



“We stopped sharing when we became civilized”: A Model of Colonialism as a Determinant of Indigenous Health in Canada

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Abstract

In the post-World War II era, attention to the poorer health outcomes of Indigenous peoples led to a gradual shift in the discourse surrounding Indigenous-State relations in Canada. By the 1980s, the federal government devolved policies involving First Nations, resulting in First Nations control of the local delivery of federal and provincial government programs and services such as social welfare and capital for improved infrastructure and economic development. We conducted qualitative research examining the perceived impact of increased local control and access to social and economic investments on *mino-bimaadiziwin* (“good health”) in five Ojibwa/Anishinabe First Nations in northeastern Ontario, Canada. Results suggest these interventions have reduced community solidarity, led to higher unemployment, poorer health and a reliance on materialism, technology, and social programs. There are community divisions between those who have benefited and those who have not. Indigenous communities frame past life ways as a guide to improved *mino-bimaadiziwin*.

INTRODUCTION

Indigenous peoples in Canada have poorer health outcomes than the general population (Reading & Wien, 2009) and the necessary approaches to improve Indigenous health inequalities are still poorly understood. Indigenous health disparities are in large part due to Canada’s colonial history and the resultant inequities in the social determinants of health (SDoH) (Greenwood et al., 2015; Czyzweski, 2011). A greater understanding of Indigenous social determinants of health is necessary, given the poor psychosocial, socioeconomic and physical environments that characterize Indigenous peoples’ experience today (Boyer, 2014; Smylie, 2009). The literature on social

determinants of health is well established though the focus on colonialism as a determinant of Indigenous health is limited (Czyzewski, 2011; Greenwood et al., 2015; Jacklin & Warry, 2012; Reading & Wien, 2009).

A byproduct of Canada's colonial history is the collapse of Indigenous economies due to losses of land and self-determined ways of life (Boldt, 1993; Warry, 2007). Economic variables have a significant impact on health including mortality, morbidity, and access to health care services. Therefore to improve our understanding of Indigenous health, there is a need to study the health consequences of government socioeconomic interventions in the form of the devolution of government and health services for Indigenous peoples in Canada. Colonial policies have furthermore marginalized Indigenous participation in the mainstream economy (Shewell, 2004).

We present a framework to understanding how socioeconomic factors, being a product of federal government policies, influence individual, community, and systems-level aspects of Indigenous health, which is supported by the Truth and Reconciliation Commission of Canada (2015, p. 322). In particular, TRC call to action 18 acknowledges the state of Indigenous health results from Canadian government policies (ibid.). Given the nature of First Nations reserve communities and their colonial relationship with the federal government, policies resulting from this relationship impact all aspects of First Nations life. This impact includes health services, economic development, social service provision, and governance. In this article, we contribute to a greater understanding of colonialism as a determinant of Indigenous health by integrating the voices and embodied experiences of colonialism as encountered by Indigenous peoples in northeastern Ontario, Canada. More specifically, we develop a conceptual model to represent the interrelationships between colonial socioeconomic pressures and the holistic experience of good health, *Anishinabe mino-bimaadiziwin*.

ANISHINABE MINO-BIMAADIZIWIN

The Indigenous peoples of northeastern Ontario are known as the Anishinabek (plural; Anishinabe is singular), meaning the “people” (Union of Ontario Indians, 2016). The Anishinabe conception of good health, known as *mino-bimaadiziwin* informs this study. It goes beyond the Western, individualistic, physically focused model of health.

There are various renditions and translations of the term *mino-bimaadiziwin*, we follow the Anishinabek Nation's definition of "good health" for this term (Union of Ontario Indians, 2016).

In the 1990s, Warry examined community healing and self-government on the north shore of Lake Huron, which is part of our study region. He found high levels of unemployment and a reliance on social assistance, which in turn resulted in ill health (Warry, 2007, p. 63-92). Warry pointed out that these socioeconomic outcomes result from systematic discrimination faced by Indigenous peoples. In turn, this leads to a holistic impact on Indigenous families, for example, the poor physical and mental health and poverty limiting the potential for children (ibid.). For those employed, opportunities are mostly restricted to the Band office, leading to a two-tiered class system: those employed and those unemployed. Jealousy and resentment results from disparities in material acquisitions (ibid.). Furthermore, Warry observed that the individualization of economic opportunities and social assistance had transformed Indigenous sharing and reciprocity. Warry also found that in general there was poor housing and inadequate infrastructure (ibid, p. 71-74). Furthermore, concerns were not only limited to socioeconomic issues, but marginalization was also linked to "low cultural esteem" and a "lack of cultural identity" (ibid, p. 84).

