COLONIZATION EMBODIED: DIABETES IN SHESHATSHIU

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To my Mother, who taught me how to listen

&

Thank-you to all of the people in Sheshatshiu who participated in this research, and to Peter, Trudy, Jackie, Ben, David, Molly and all of the other friends whose support and interest kept this project fresh and exciting.

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Abstract

This research explores the Innu experience of Type II diabetes in Sheshatshiu, Labrador. The unique political history and social structure of the Sheshatshiu Innu is linked to the historic and current provision of health care and the health status of Innu people in Sheshatshiu. An examination of the lifestyle and culturally relevant approaches to Type II diabetes indicates the trend towards individualism in public health, and the perseverance of colonial attitudes to native health. Innu conceptions and experiences of Type II diabetes emerged from an analysis of community-based, qualitative interviews conducted with Innu community members. The insights offered by the Innu illuminate the disease experience in Sheshatshiu, and are also relevant to native and non-native people across Canada. The interviews revealed that the Innu understand Type II diabetes to be a disease of colonization. The Innu argue that the broader political, legal and economic context must be considered in order to achieve health in Sheshatshiu.

June 26, 2006

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Glossary of Innu terms

akaneshau: white person

ashkui: open water in the ice (as defined in the *Labrador Project*)

atik'u: caribou

Innu Aimun: Innu language

Innu Eitun: skills for being out on the land living an Innu lifestyle

Innu Tukuna: Innu religion and medicine

kak'u: porcupine

mishum (nutshimit mishum): food (wild food)

Nitassinan (Ntesinan): Innu name for their homeland, the Québec-Labrador peninsula

nutshimit: the country/the land

Tshishennaut: Innu Elders

uapitsheshkamik'u: caribou lichen

utshimau: leader/leadership

Introduction

> The fact is that for the Innu health and ill-health are profoundly political issues, inseparable from social and economic considerations. The arrival of an elaborate health-care system among the Innu has coincided with a rapid overall worsening of Innu health. This is not to imply that one has led to the other but rather to emphasize that the health or ill-health of the Innu has been decided by factors that have very little to do with the health-care system. (Andrew and Sarsfield 1984: 429)

Currently, the government-owned Innu community of Sheshatshiu is located on the South side of Grand River at the head of Melville Inlet on the coast of Northern Labrador. Across the river the settler town of North West River occupies the original location of Sheshatshiu where, during the centuries before settlement, Innu camped in the summer months (Wadden, 1991). Like many other re-located native communities and reserves in Canada, Sheshatshiu is defined for the public and policy-makers by the medical gaze and the statistics it generates as a community plagued by physical and social illnesses (Series 1, Interviews, 2005). The mortality and suicide rates (Wotton, 1984), rates of chronic disease (Young, 1994; Samson, 2003; Waldram, Herring & Young, 1995), violence, unemployment, and school attendance and completion (Backhouse & McRae, 2002) indicate that physical and social health in Sheshatshiu are comparable to many other native communities and worse than in non-native communities in Canada.

The statistics do not lie, but they do not explain why the health status of Sheshatshiu Innu is lower than non-native Canadians, or why the community's social structures are on the verge of collapse. The Innu do not deny that Sheshatshiu is facing significant challenges and that many community members are struggling with a variety of illnesses, but they are certain that the current institutional approach to dealing with these

issues fails to address their underlying causes, and that current interventions do not offer support for the Innu to move towards the kind of healing and progress they feel their community needs (Backhouse & McRae, 2002; Series 1, interviews, 2005).

In the opening quote, Sheshatshiu resident Ben Andrew articulates the view of many Innu: that colonization is the underlying cause of illness and social breakdown in their communities. The Innu are not alone in arguing that approaches to "the native problem" must address the historical and political dimensions that the medical gaze ignores. The need to place the ills facing native communities internationally within the context of colonization is articulated by Tuhiwai Smith as "reframing":

> Governments and social agencies have failed to see many indigenous social problems as being related to any sort of history. They have framed indigenous issues in 'the indigenous problem' basket, to be handled in the usual cynical and paternalistic manner...Many indigenous activists have argued that such things as mental illness, alcoholism and suicide, for example, are not about psychological and individualized failure but about colonization or lack of collective self-determination. Many community health initiatives address the whole community, its history and its wider context as part of the problem and part of the solution. (p. 153)

