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Diversity within: Deconstructing Aboriginal community health in Wikwemikong Unceded Indian Reserve

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ABSTRACT

This paper analyzes the community health of the Wikwemikong Unceded Indian Reserve (WUIR), Ontario, Canada. Results are reported from fieldwork including participant observation, key informant interviewing and self-reported data measuring health status, risk behaviour, place of residence, self-identity, and personal history extracted from 350 interviews conducted during a community-wide needs assessment. The research aimed to create a health plan for the community; however, subsequent analysis of the needs assessment results indicates that internal diversity exists in health status and needs between the seven villages that comprise WUIR. The analysis suggests variation in health status and risk-taking behaviour among community members may be related to varying colonial histories among the villages. The implications of intra-community variation in health status in First Nations are discussed in relation to influential health policy theories such as the determinants of health and health transfer policy in Canada.

Introduction

All First Nation communities are unique. Garroutte, Kunovich, Jacobson, and Goldberg (2004: p. 2235), writing about the Cherokee, describe how members of the same tribe often constitute a multi-ethnic population with some members identifying strongly with Cherokee culture and others with Euro-American culture. Ellerby, McKenzie, McKay, Gariépy, and Kaufert (2000: p. 847) describe the variation in Aboriginal cultures found in Canada and discuss how the introduction of Christianity increased that diversity. In Canada there are 608 First Nations, 52 main cultural groups, and over 50 languages (Indian and Northern Affairs Canada [INAC], 2006). The term First Nation replaces the term "band" and is used to refer to Indian communities or people but not Inuit or Métis. Aboriginal is used to refer collectively to all Indians, Inuit and Métis peoples as defined in the Constitution Act 1982, Section 35 (Waldram, Herring, & Young, 2006). Numerous studies confirm the abysmal state of health experienced by First Nation communities (Canada, 2001; FNIRHS, 1999; Health Canada, 1996, 1999; Mao, Moloughney, Semenciw, & Morrison, 1992). Research with a greater community-level focus demonstrates that even closely related First Nation communities may have different health experiences (Beckett, 1998; Herring, 1994; Proulx & Turcotte, 1996).

The anthropological research reported in this paper was conducted with the Wikwemikong Unceded Indian Reserve (WUIR) from 2000 to 2002. WUIR is the largest community on Manitoulin Island, Ontario, Canada, with 2700 on-reserve members. It is the ancestral home of three Anishnabe (Algonkian) cultures: Odawa/Ottawa, Ojibwa and Pottawatomi. It is comprised of seven villages dispersed over 105,300 acres of land. The main village of Wikwemikong is the largest and contains the majority of services. The remaining six rural villages are known locally as the satellite villages (Fig. 1). Municipal services (e.g., water, sewer) are only available in Wikwemikong village. Although these villages are neither isolated nor completely distinct from each other, each has their own history, geography, resources and needs.

The focus of this paper is on variation in health needs and health status among the villages in WUIR and how observed inequalities in health are related to intra-village variation in colonial experiences. The findings are discussed in relation to the determinants of health model which shapes health policy in Canada. It is argued that the notions of culture and colonialism must be more carefully considered as predominant forces in the interplay of determinants of health for First Nations. Demonstrating and understanding heterogeneity has important implications for the application of Aboriginal health policies, such as health transfer policy in Canada. This policy provides First Nations in Canada with the option to transfer funding for the administration and delivery of health programs from the federal government to local governance. It advocates the provision of culturally appropriate and community