In 2011, Czyzewski formally introduced colonialism as a distal determinant of health in Indigenous health research. She based this on a critical review of Indigenous health discourse with an emphasis on critiquing colonialism as an unfinished project with particular reference to the persistence of racism and assimilation. Colonialism is situated historically through epidemic disease (e.g. smallpox), residential schools, land dispossession, sedentarization, and separation from the mainstream economy (ibid, p. 3). According to Czyzewski, colonialism is a distal determinant forming the structural and systemic disparities that are beyond the individual or community and are the "*causes of causes* for unjust life situations for particular groups or people over others" (ibid, p. 4). In particular, Indigenous mental health discourse involves stereotypes and "othering," which essentializes and constructs a "disordered" category and this colonial discourse is a "*circumstance* that determines Indigenous mental health..." (ibid, p. 6). The principal issue in the SDoH literature examines populations as a whole and in doing so makes

colonialism invisible compared to advantaged people in society and thus perpetuates inequality by not allowing Indigenous peoples to determine “their health and what actions are needed to address health disparities” (ibid, p. 9).

Jacklin and Warry (2012) further develop colonialism as a determinant of health by situating the concept in their prior Anishinabek health research in our study region. Aside from citing history and policy, the authors point out the fact that health care providers do not comprehend the significance of colonialism in understanding it as a determinant of health (ibid, p. 377). In turn, adverse experiences of Indigenous peoples with state authorities (e.g. child welfare) and institutions (e.g. residential schools) have resulted in Indigenous peoples mistrusting care services (ibid, p. 378). Thus in many instances, biomedical practitioners do not understand that Indigenous peoples recognize biomedicine as a colonial state system. The authors argue the pathway to addressing the legacy of colonialism in Indigenous health is decolonization via community control and capacity building in health care and applying Indigenous social determinants of health to inform policy and practice at the federal, provincial and local levels of government (Greenwood et al., 2015).

The colonialism SDoH literature focuses on the structural context of colonialism, e.g. land dispossession, assimilationist policies (Indian Act, residential schools), socioeconomic marginalization, and a call for decolonizing the Indigenous-State relationship. However, less emphasis is focused on how Indigenous peoples in Canada articulate and experience colonialism as an SDoH, and except Greenwood et al. (2015), their voice is absent from this literature. In this article, we share results of a qualitative study that contributes to a greater understanding of colonialism as an Indigenous SDoH.

SETTING

Northeastern Ontario is a vast region and encompasses the Districts of Algoma, Cochrane, Manitoulin, Nipissing, Sudbury, and Timiskaming (Buse & Mount, 2011, p. 6). There are seven First Nations in each of the Algoma and Manitoulin Districts and five in the Sudbury District, for a total of 19 First Nations in our study region (ibid. pg. 12, 73, 158). The following study includes five First Nations in total, one from the District of Algoma, three from the District of Manitoulin and one from the District of Sudbury.

In 2016, Statistics Canada compiled socio-demographic information of the First Nations (on-reserve) in Ontario. The employment rate is 54.1% and 52% of the population between the ages 25-64 completed postsecondary education (certificates, diplomas or degrees). Approximately half (51%) rated their health as excellent or good. This compares to the non-Indigenous population in Ontario: 75.5% are employed, 65% have completed postsecondary education, and 71.7% rate their health as excellent or good (Kelly-Scott, 2016).

The First Nations in our study region are Anishinabek First Nations and share a common cultural heritage and legacy of colonialism. The First Nations in this study were subject to three historic Treaties: Manitoulin Treaties 1836 and 1862 (Manitoulin District) and Robinson Huron 1850 (Algoma and Sudbury Districts) (Surtees, 1994). The region has historically relied on a natural resource economy, mostly in mining and forestry (Buse & Mount, 2011).