This research seeks to contribute to the reframing of native health and social issues as the result of colonization through an exploration of the Innu experience of Type II diabetes[1] in Sheshatshiu. It aims to contribute to the diabetes prevention effort through an exploration of the full range of factors – from individual lifestyle choices to region-wide policy decisions – affecting the prevention and treatment of diabetes in Sheshatshiu. The research provides an Innu-informed, community-based account of diabetes that challenges the acceptance of diabetes as fundamentally a necessary outcome of acculturation and secondarily as the fault and responsibility of individuals. It highlights

[1] From this point forward, wherever the word 'diabetes' is used, it is meant to refer specifically to Type II diabetes.

the need for deeper intervention policies that aim to improve society and individuals' living conditions, as well as changing behaviour. Samson draws the link between biomedicine, colonization, settlement, individualistic health care approaches, and diabetes among the Innu:

> In Labrador and other areas of the world where it is clear that colonial domination has a tangible form, biomedicine frequently functions as an aid to the hegemony of the state.[2] By refusing to acknowledge and recognize colonized peoples in terms of their histories and experience, medicine has concentrated on identifying what the natives lack and what is necessary to absorb them silently into the mainstream of the settler society...One way in which this colonial relationship can appear blurred is through the invoking of genetics as the cause of Innu afflictions, and here diabetes presents a case in point. Diabetes is a new and especially debilitating disease for the Innu. It was never reported when they were permanent nomadic hunters...Yet, according to Stacey McIver, the dietician at the hospital in Goose Bay, the vast majority of Innu patients that she sees are diagnosed with diabetes and obesity. (Samson, 2003, p. 239)

The current clinical approach to Type II diabetes prevention and treatment, the 'lifestyle' model, prioritizes changing individuals' lifestyles to reduce the risk factors that are related to diet and activity levels (Canadian Diabetes Association, 2003). An examination of the tools of the lifestyle approach demonstrates that the 'individual' is defined in practice as a self-sufficient, isolated, autonomous unit with the freedom to choose from any number of lifestyles (Petersen & Lupton, 1996; Tesh, 1988). The success of the lifestyle approach depends on the ability of diabetics to make and sustain significant lifestyle changes, but the treatment does not consider the political, social and economic obstacles to change or offer any support for overcoming them (Benyshek et al., 2001; Joe & Young, 1994; Thompson & Gifford, 2000). The only kind of obstacle that is considered is psychological – in other words, if a diabetic does not engage in lifestyle changes it is because he or she lacks the discipline, lacks understanding about the disease

[2] See also Kelm (1998, 2004) and Tuhiwai Smith (1999).

and the reasons behind treatment suggestions, or in the case of native diabetics, is misguided by faulty cultural beliefs (Garcia-Smith, 1994; Hickey & Carter, 1994).

Type II diabetes is a compelling disease to study in native communities because of the individualistic psychological focus of the lifestyle approach, and the fact that this approach is *not* working. The results of the lifestyle approach in native communities are interesting not because its apolitical, ahistorical, individualistic, psychological orientation is unique to diabetes treatment, but rather, because it epitomizes the approach to "the native problem" in general since the earliest years of colonization. Tuhiwai Smith talks about the need to reframe the native experience within history, but the appropriate history itself first needs to be presented. The aim of decolonization and anti-colonization is firstly, to topple the colonial version of history in which the colonization of native people, and their decimation by introduced physical and social illnesses, was inevitable. Secondly, decolonizing perspectives aim to point out that this decimation, rather than being the fault of "faceless pathogens" (Kelm, 1998, p. xix) and naturally occurring physical and cultural inferiority, was a direct result of colonial policies and practices (Kelm, 1998; Benyshek et al., 2001).

For native groups, rather than being a lifestyle disease, diabetes ought to be conceptualized as a disease of colonialism. From this perspective, diabetes is only one of many symptoms of the larger disease of colonization[3] (Tuhiwai Smith, 1999, p. 153; see

[3] I use 'colonization' as defined by Kelm. Kelm draws from Frideres, but qualifies his position. Colonization describes a process that:

> includes geographical incursion, sociocultural dislocation, the establishment of external political control and economic dispossession, the provision of low-level social services, and finally, the creation of ideological formulations around race and skin colour, which position the colonizers at a higher evolutionary level than the colonized. Canadian colonization...conforms to this process-driven definition. (1998, p. xvii)

also Kelm, 1998; Waldram, Herring & Young, 1995). The failure of the lifestyle approach presents us with the opportunity to demand that responses to native health and social issues become political and historical, and integrate social and economic concerns of everyday life in native communities.

