POWER AND POLITICS: THE IMPACTS OF SETTLER COLONIALISM ON HEALTH INTERVENTIONS TARGETING INDIGENOUS CANADIANS

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"We must reflect on power as a complicated field of relations, in order to fully understand how it acts on people who are the targets of global health interventions".

Abstract:

Since the colonisation of their land in 1534, Canada's Indigenous population has suffered adverse health outcomes of colossal magnitude. The intergenerational impacts of such events persist in the current day, with contemporary Indigenous Canadians experiencing extreme health disparities in comparison with their non-Indigenous counterparts. Consequently, Indigenous Canadians are targeted by numerous health interventions which, despite claiming to improve health outcomes, often see no benefit and more concerningly, reinforce negative health behaviours and spur discrimination, thereby propagating Canada's neo-colonial political agenda. This narrative essay employs Patricia Hill Collins' matrix of domination to explore the power relations underpinning such health interventions and provides recommendations for reforms within Canada's healthcare system. Although Indigenous activism and sovereignty are occurring within the hegemonic and interpersonal domains of power, the studies analysed herein reveal that many health interventions fail to yield positive results due to persistent racist legislations and establishments within the structural and disciplinary domains of power. As such, nationwide political reforms must move beyond encouraging simple 'partnerships' between Indigenous and Euro-Canadian healthcare officials, to foster true Indigenous healthcare leadership and autonomy.

Resumé:

Depuis la colonisation de leur territoire en 1534, les populations autochtones du Canada ont souffert de problèmes sanitaires d'une ampleur colossale. Les impacts intergénérationnels reliés à ces enjeux persistent de nos jours : l'état de

santé des personnes autochtones du Canada aujourd'hui montre des inégalités extrêmes avec celui des personnes allochtones. Par conséquent, les autochtones sont les cibles de plusieurs interventions sanitaires qui devraient améliorer leur santé mais qui n'offrent souvent aucun bénéfice. Plus inquiétant encore, ces interventions tendent à renforcer des comportements sanitaires néfastes et encouragent la discrimination. Elles perpétuent ainsi l'agenda politique néocolonial du Canada. Cet essai narratif utilise le concept de matrice de domination de Patricia Hill Collins pour explorer les relations de pouvoir sous-jacentes à ces interventions sanitaires et offre des recommandations de réformes pour le système de santé canadien. Bien que l'activisme et la souveraineté autochtones se produisent à même les sphères hégémoniques et interpersonnelles de pouvoir, les études sur lesquelles s'appuie cet essai suggèrent que plusieurs de ces interventions sanitaires ne parviennent pas à obtenir des résultats positifs en raison des mesures législatives et d'institutions racistes à l'intérieur des sphères disciplinaires et structurelles du pouvoir. En ce sens, des réformes politiques nationales doivent faire davantage que d'encourager de simples partenariats entre les responsables autochtones et euro-canadiens de la santé afin de promouvoir un leadership et une autonomie véritables en soins de santé autochtone.

Key Words

Indigenous – Canada – healthcare interventions – power – politics

Introduction

The phenomenon of power is long contended within the expansive sphere of health, from its direct effect upon individuals' abilities to lead disease-free and fulfilling lives, to its entrenched and pervasive governance of global healthcare agenda-setting. In its most basic form, power has been defined as the "ability to act or affect something strongly" (Oxford English Dictionary, 2006). However, to more scrupulously understand how power, and its accompanying politics, act on people, multiplex conceptualisations must be employed. Patricia Hill Collins, author of Black Feminist Thought, comprehends power in terms of the dialectical interconnectedness of oppression and empowerment; applying black feminist epistemology to illuminate this intersectionality. Collins puts forth a matrix of domination, wherein power (and coincident empowerment) can be understood to function within four interlinked domains, those being: the structural domain, relating to the macro-organisation of social institutions; the disciplinary domain, comprising position-

ality and legislative authority; the hegemonic domain, involving discourse and symbolism; and the interpersonal domain, concerning the micro-organisation of daily social practices.