In 2006, the Anishinabek Nation passed a resolution to address poverty on its member First Nations (including Algoma, Manitoulin, and Sudbury Districts). The result was the establishment of an economic blueprint with the objective of, “achiev[ing] prosperity and well being through the active pursuit of economic development, business ownership, and employment creation” (Anishinabek Nation, n.d.). The Waubetek Business Development Corporation serves our study Districts, which is Anishinabek-owned and focuses on First Nations business and economic development. As of 2015, it has invested \$65 million in over 3,000 Indigenous businesses in its catchment, and 94% were still in operation (Madahbee, 2015, p. 26).

All First Nations in this region have local delivery of health care services through the 1986 Indian Health Transfer Policy. Though the policy dates to 1986, it was not until the 1990s that First Nations in northeastern Ontario took local control of health services (Maar, 2004; Warry, 2007; Jacklin & Warry, 2012). Warry and Jacklin (2012, p. 382) have evaluated the local delivery of health services in the Districts of Algoma and Manitoulin and found that community control has led to an improvement in quality and access to culturally-appropriate services.

Since 1994, the Province of Ontario, through the Aboriginal Healing and Wellness Strategy (AHWS), has funded ten health centres to provide specialized and

culturally relevant health services to Indigenous peoples who live on and off First Nations in Ontario. There are three centres in each of the Districts of our study region: N'Mninoeyaa Health Access Centre (Algoma); Noojmowin Teg Health Access Centre (Manitoulin); and Shkagamik-Kwe Health Centre (in the Sudbury District City of Greater Sudbury) (Association of Ontario Health Centres, n.d.). In an evaluation of the Noojmowin Teg Health Access Centre, Maar (2004, p. 63) found the provision of specialized mental health (e.g. psychologists) and traditional medicine (access to traditional healers) had an overall enhancement of care though there is a tension at the community level with finding compatibility between federally and provincially funded health programs.

METHODOLOGY

A community-based participatory action research (CBPAR) framework informs our research project and community members were active in the research project. CBPAR engages in research leading to community empowerment or self-determination (Jacklin & Kinoshameg, 2007). Most of the First Nations in the Districts that comprise our study were invited to collaborate in this study, and five First Nations expressed an interest in participating at that time. Each of the participating First Nations took part in planning sessions to determine the research governance framework. The consensus of the management structure reached was a community-based study steering committee comprised of participant First Nations health and economic development representatives and researchers with the responsibility of determining the research methodology, research questions, and timeframe. The steering committee reached a consensus for a pilot study with a focus group methodology (Bernard, 2011, p. 172-175) with the central research question being: How is *mino-bimaadiziwn* in First Nations communities influenced by socioeconomic factors at the individual, community, nation, and service systems levels? This research project received ethics approval from the Manitoulin Anishinabek Research Review Committee and each Chief and Council of participant First Nations passed a resolution in support of this investigation. All participants received a honourarium and hot lunch. Sessions ranged in length between 1-1.5 hours and were held in First Nation community centres. Focus group questions comprised of a series of historic (based on

community memory) and contemporary economic and health questions. Responses to questions were audio recorded and transcribed verbatim. We conducted a grounded theory analysis (Bernard, 2011, p. 435-439) of transcripts focusing on participants' perceptions of changes in socioeconomic issues and *mino-bimaadziwin* over time and what might have caused these changes. In line with grounded theory analysis, the researchers discussed emerging themes between focus groups and adjusted the focus group questions based on this early analysis. Data saturation was reached prior to the final focus group. The transcripts were coded by two researchers using QSR International's NVivo 10 Software. The researchers compared the coding scheme and resolved discrepancies during follow up discussions. We did not approach our research with an a priori theory, but rather formed our theoretical perspective based on transcript themes.

RESULTS

In total 88 adult and Elder members of all of the First Nations participated in twelve focus groups with nearly equal representation from those in administrative health and economic positions (47) and community members knowledgeable of health and economic history and contemporary issues (41). Focus groups with administration and community members were held separately for the reason that we anticipated community members might be less open to certain questions based on professional relationships with administrative members, e.g. health provider-patient, or social service provider-community member service recipient. Based on our data analysis, participants spoke of community work histories as shifting from a reliance on seasonal and off-First Nation employment to mostly on-First Nation administration work. Correspondingly, there is a change from limited social services in the past to a higher degree of, and reliance upon, social services in the present. In comparing the past to the present, a major theme was a memory of greater self-determination and cultural values and a sense of less self-determination and cultural values in the present. The contemporary community health involves having a significant chronic disease, and the introduction of technology (e.g. televisions, video-gaming) has decreased social and physical wellbeing, and the lack of economic opportunities has led to an erosion of mental wellbeing. Presented in the

following are results in two main thematic categories: socioeconomic and *mino-bimaadiziwin*. In our results, we describe the main themes and provide quotes highlighting the thematic findings. Lastly, using an interpretivist approach, we construct a conceptual model as a tool for understanding the relationship between colonial socioeconomic pressures and the experience of *mino-bimaadiziwin* by the Anishinabek and its impact over time.