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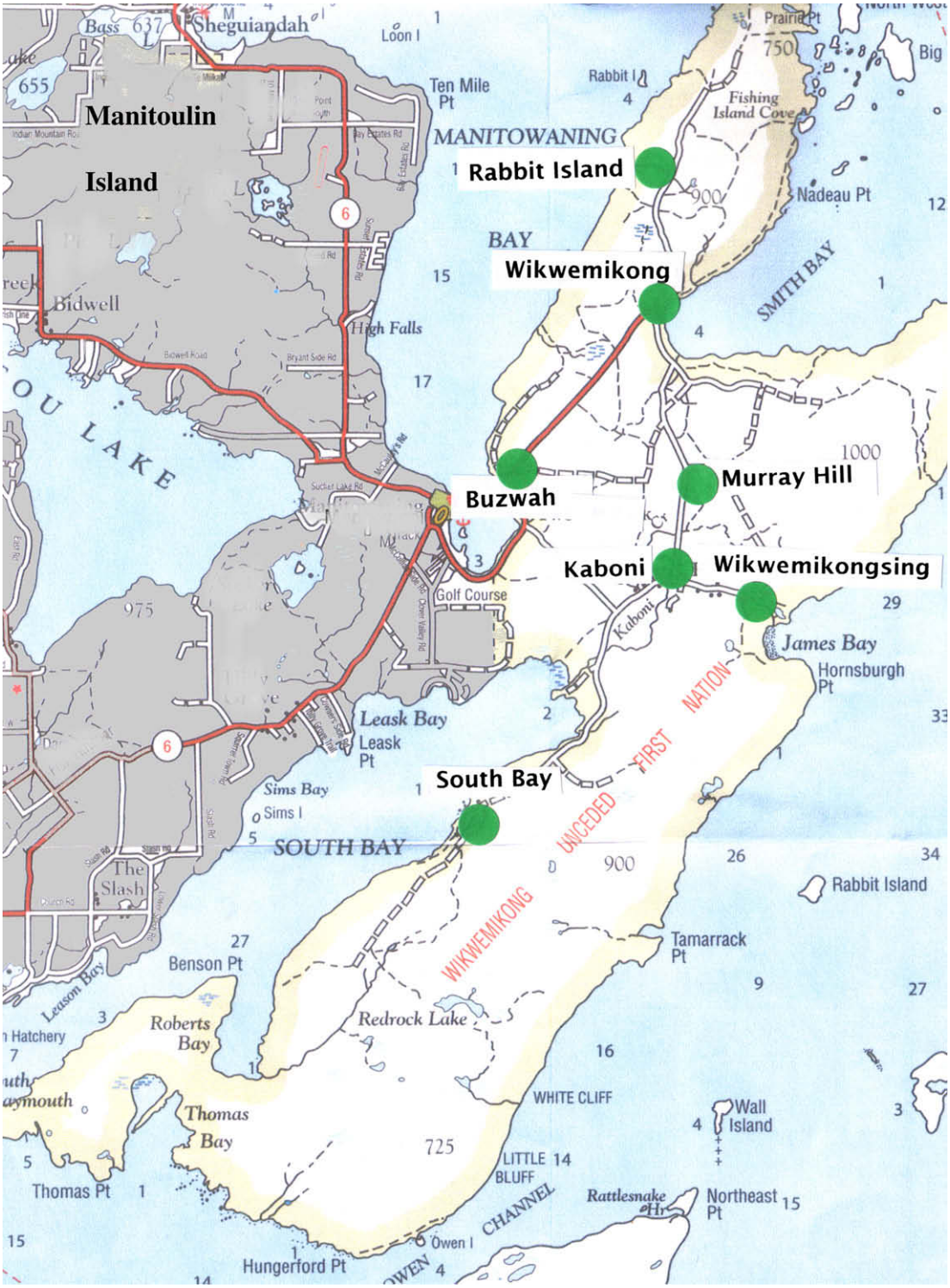

Fig. 1. Map of Wikwemikong villages.

specific health care programs and self-determination (Canada, 1986; Health and Welfare Canada, 1992). The WUIR entered into its first Health Transfer Agreement with the federal government in 1994 and renewed this agreement in 2000 and 2005. As such the local governance is charged with the task of designing and delivering health programming geared to local needs within the parameters of this policy (Jacklin & Warry, 2004).

The degree of influence colonial processes have had on each village is gauged by an examination of the villages' potential for interaction with colonial forces. Specifically I consider for each village: the presence of government or church run schools, churches or missions, the number of people who attended residential schools or who had parents attend residential schools, and the degree of economic/government interest in the village as