Collins' framework provides a medium to navigate through various dynamics within global health, particularly, the relationship between health interventions and the targets upon which they act. Such interventions are often so socioeconomically, politically, culturally and geographically distanced from those they aim to 'help', that any immediate relief is soon negated by the concealed exacerbation of inequities that the strategies deliberately fail to address (Abimbola, 2018). Thus, the elite group of wealthy, political and technocratic global health actors retain their power whilst propagating the false imagery of philanthropism and humanitarianism. An example of such targets is Canada's Indigenous population, for whom contemporary racism and social exclusion comprise the legacy of European settler-colonialism. This essay will refer to Collins' framework to dissect the complex field of power relations underpinning interventions that have targeted Indigenous Canadians, critique their pitfalls and provide recommendations for their rectification.

Colonialism and Indigenous Health

Canadian Independence Day is commemorated on the 1st of July, with 2022 marking 155 years since the three colonies of United Canadas, Nova Scotia and New Brunswick merged to form Canada, a self-governing dominion of the British Empire, which gained full constitutional autonomy following the Canada Act of 1982. These historical landmarks are paramount within the Canadian educational system. Less frequently discussed, however, is the year 1534, in which the territory was brutally claimed by the French, and excluded from mainstream curricula entirely is the land's preceding twelve-millennia inhabitation by its Indigenous peoples (Donald, 2012). Donald remarks that "the average Canadian citizen comprehends colonialism as something that happened elsewhere, like Africa or Asia" (p. 91), displaying ignorance towards the barbarous European settler-colonialism regime that Aboriginal Canadians were subjugated to. Unlike the countries ravaged during the New Imperialism era, such as the Democratic Republic of the Congo and India, for whom independence days represent their peoples' emancipation from a colonial empire, Canada's 'independence' day did not see the returning of the land to its Indigenous inhabitants. On the contrary, Indigenous Canadians continue to suffer great socioeconomic, political and health-related inequities compared with their non-Indigenous counterparts, facilitated by the persistence of prejudicial laws that spur their marginalisation in contemporary Canada (Matthews, 2019).

Existing within the disciplinary domain of power, specifically within Canada's healthcare system, an example of colonial legislation that remains to control the oppression of Indigeneity is The Indian Act, passed in 1876 to systematically discriminate against Indigenous peoples by restricting their rights, movements and cultural practices (Nixon et al., 2018). This legislation confers the Federal Government the authority to decide who is legally 'Indian', a precursor to receiving official status that entitles Indigenous persons to health insurance, amongst other benefits (and restrictions). However, many Indigenous Canadians, notably those of Inuit and Métis subpopulations, are unable to meet the overly bureaucratic criteria. Such individuals are therefore forced to pay crippling out-of-pocket sums of money when seeking healthcare. Canadian Indigeneity is consequently inextricably linked with poor health, resulting in critically high rates of mortality attributable to suicide, domestic violence, murder and chronic diseases in Canada's Aboriginal population (Browne et al., 2022). For example, Turin et al. reported that a staggering 87.3% of First Nations females and 75.6% of First Nations males develop type II diabetes mellitus (T2DM) in their lifetime (2016). When compared with a national prevalence of T2DM that is approximately ten-fold lower at 7.8% (Statistics Canada, 2021), the grave health disparities between Indigenous and non-Indigenous Canadians are exposed.

Conformist hegemony has long attempted to quash the historical impact of centuries of ruthless colonialism on Canadian Indigenous peoples within conventional global health discourses, yet indefatigable activism and litigation within this domain have made some headway in terms of political accountability and acknowledgement. Nonetheless, this recognition is still to be accompanied by robust empirical research into how neo-colonialism impacts the current health of Indigenous peoples (Madokoro, 2019).