SOCIOECONOMIC THEMES

ECONOMIC HISTORY

Participants spoke of most historic employment being seasonal and off-First Nation. Economic opportunities were generally in the natural resource sector such as forestry, mining, and making crafts and cooking and cleaning for the tourism industry (e.g. in tourist lodges). Informal economic options were significant and included small-scale farming, fishing, hunting, blueberry picking, bartering, and carpentry. Farming, hunting and fishing produce were bartered, and blueberries sold. There was an overall sense of family and community economic reliance.

Farming itself was self-sustained for most families. Most family farms were just like the Mennonites; we produced most of what we needed. Most families traded goods [...] so that was a type of a communal system [where] we redistributed food and resources, same thing with salted fish, deer meat, moose meat, [and] the harvesting [of] seagull eggs in the spring. (Manitoulin C Focus Group)

ECONOMIC PRESENT

The economic present in the First Nations in our study involves employment options on-First Nation, mostly in administration such as community and social services and to a lesser extent, small businesses. Participants emphasized this shift to an economic reliance on administration, health, social services, which are in essence, extensions of the government. Those who are not employed rely on welfare.

I think that there's still quite a substantial divide in well to do people who have some economic stability versus those that don't or have to rely on social services and other agencies to kind of help them meet the needs of themselves or their families. (Manitoulin A Focus Group)

SELF-DETERMINATION IN THE PAST

In the past, there was a reliance on Indigenous knowledge, community, family, and the will to maintain and nurture these relationships. Indigenous knowledge manifested in harvesting traditional medicines, hunting, fishing, and a general community-centredness. Few people relied upon social assistance, in part because it was not available, and community members and family members built their homes, barns and most people had gardens. Participants equated this with having self-determination in the past.

I think way back then, it was a way of survival for all the families within the community, and they needed to depend on all those wild berries that grew at a particular time of the year. Also the harvesting of, you know, the moose, the deer, even the fish, that was all done at a particular time of the year and because of how the family unity was way back then, people shared all of those natural resources with one another. (Algoma Focus Group)

DECREASED SELF-DETERMINATION IN THE PRESENT

In contrast to the past way of life, participants have indicated a community-centred dominant logic is no longer present. Government social programs have led to decreased reliance on family and community and a growing reliance on government assistance (via the First Nation administration). The new generation of community members faces new challenges. With the increase in government involvement, a portion of the community members engages in day-to-day living that is in relationship to services provided by their First Nation administration. On the other hand, government programs have less impact on those with stable employment.

There's this multigenerational reliance and dependence on the system, and when you've been told you can't do it, we'll take care of you, and all this paternalistic, systemic history, then why would you if someone can do it better? You listen to the doctor, you listen to the bureaucrat, you listen to the Chief and Council. If I have a problem I can run to them and they will help me, they will fix it. (Sudbury Focus Group)

RESTORATION OF COMMUNITY VALUES

Connected to reflections of decreased self-determination in the past, participants called for a return to community values such as sharing, helping and teaching one another and self-determination. Suggested pathways to this include a return to gardening, hunting,

fishing and exploring unique economic opportunities such as ecotourism, partnering with industry and promoting more businesses in the community.

We relied so much on our natural environment. We have people who have so much knowledge about, you know, trails and old, you know, best fishing spots and prime areas for agriculture, things like that [...]. So getting people to be more business minded and to look at things as how they can fit themselves into an opportunity is sort of what we're trying to focus on as well, so going back to some of the natural resource stuff. (Algoma Focus Group)

MINO-BIMAADZIWIN THEMES

GREATER MINO-BIMAADIZIWIN IN THE PAST

A parallel to a greater sense of self-determination in the past is a greater sense of *mino-bimaadiziwin* in the past evidenced by recollections of the consumption of natural foods from gardens, farming, hunting, and fishing. Regular physical activity was a common occurrence with children and youth at play outside and most economic activities incorporated manual labour. Given the community-centredness in the past, there was more socializing, a strong work ethic, sharing, and helping.