In her thesis on science education for native students Trudy Sable notes that the "field of education has undergone its own evolution in terms of approaches to researching and analyzing Aboriginal peoples" (2005, p. 17) and that this evolution has gone through four different approaches: individual, cultural, institutional and social structural (Wotherspoon and Schissel in Sable, 2005). The field of health has undergone a similar evolution. While early approaches to the 'native health problem' centered on theories of racial inferiority, in more recent times this blatantly racist approach has been replaced with analyses that are only superficially different. Individual theories focus on the hereditary and biological factors and therefore locate deficiencies in individuals rather than in surrounding conditions. Cultural approaches portray cultural beliefs and practices as barriers to appropriate behaviour, thereby spreading the blame out from the individual to include his or her cultural environment, but still ignoring larger systemic factors. The institutional and social structural approaches finally begin to take these larger systemic factors, such as institutionally embedded racism, power imbalances, class, gender, labour relations, and socioeconomic inequalities (Sable, 2005, p. 18), into account.

These same four categories are evident in the evolution of diabetes care. The individual approach is the search for genetic causes and the lifestyle conceptualization of

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Departing from Frideres, Kelm argues that colonization does *not* inevitably create a "quiescent population" who "when they finally awake to their condition are unable to change their 'subordinate status'". Rather, the power of colonization is "diffuse, dialectical, and subject to competing positions both from with the society of the colonizers and from the colonized" (1998, p. xvii). Kelm states that "oppositional voices to Canadian Indian policy always existed," – this is clearly the case for the Innu of Sheshatshiu.

the disease (Petersen & Lupton, 1996; Tesh, 1988; Thomson & Gifford, 2000). The cultural approach is the search for culturally appropriate diabetes care. Most 'culturally appropriate' diabetes prevention programs conclude that culture is a *barrier* to effective care and focus, not on changing treatment strategies to reflect fundamental cultural differences, but on training providers to present clinical treatment suggestions without offending patients (Hickey & Carter, 1994; Joe & Young, 1994). Recent successful, innovative diabetes prevention programs, such as the Kahnawake Schools Diabetes Prevention Program (Macaulay et al., 1997), recognize the importance of institutional, economic, political and socio-structural factors. Understanding diabetes among native groups as a subsidiary condition of colonialism allows us to recognize that the approach to the disease must move into the third and fourth stages of this evolution. Reframing diabetes as a colonial disease allows us to see the fundamental determinants of the disease as institutionally and systemically embedded power imbalances, and political, structural, and economic inequalities. In other words, diabetes is not primarily the product of laziness, poor choices or genetics, but rather of the purposeful destruction of culture and takeover of political and resource-based autonomy by the dominant governments (Andrew, B., 1984; Kelm, 2004, 1998; Samson, 2003; Tuhiwai Smith, 1999).

That Type II diabetes is a major concern in society today is clear. The continuous news-casts about the state of the disease and the commitment of significant national funding towards improving diabetes prevention and care[4] speak to the priority of the disease on both the popular and the policy-making level. One day the news announces

[4] In 1999, Health Canada initiated a five-year, 115 million-dollar effort to address the issue of diabetes for *all* Canadians. 58 million was allocated to the Aboriginal Diabetes Initiative.

that diabetes has reached epidemic proportions in New York city (Kleinfield, 2006), another day diabetes among First Nations people from the farthest corners of Canada is being described as a pandemic (CBC News, 2006). The highest rates of diabetes are experienced by the Pima (Garcia-Smith, 1994), a native group living in Arizona, but the disease is also prevalent outside of North America -- particularly in developing countries, ethnic minority groups, migrant populations and disadvantaged communities everywhere (Benyshek, Martin & Johnston 2001, p. 29). The use of the terms 'epidemic' and 'pandemic' speak to the exponential rates and growing prevalence of the disease, while the widespread locations of concern demonstrate that it is affecting both native and non-native people (and other ethnic minorities) living both in urban and rural or remote locations. Furthermore, the fact that rates and prevalence are rising while the age of onset and diagnosis is falling demonstrates that prevention and education strategies are not working (Hickey & Carter, 1994)). Diabetes, rather than remaining in the clinical realm, is a social and political issue (Benyshek et al., 2001; Joe & Young, 1994; Samson, 2003; Thompson & Gifford, 2000).