Indigenous Healthcare Injustices in Canada

Within Canada's contemporary healthcare regime, Indigenous needs are confronted by systemic racism that is embedded within the structural and disciplinary domains of power, manifesting as inequitable healthcare institutions and unjust resource allocation, respectively, thus contributing to the ongoing ethnocide of Aboriginal Canadians (Matthews, 2019). Such discrimination occurs at both a national level, exemplified by the chronic underfunding of nursing stations in Indigenous communities (Officer of the Auditor General of Canada, 2015), and at an individual level, with the death of Brian Sinclair subsequent to his being left untreated for thirty-four hours in an emergency room in Winnipeg being a prime example (Brian Sinclair Working Group, 2017). These are not anomalous occurrences in which

the Canadian healthcare system has failed, rather they represent the "ongoing structure of domination" and systemic violence that prioritises Euro-Canadians' (those with European ancestry) health and rights over those of non-Euro-Canadians, notably the Indigenous population (Wolfe, 1999). These instances expose neo-colonialism as the overarching distal social determinant of ill-health for Indigenous Canadians, birthing intermediate determinants such as the inability to maintain a cultural identity, which in turn form the proximal determinants that operate within the interpersonal domain of power, manifesting as poverty and everyday racism, (Jaworsky, 2018; Matthews, 2019).

Notice how the aforementioned events have been documented in oversimplified, prosaic government texts or underfunded support-group reports rather than in scholarly literature. This censorship represents the complicit marginalisation of Indigenous intelligentsia, strife and triumph from the global stage. Historically, the majority of publications recounting the subject of Indigeneity in peer-reviewed journals has been accredited to Western authorship, thereby fabricating a Eurocentric narrative that appropriates and undermines the authentic Indigenous experience (Dei, 2000). However, as previously mentioned, resistance has been cultivated within the hegemonic domain of power. Indigenous scholars have challenged mainstream ideologies in this closed scholastic space, whilst concomitantly claiming a distinct space within academia that is populated by both ancient Indigenous wisdom and evolving Indigenous knowledge and experience (Pidgeon, 2016).

Healthcare Interventions Targeting Indigenous Canadians

The literature detailing interventions aimed at Indigenous Canadian communities reveals that they have been largely unsuccessful. For example, the Pelletier, Smith-Forrester and Klassen-Ross systematic review published in 2017, researching the effectiveness of five physical activity interventions targeting Indigenous Canadian adults, reported only minor health gains, with merely one intervention successfully reducing BMI and two interventions minimally decreasing systolic blood pressure and cholesterol. In fact, detrimental effects were more frequently observed, with two interventions leading to long-term decreases in participants' physical activity levels. Investigation into the reasons behind these interventions' inefficacy ought to have been conducted, or at the very least hypothesised, in order to improve future research attempts, yet there was no mention of this in the article. One possible explanation for the studies' failure could be attributable to the investigators' lack of reflexivity regarding their positionality and biases, concepts that exist within the disciplinary and interpersonal domains of power, respectively. Four of the five studies included in the review trialled interventions that involved

"supervised" physical activity. The authors asserted that supervision was necessary to ensure the participants' "adoption" of Western lifestyle habits. However, this terminology lends to the notion that Indigenous people lack autonomy and ignores the imposition of sedentariness onto Indigenous communities by way of barriers, such as overcrowding and the absence of outdoor illumination, which hinder residents from undertaking physical activity on the isolated reserves onto which they have been ousted (Frost et al., 2010). Notice the concomitant demonstration of hegemony, with the authors selectively employing a discourse that shifts the blame from the system to the individual. Furthermore, the studies were short in duration, lasting between thirteen weeks and twenty-four months, with the authors concluding that it was "unclear whether any of the interventions […] [were] maintained or if […] [the] study findings [were] transferred to the communities" (Pelletier, Smith-Forrester and Klassen-Ross, 2017, p. 247). This indicates that the studies served a checkbox purpose rather than a genuine effort to curb inequalities, as the latter would have involved long-term follow-up and exploration of the interventions' shortcomings with subsequent recommendations for future trials.