Our parents had gardens going. There [were] vegetables, potatoes, carrots, turnips and then peas and beans. There was no such thing as fertilizer. They were just plain from the garden and then we had moose meat, deer meat, rabbits and partridges and chickens, and then we got eggs served from the chickens. (Algoma Focus Group)

INCREASED CHRONIC DISEASE AND POOR DIET

There is a noted increase in chronic diseases in the present. Diabetes, cancer, and arthritis are significant in the First Nations. The introduction of commercial food is a cause for poor health outcomes.

When you look back as to what you ate when you grew up, that was really good and healthy, but today we have so much processed foods, we get a quick burger here and there, that food is not healthy, and our systems can't digest that. (Algoma Focus Group)

INCREASE IN TECHNOLOGY AND MATERIALISM

Participants reflected and observed the growth in technology has an impact on individual, family and community wellbeing. Technology such as satellite television and

video-gaming has influenced critical socialization that took place in the past where community values dominated, and Indigenous teachings shared, and physical activity took place with alternative activities such as outside play by children and youth. In effect, an individualizing process is under way that is transforming community-centric First Nations to an individual-focused livelihood. In turn, materialism has impacted community members with an unequal accumulation of material goods associated with employment. Materialism and technology have compromised community socialization, while materialism, in particular, has led to jealousy.

It just seems like the mentality is everybody for themselves. Somewhere along the lines, it shifted from I'm going to do something selfless to make you happy because I know if I'm in the same situation, someone will do it for me. But now it's turned into I don't think I'm going to do that because when I'm stuck in a tough spot, no one's going to help me. (Sudbury Focus Group)

UNEMPLOYMENT LEADS TO POOR MENTAL HEALTH

The final theme we found in our research was the connection between unemployment and poor mental health. Participants who were employed reflected upon the impact it had on the individual and noted it provides one with a sense of accomplishment, increase in self-esteem and confidence, feelings of purpose and identity, and it decreases stress. In turn, unemployment leads to poor mental health and may lead to drug and alcohol abuse.

40 percent of our band membership right now is on [sic] poverty, they just don't have enough to go around. So what kicks in? Drugs. What kicks in? Alcoholism. What kicks in is family breakups, what kicks in is the more need of other services. So it's a long, long drawn out situation that we're faced with right now that was put here in (First Nation) by another government, not by our people, but now our people are so engrained in this mentality that somebody else is going to take care of us. (Manitoulin C Focus Group)

DISCUSSION

Our discussion begins with a return to the original research question guiding our research project: How is *mino-bimaadziwin* in First Nations communities influenced by socioeconomic factors at the individual, community, nation and service systems levels? Based on focus groups held in First Nations in the Districts of Algoma, Manitoulin, and

Sudbury, we discuss these findings within the context of colonialism as a determinant of health.

Participants' narratives of social and economic histories characterized the past as being focused on community and family. Social welfare programs were limited, and the First Nation administration was a small fraction of what it is today. As such, individuals had no choice but to rely on family and community as a support network. Economic opportunities on the First Nation were limited, and there was a reliance on seasonal employment off the First Nation such as in forestry, mining, blueberry picking, and making tourist crafts and work at tourist lodges. The limited economic options were offset by alternative subsistence through fishing, hunting, and gardens. Limited technology resulted in physical play taking place outdoors by children and youth, and the near absence of television meant socializing held with community members as a form of entertainment, and more importantly, as a way to pass community knowledge and history to the next generation.

In the past, First Nations *mino-bimaadiziwin* in our study area was community-centred and non-materialist. The absence of materialism meant that possessions did not drive social class positioning, and community members lived a relatively egalitarian way of life. Community values emphasized social relationships and connections to the land. It was common for community members to hunt, fish, harvest traditional medicines, and engage in gardening. A community transmission of these practices took place given the community-centred logic that dominated at the time. First Nation administrative programs were limited and had relatively little impact on the day-to-day living of community members. In the past articulations of health, the communities relied mostly on natural foods that were hunted, fished or grown and there was a strong sense of community with seasonal employment taking place to meet basic needs. Upon reflecting on the past, participants concluded: "*We were poor but didn't think we were poor*" (Manitoulin B Focus Group).