It is crucial to recognize that diabetes is significantly affecting both non-native and native people and that many of the determining factors of the disease are common to both natives and non-natives. However, it is important to acknowledge experiences of the disease that are unique to native people. Furthermore, it is necessary to distinguish which of these unique experiences apply to all native groups regardless of location, history, and community socio-political structure and economic standing, and which experiences are products of the particular combination of conditions that characterize specific communities. In other words, in order to arrive at a useful understanding of how

diabetes is operating, one must always be asking is this a 'native experience' or is this a 'rural experience' or is this an 'experience of poverty' or is this a 'northern experience' and so on.

> Oh yes [the lifestyle approach] worked well if people listens. But some people don't, right. I mean this is where I told doctor about this – 'I can't live the way you live' I said, 'my lifestyle is different than yours.... I mean, this is the life-time diabetic right. I mean, rest of my life.' (Series 1, Lionel Rich Interview, 2005)[5]

The Innu of Sheshatshiu reject the conceptualization of Type II diabetes as a 'lifestyle' disease; they see it instead as a disease of settlement and community life. The Innu understand settlement to be a colonial project imposed on the Innu by the provincial and federal governments and the Roman Catholic Church; hence among the Innu the underlying cause of diabetes is seen to be colonization, not deficiency in Innu individuals' choices or bodies or in Innu culture.

Background and Research Questions

I was introduced to the Innu in 2003-04 during which time, as a Science Horizons intern with the *Labrador Project*,[6] I helped to run capacity-building and skill-transfer modules for the Innu Environmental Guardians Program and to develop joint knowledge creation opportunities among Environment Canada, the Innu Nation and Saint Mary's University. Participation in these activities brought vividly to life the tension between issues of hegemony, voice appropriation, loss of autonomy and deepening dependence on the one hand, and hopes for integration on the other – tensions that, though encountered

[5] In accordance with Guidelines for Ethical Research among Native people, for those individuals who requested to remain confidential, name changes were made. For those individuals who wanted to be named, their actual names are shared.

[6] The Labrador Project is a research partnership between the Gorsebrook Research Institute, Environment Canada, and the Innu Nation. Since 1997 these partners have been "working together to explore new ways to connect Innu knowledge and western science" ("About the Labrador Project", 2003 para 2.). The project documents, maps, and archives Innu ecological knowledge, and continues to develop a cross-cultural, community-based, educational program called the Innu Environmental Guardians Program ("The Labrador Project", 2003).

before in post-colonial literature[7], had merely been abstract complexities, concerns I could not understand viscerally.

Working with the Innu I had discovered my place within colonialism, and this discovery shook the foundations of my understanding of research.

> The word itself, 'research', is probably one of the dirtiest words in the indigenous world's vocabulary...it stirs up silence, it conjures up bad memories, it raises a smile that is knowing and distrustful...The ways in which scientific research is implicated in the worst excesses of colonialism remains a powerful remembered history for many of the world's colonized peoples. (Tuhiwai Smith, 1999, p. 1)

My presence in the community and my role as a researcher was a product of the colonization, past and present, of the Innu. Before I could begin to think about an "appropriate" research project and tackle the potential pitfalls of proceeding from within the hegemonic paradigm, I had to evaluate the motivations behind my desire to do research in the first place. I had to *notice* that I was operating on the unquestioned assumption that research is by its nature "serving a greater good 'for mankind', or serving a specific emancipatory goal for an oppressed community" (Tuhiwai Smith, 1999, p. 2) and then accept instead that research itself has been, and continues to be, one of the most powerful tools of colonization (Kelm, 1998):

> The power of research [is] not in the visits made by researchers to our communities, nor in their fieldwork and the rude questions they often asked...At a commonsense level research was talked about both in terms of its absolute worthlessness to us, the indigenous world, and its absolute usefulness to those who wielded it as an instrument. (Tuhiwai Smith, 1999, p. 3)

I decided to embark on this current research project upon the strength of the encouragement I received from the *Tshishennaut* (Innu Elders) and other community members I asked about the pros and cons of my conducting more research. They

[7] I prefer not to use the term "post-colonial" as it suggests we have moved past colonization. It is clear that we are still in a colonial relationship with Native people (Tuhiwai Smith, 1999, p. 7, 14).

suggested that if I could secure funding from outside the community, a study of the related issues of diabetes, food and culture-change would be interesting and helpful to them. The Master's Program in Atlantic Canada Studies at Saint Mary's University offered me the financial, technical, academic, and experiential support I needed to carry out the study suggested by the Innu I consulted with. Having secured the approval of the Innu Nation and the Saint Mary's Research Ethics Board, I was able to begin shaping a study of diabetes, food and culture-change.

