traditional” and western medical approaches are used concurrently. Several urban Aboriginal health access centres in Ontario and one in Winnipeg have “traditional healers” or “cultural coordinators” as well as physicians, nurse practitioners, and nurses on staff. In these centres, clients may access appointments with traditional healers, western medical professionals or both. In addition,

^{††}J Soc Obstet Gynaecol Can 2000;22(12):1070–81.

some acute care hospitals have policies that facilitate the use of traditional medicines, including the burning of sage, cedar, sweetgrass or tobacco in the hospital setting.

While not strictly a “traditional medicine,” Inuit diets are very different from those of other Aboriginal peoples. Many Inuit living in the north have diets consisting largely of traditional or “country” foods, including marine mammals such as seals and whales, caribou, Arctic char, and a variety of birds. Many of these foods are regularly eaten raw and frozen, and the sharing of animals and eating together is an essential element of Inuit social and cultural life. Reinforcing traditional or “country” foods can be particularly useful if considered in the context of diabetes prevention and maintenance of blood sugars.

RECOMMENDATION C10

Health professionals should take advantage of workshops and other educational resources to become more sensitive to Aboriginal peoples

Understanding the nuances of a different culture and integrating this understanding into the provision of clinical care is challenging and complex. Jecker suggests that this process involves not only gathering information about the cultural context of the client, but “re-examining personal values and ... reinterpreting, reordering, or changing them in light of the case.”⁶⁴ The recommendations regarding education of health professionals in this document are in keeping with previous recommendations regarding caregiver education.^{16,17}

Aboriginal cultures in Canada are diverse and dynamic. Individuals originally from the same geographic and language group may have very different worldviews depending on their life experience and exposure to non-Aboriginal culture via the media, foster homes/adoptive families, churches, and the educational system. In urban settings, the health professional is likely to encounter Aboriginal individuals from a wide variety of distinct geographic and language groups, each of whom may have adapted to urban life or “acculturated” in a unique way.

Health professionals newly approaching work with Aboriginal peoples often look for a “recipe” or set of cultural rules to follow. While some principles, such as Brant’s ethic of non interference, may provide useful background information, “recipe” approaches run the risk of perpetuating cultural stereotypes and do not allow for inter- or intra-cultural diversity among Aboriginal peoples. In much the same way that most health professionals would prefer to learn clinical medicine experientially at the bedside rather than reading a case report, learning to understand and mediate the worldview of a different culture may be best done experientially in a workshop setting, through the use of roleplaying, participation in cultural events, and discussion. Health professionals are encouraged to use their excellent observation and communication skills to build their understanding of cultural nuances.

Organizations of Aboriginal health professionals, such as the Aboriginal Nurses Association of Canada, National Indian and Inuit Community Health Representatives Organization, Native Physicians in Canada, and the Native Psychologists Association are excellent resources for health professionals trying to broaden their understanding of Aboriginal health. Health care providers are encouraged to get to know these organizations and work in

collaboration with them. Some of these organizations have newsletters, web pages, and resource publications. (See resource section following section D).

RECOMMENDATION C11

Health professionals should get to know Aboriginal communities and the people in them

Brant notes that “in keeping with the ethic of non interference, it is not possible to instruct a stranger regarding local practices or protocols. Rules can never be stated, for to do so would interfere with the individual’s right to behave as he sees fit.”⁵ This is what anthropologists would describe as “high context” culture, where cultural rules and protocols are implicitly understood and subtly communicated, often through body language; in contrast to “low context” cultures where communications are verbal, explicit, direct, and open to questioning or verbal clarification. If one truly wishes to achieve cross-cultural understanding in a “high context” situation, one can only do so by spending time in the context and building relationships with the people so that one is no longer seen as a stranger. “High context” learning is experiential. Indeed, role modelling, a form of experiential learning in which students are shown how rather than told how, is the traditional style of teaching for many Aboriginal peoples.⁵

In keeping with the idea of an experiential approach to cross-cultural understanding, health professionals are encouraged to visit Aboriginal communities. A visit to a remote First Nations, Metis or Inuit community will provide a multitude of invaluable insights not available in any library. The visitor should keep in mind, however, that Aboriginal peoples have many reasons not to trust an outsider, no matter how well intentioned. Health professionals visiting an Aboriginal community may be subject to close observation. In keeping with the notion of “high context,” visitors may be understood more in terms of what they do than what they say they will do. Establishing trust and respect in a community takes time. Most Aboriginal communities have experienced an extensive turnover of health care providers over the years. A point of comparison might be to imagine what it would be like to have a new family physician every few months or to meet a ‘fly-in’ doctor once and never see them again. Traditionally, community members knew each other and established their community roles and responsibilities over a lifetime. Many Aboriginal communities seek a commitment to the community from the health professional.

By spending time getting to know Aboriginal communities and the people in them, health professionals will gain valuable insight and enhance the establishment of trust relationships. The power inequities associated with colonization and health care relationships mean that a visitor to a cross-cultural setting is advised to take personal responsibility for their own cross-cultural learning. A self directed learning style based on careful, unobtrusive observation and participation over time may be most compatible with cultural protocols.

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