The present way of life for First Nations in our study portrays as the opposite of the past. Employment is now mostly on the First Nation with the bulk of it being with the administration in the areas of social services, education, health services, law enforcement and to a lesser extent, small businesses. There has been a significant improvement in

social welfare programs and in turn family and community no longer provide social welfare functions. The marked improvement of government services means all possess necessities for living. Materialism is the new reality for First Nations where material goods mark differences associated with employment. Technology has furthermore shifted entertainment options from storytelling and outdoor play to television viewing and video-gaming.

Technology has further impacted physical wellbeing. Children and youth no longer engage in outdoor play to the extent they did in the past. Automotive vehicles have replaced walking and machinery has replaced physical labour in farming and forestry. The increase in stable employment or access to social assistance has resulted in more reliance on the grocery store and less on gardening, fishing or hunting. We note these practices are not absent since hunting and fishing still take place and there are some who retain gardening, and there has even been a community garden project in one of the First Nations in our study. However, First Nations do not rely upon hunting and fishing to the extent they did in the past.

Based on the focus groups, a confounding issue for the First Nations in our study is the increase in chronic diseases such as diabetes and cancer. Diabetes and cancer were not common in the past and participants speculated that limited physical activity and diet connects to the present manifestation of a chronic disease.

Mental and social health issues have increased. In particular, there has been a shift in identity and the community social fabric. There is less of a reliance on community, and individualism is something new that is taking place. Correspondingly decreasing mental and social wellbeing is due to what we refer to as a diminishing of cultural practice. Though participants did not explicitly reference social changes as relating to culture, our research suggests socialization and connections to the land are integral to Indigenous cultural practice. Culturally distinct storytelling and knowledge dissemination of hunting and fishing took place as part of community socialization in the past and in the present this is compromised with less reliance on this form of livelihood and a decrease in community-level socialization. There is furthermore a shift in identity taking place. Family, community, and land formed an integral form of subsistence and were core to one's being. For the unemployed portion of the First Nations in our study, a reliance on

social welfare, and the community divisions between those with and those without resources have shifted the meaning of livelihood. The limited opportunities are creating schisms in the community. In recognition of this issue, a participant remarked, “*we stopped sharing when we became civilized*” (paraphrased, Algoma Focus Group). Complicating this divide is drug and alcohol abuse and the increase in chronic diseases. In reflecting upon the present, we found participants evoked the memories of past *mino-bimaadiziwin* as a way to inform a pathway to a better future.

There is hope for a healthier today and route to address social problems and chronic disease and the increasing reliance on social welfare programs. By way of reflecting upon the past, participants called for a return to natural foods and less of dependence on social welfare programs and reliance on community. In turn, more financial investments are required to address unemployment in the First Nations. We found community members in effect were generous in the social and cultural capital in the past but had little money. In contrast, there is an increasing divide in the levels of materialism at present, and there is less community-wide social and cultural capital.

We now turn our discussion to situating our findings and discussion in the broader literature. Our research findings are consistent with those of Czyzewski (2011) and Jacklin and Warry (2012), which trace the emergence, and implications of colonialism as a determinant of health. Our findings are furthermore consistent with Warry’s (2007) study that found the development of social class structures forming on First Nations due to limited economic opportunities and the consequent growing reliance on social welfare (Boldt, 1993; Warry, 2007).

As we have noted, previous research has focused on macro (or distal) elements of colonialism (e.g. government policy, racism) and its manifestation as a determinant of health and the emphasis is on the lack of control or the imposition of another way of life by a non-Indigenous settler society. The embodied articulation of this manifestation is absent in these studies. Our research illuminates an integrated articulation of this process; specifically how distal structures are changing and shifting individual-family-community relationships. Based on our results, we have developed a conceptual model that illustrates how these distal structures impact on the experience of *mino-bimaadiziwin* (Figure 1).