A more recent systematic review studied the efficacy of school-based nutritional interventions targeting First Nations Indigenous schools (Gillies et al., 2020). The nature of this research reveals inequalities amongst different Indigenous Canadian groups, evidencing the tendency for studies to focus on First Nations communities, resulting in a more pronounced underrepresentation of Inuit and Métis populations. Referring back to Black Feminist Thought, Collins remarks that at any given point in time, all individuals derive both advantages and disadvantages from a multitude of coexisting power relations (2002). Within the oppressed, there remains a hierarchy of privileges spurring survival.

Gillies' review also demonstrated little success, with the authors of included studies repeatedly shifting the blame to individuals' and their choices, rather than appreciating the contextual constraints of Indigeneity in Canada. In terms of nutrition, the traditional Indigenous Canadian diet is far healthier than that of the West, comprising unprocessed foods rich in vitamins and minerals and low in saturated fats (Bruner and Chad, 2013). However, Indigenous communities have been stripped of their ability to hunt and eat as per their culture (recall The Indian Act) and residents of reserves are subject to extreme financial insecurity and food shortages, with residents resorting to inexpensive processed foods to mitigate the lack of affordable fresh produce (Fieldhouse and Thompson, 2012). As per Collins' matrix of domination, we can extrapolate that this is not an unintentional error. Rather, it embodies the deliberate exertion of structural power over Indigenous communities – in minimising the availability of nutritious food options, the Canadian government continues to tighten its

control over Indigeneity by propelling individuals towards harmful food items that sustain adverse health sequelae, whilst concomitantly fuelling consumerist habits that fund the inequitable food industry.

In both reviews, the researchers have ignored race where it ought to be acknowledged; a phenomenon Collins coined 'colour-blindness' (2015). Perhaps if the barriers to physical activity and healthy nutrition were addressed by subsidising streetlamps and providing adequate nutritional sustenance in reserves, for example, Indigenous health outcomes in Canada would improve without the need for resource-intensive interventions. Evidently, this would only be the tip of the iceberg, however, relatively simple, locally led strategies have been shown to yield appreciable effects among Indigenous communities globally (Gracey and King, 2009; McDermott et al., 2001). The verticality of the strategies presented in the aforementioned systematic reviews demonstrate that the biomedical, technocratic and positivist Western approach to health and healthcare is not applicable to all contexts. The Western healthcare model is founded upon the treatment of diseases through commercially manufactured drugs, with interventions being assessed by their ability to produce quantitative statistical evidence. It is unjust to employ Western tools to evaluate non-Western healthcare systems and doing so tremendously underestimates the benefits and successes of alternative epistemologies. Indigenous communities cannot (and should not have to) 'prove' their customs' efficacy by Western standards of measurement.

Recommendations

The Indigenous Canadian model of health rejects mind-body dualism and materialism, encompassing a broader outlook of wellbeing based upon the right to self-determination and the interdependence of the individual, community and land (Gallagher, 2019). Aboriginal cultural healing practices were violently effaced by settler-colonialism and continue to be suppressed by contemporary government policies, leading to negative health outcomes. Canada's indifference towards the colonial trauma inflicted upon Indigenous peoples has diminished Aboriginal individuals' and communities' confidence in the conventional healthcare system. However, emerging evidence has revealed that a pivotal method of trust-building and hence reduction in Indigenous ill-health occurs via Indigenous-led partnerships with mainstream Canadian health services. Such collaborations must be grounded in Indigenous wisdom, acknowledge the lasting impact of colonialism and tackle the social determinants of Indigenous health (Allen et al., 2020).