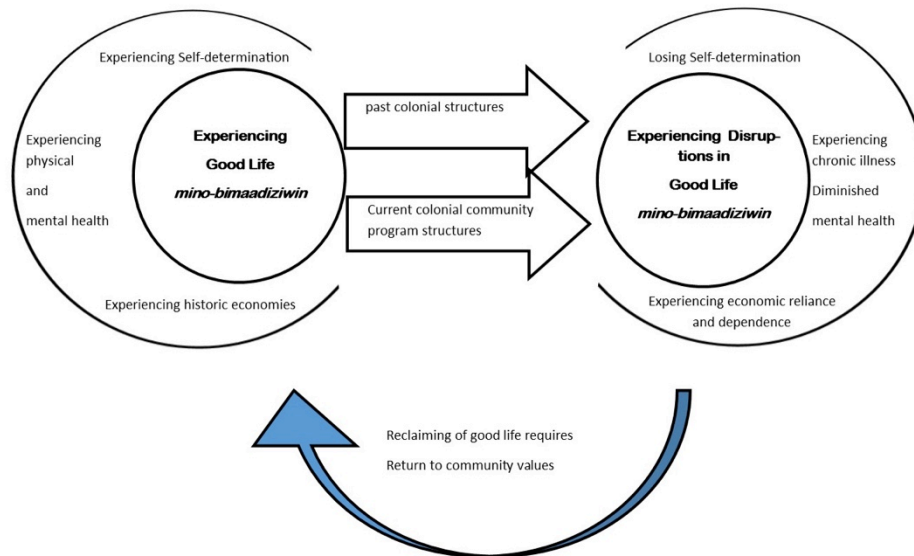


Fig. 1: Conceptual Model for the Impact of Colonial Pressures on the Anishinabek Mino-Bimaadiziwin

On the surface, it would seem the infusion of government capital in the provision of social, economic, and political services would result in an improvement in Indigenous health. However, using the Indigenous concept of *mino-bimaadiziwin*, it is clear that colonial structures do not support the experience of the good health at the individual or community level. In our research, participants equated self-determination, good physical and mental health, and historic economies with the experience of good health. However, the effect of past colonial practices on *mino-bimaadiziwin* is exacerbated by the insidious colonial approach to current community programming. For example, our research findings suggest that since the government in effect stipulates how programs operate, the controlling manner in which services occur gives the impression the services are First Nations controlled when in fact there remains indirect government control of Indigenous populations. Therefore, the experience for many individuals remains a loss of self-determination and economic dependence. These distal structures, in fact, have gradually modified Indigenous governance structures that existed before World War II in the form of reciprocity, egalitarianism, community-centredness, and connection to the land and

Indigenous knowledge derived from the intersection of these components. Our model illustrates this interrelationship between colonial socioeconomic pressures and a disruption in the experience of good health, Anishinabe *mino-bimaadiziwin*.

CONCLUSION AND FUTURE RESEARCH

Past colonial policies such as the Indian Act restricted and compromised Indigenous sovereignty. Treaties ended sovereignty over lands and limited access to regional resources and hence negatively affected livelihoods. Residential Schools and social service organizations took many children away from homes (known in Canada as 'the Sixties Scoop'). The existing literature on the colonialism as a determinant of Indigenous peoples health demonstrates how these aspects have impacted Anishinabek *mino-bimaadiziwin*.

Our research examined the community perceptions of socioeconomic wellbeing in the past and present in light of increased federal and provincial socioeconomic interventions in the present. Rather than improving wellbeing, research participants suggest these interventions function as a continuation of colonialism. The controlling manner in which the provision of socioeconomic interventions via social services, different economic options, and decreased community control has led to a restructuring of colonialism in Canada that has impacted Indigenous health. The narratives captured in our research reveal that the Anishinabek First Nations do not object explicitly to the introduction of social and health services and economic change. They object to the lack of control and the consequent lack of a quality of life that has resulted in the manner in which these services occur. First Nations in our study advocate for more control of their political and social circumstance as a pathway of addressing colonialism as a determinant of Indigenous peoples health. Our model illustrates this pathway from the perspective of the experience of *mino-bimaadiziwin*, the Anishinabek understanding of good health. It serves as a guide to estimate the impact of socioeconomic and health programs at the community level. Based on our model community programs must focus at the same time on good health/mental health as well as bolster self and economic self-determination in order to support good health, *mino-bimaadiziwin*.

Future research needs to address how transformative socioeconomic and health models of service delivery are necessary to address the problem of lack of Indigenous control. There are other First Nations-provincial-federal models that have emerged and merit consideration. The British Columbia First Nations Health Authority may offer a practical pathway to addressing colonialism as a SDoH. The B.C. model, informed by the SDoH framework, involves Indigenous participation in program and service delivery incorporating cultural safety and Indigenous conceptions of health (O'Neil et al., 2017). The model collaboration in B.C. and the T.R.C.'s calls to action to reconcile the legacy of colonial policies offer promising frameworks to address colonialism as a SDoH of Indigenous health in Canada.

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REFERENCES

- Anishinabek Nation. (n.d.). The Anishinabek Nation Economy: Economic Blueprint.
Retrieved from <http://www.anishinabek.ca/nation-economy-blueprint.asp>.
- Association of Ontario Health Centres. (n.d.). Aboriginal Health Access Centres.
Retrieved from <https://www.aohc.org/aboriginal-health-access-centres>.
- Bernard, H. (2011). *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. Toronto: AltaMira Press.
- Boyer, Y. (2014). *Moving Aboriginal Health Forward: Discarding Canada's Legal Barriers*. Saskatoon: Purich.

- Boldt, M. (1993). *Surviving as Indians: The Challenge of Self-Government*. Toronto: University of Toronto Press.
- Buse, D., & Mount, G. (2011). *Come on over!: Northeastern Ontario, A to Z*. Sudbury, ON: Scrivener Press.
- Czyzewski, K. (2011). Colonialism as a Broader Social Determinant of Health. *The International Indigenous Policy Journal* 2 (1): Article 5.
<http://ir.lib.uwo.ca/iipj/vol2/iss1/5>.
- Greenwood, M., de Leeuw, S., Lindsay, N., & Reading, C. (Eds.). (2015). *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social*. Toronto: Canadian Scholars' Press.
- Jacklin, K. & Warry, W. (2012). Decolonizing First Nations Health. In J. Kulig & A. Williams (Eds.), *Health in Rural Canada*, (pp. 373-389). Vancouver: University of British Columbia Press.
- Jacklin, K. & Kinoshameg, P. (2008). Developing a Participatory Aboriginal Health Research Project: "Only if it's going to mean something." *Journal of Empirical Research on Human Research Ethics*, 3(2), 53-68.
- Madahbee, D. (2015). Everyone benefits when Aboriginal enterprise succeeds. *Northern Ontario Business*, Aboriginal Business, July, 26.
- Maar, M. (2004). Clearing the Path for Community Health Empowerment: Integrating Health Care Services at an Aboriginal Health Access Centre in Rural North Central Ontario. *Journal of Aboriginal Health*, January, 54-64.
- O'Neil, J., Gallagher, J., Wylie, J., Bingham, B., Lavoie, J., Alcock, D. & Johnson, H. (2016). Transforming First Nations' health governance in British Columbia. *International Journal of Health Governance* 21(4), 229-244.
- Reading, C. (2015). Structural Determinants of Aboriginal Peoples' Health, In M. Greenwood, S. de Leeuw, N. Lindsay & C. Reading (Eds.), *Determinants of Indigenous Peoples' Health in Canada*, (pp. 3-15). Toronto: Canadian Scholars' Press.
- Reading-Loppie, C., & Wien, F. (2009). *Health Inequities and Social Determinants of Aboriginal Peoples' Health*. Prince George, BC: National Collaborating Centre for Aboriginal Health.

- Scott-Kelly, K. (2016). Aboriginal peoples: Fact Sheet for Ontario. Retrieved from www.statcan.gc.ca/pub/89-656x/89-656-x/89-656-x2016007-eng.pdf.
- Smylie, J. (2009). The Health of Aboriginal Peoples, In D. Raphael (Ed.), *Social Determinants of Health: Canadian Perspectives Second Edition* (pp. 280-304). Toronto: Canadian Scholars' Press Inc.
- Surtees, R. (1994). Land Cessions, 1763-1885, In R. Rogers & D. Smith (Eds.) *Aboriginal Ontario: Historical Perspectives on the First Nations* (pp. 92-121). Toronto: Dundurn Press. Truth and Reconciliation Commission of Canada. (2015). *Honouring the Truth: Reconciling for the Future. Summary of the Final Report of the Truth and Reconciliation Commission of Canada*. Retrieved from http://nctr.ca/assets/reports/Final%20Reports/Executive_Summary_English_Web.pdf
- Union of Ontario Indians. (2016). Health Overview. Retrieved from <http://www.anishinabek.ca/departments/health-secretariat-2/overview/>.
- Warry, W. (2007). *Unfinished Dreams: Community Healing and the Reality of Aboriginal Self-Government*. Toronto: University of Toronto Press.

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