Allen et al.'s report stipulates instances wherein such partnerships were successful. For example, the Vancouver Native Health

Society, a multidisciplinary drop-in clinic established in 1993, provides both traditional Indigenous and Western healthcare services. Community Elders employ cultural teaching circles to explore detrimental behaviour patterns exhibited by patients and subsequently break these cycles. A participatory observation study revealed that this technique reduced substance use from 100% to 42% within a five-year period (Benoit, Carroll and Chaudhry, 2003). On the basis of this example, Allen et al. constructed an inventory for Western-trained Canadian healthcare workers to foster collaborative environments that promote Indigenous inclusivity. The checklist's clauses include being reflexive of one's biases, admitting socio-historic injustices and learning from Indigenous practitioners. However, this framework remains flawed. Firstly, it implies that Indigenous peoples require 'modern' partnerships to reclaim their health. Matthews remarks that within the interpersonal domain of power, preservation of a cultural identity alone is an impactful protective factor against suicide (2019). Indigenous communities do not require Western input to thrive; they require self-government. Where Indigenous activism has assembled, for example the 'Idle No More' protests of 2012, resounding sentiments of Indigenous sovereignty and solidarity have proliferated (Barker, 2015). Secondly, it assumes that local Elders will readily divulge their sacred rites with the system that has exploited them for centuries. 92% of Indigenous patients who use traditional medicine fear disclosing this information with mainstream Canadian healthcare professionals (Shawande, 2010). This reluctance towards collaboration is justified given the potential for abuse of traditional wisdom, which could lead to the cultural appropriation of Indigenous methods through overharvesting of medicinal plants for commercial manufacturing, for example (Allen et al., 2020). Hence, official legislation embedded within the disciplinary domain of power is imperative to protect Indigenous knowledge, prevent tokenism and cultivate Indigenous leadership in Canadian healthcare.

Within international structural and disciplinary affairs, Canada boasts its foreign policy's commitment to multilateralism and the promotion of human rights (Bernauer and Slowey, 2020). Prime Minister Trudeau has pledged to "[return] to traditional Canadian values" by funding research in low- and middle-income countries to advance the nation as a global pioneer of socially progressive health equity (Nixon et al., 2018, p. 1736). However, this research has demonstrated that Canada's "traditional values" comprise the deep-rooted discrimination against Indigenous communities. For the Prime Minister's words to ring true, it is of cardinal importance that Canada redirects its focus internally by reallocating resources to tackle domestic inequities and improve the health of Indigenous peoples. Collins draws upon this irony, remarking that the racialised groups

that 'global health' claims to 'help' are often lost from the equation in the process of advancing large-scale corporate and political interests (2008). Likewise, health systems researcher, Seye Abimbola, reminds us that community- and domiciliary-level ventures generating tangible impacts on individual human beings' lives are of equal significance as mass-scale interventions targeting billions (2019).

Conclusion

In dismantling the power relations that underpin interventions targeting Canada's Indigenous population using Collins' power framework, one observes the interconnectedness of oppression and empowerment. The dialectical nature of these phenomena manifests as relentless subjugation and prejudice within the structural and disciplinary domains, opposed by intensifying solidarity and resistance within the hegemonic and interpersonal domains. Interventions that have aimed to improve Indigenous health outcomes have largely been unsuccessful, owing to the deep-seated Eurocentrism that pervasively endures within the contemporary Canadian healthcare system. Reductionist vertical interventions are not sufficient to bring about the radical social change that Canada requires to become a model of equity. Similarly, whilst the displays of Indigenous activism are admirable and crucial in maintaining a cultural identity, it is imperative that collective political action occurs within the structural and disciplinary domains to reform the colonial legislation that discriminates against Indigeneity. Power acts as a complex field of relations. As such, complex solutions are required to move towards a newfound 'politics of empowerment' (Collins, 2009), in which Indigenous communities are no longer on the side-lines and Elders are not tokens in commercialised Western health schemes, but autonomous leaders within a dual healthcare system.

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