I set out the following research question to guide my literature review and preparatory research into the topics of diabetes, food and culture-change:

> 1) How has the conceptualization and treatment of diabetes as a life-style disease primarily caused by genetic selection impacted intervention policies in aboriginal communities?

For example, does a focus on genetics overlook the role of public policy in creating the conditions that contribute to high rates of aboriginal diabetes, and therefore lead to interventions that do not address the broader systems of power affecting aboriginal communities? Does conceptualizing diabetes as a life-style disease imply that aboriginal people have the resources to improve their health but fail to do so, therefore leading to interventions that fail to address economic and structural barriers to improving health?

To place the Innu at the forefront of the research and apply to the Sheshatshiu Innu the need for a contextual and structural approach (that allows location, income, and family, community and state-level politics to emerge), I set out this second research question:

> 2) How does the Innu perception and experience of diabetes compare with the clinical conception of diabetes and approach to diabetes prevention and management? And how well is the lifestyle approach working for Innu diabetics?

To answer this second question, I first conducted a secondary analysis of an already existing data series of interviews and other dialogue with the Innu of Sheshatshiu. Using the insights provided by this secondary analysis, I later conducted new interviews in Sheshatshiu that were designed to elicit perspectives on diabetes, food and culture change. This research did not attempt to provide an exhaustive account of the experience of all diabetics in the community, nor did I conduct any epidemiological studies of the emergence, rates, or prevalence of diabetes in Sheshatshiu.

The first research question was designed to keep my focus broad and guard against my slipping into the individualistic, psychologically-oriented frame of reference that is both familiar to me as a result of my academic and familial background, and that is assumed by the medical paradigm. I hoped to engage in a literary dialogue focused around the treatment of diabetes between structural, historical and contextual approaches, and apolitical, individualistic, mechanical approaches to health care. The need for this dialogue proved to be significant.

The article written by Andrew and Sarsfield, from which the opening paragraph of the thesis is excerpted,[8] demonstrated the power of my biases. Despite being on guard against falling towards the familiar and letting the medical paradigm dominate, I had invested full focus on the medical system. During the earlier stages of my preparatory research, my view had become dogmatically anti-health care. This dogmatism did not include consideration of the broader economic, social and political context, or of the

[8] The fact is that for the Innu health and ill-health are profoundly political issues, inseparable from social and economic considerations. The arrival of an elaborate health-care system among the Innu has coincided with a rapid overall worsening of Innu health. This is not to imply that one has led to the other but rather to emphasize that the health or ill-health of the Innu has been decided by factors that have very little to do with the health-care system. (Andrew and Sarsfield 1984: 429)

structural factors of life in Sheshatshiu. I was so intent on criticizing the nuts and bolts of the health care system that I had forgotten about stepping outside the medical paradigm altogether. The article pushed the concerns I had been focusing on into the background and transferred the emphasis from the medical to the political system:

> Innu people are sick and dying...not because of inadequate supplies of drugs, not because of a shortage of public health nurses, not because the nursing stations are old or poorly equipped, and not because of ineffective and insensitive health programs. The Innu are sick and dying because of a well documented syndrome of collective ill-health brought on by the enforced dependency and attempted acculturation of an entire people. This ill health will improve or worsen not according to fate or the level of health care funding but only as a result of a political choice by those now engaged in the extension of control over Innu land and Innu lives. (Andrew and Sarsfield, 1984, p. 428)

Andrew and Sarsfield's perspective fundamentally shifted my attitude towards researching "health" among the Innu. Reading it I understood that I must broaden my conception of health and of the determinants of health to include factors that I was unaccustomed to looking for, such as political power dynamics, location, geography, social status, and familial and job security. To honour this realization I designed my interview approach in order to prioritize Innu experiences, perspectives, concerns and solutions, and most importantly, to allow an Innu definition of health to determine the boundaries of the discussion. There is a place within my research for an examination of the health care system – but its function is not to locate all of the Innu health problems in the health care system. Rather, an examination of the health care system provides insight into how the political relationship between the Innu, the province of Newfoundland, and the federal government plays out on the ground.

Methods

Literature Review

The review is a compilation of clinical and qualitative diabetes literature, historical, socio-political, Innu, and government sources. The historical, socio-political and governmental literature provided background in the history of Canadian–Native relations as well as in the current colonial context. Exploring topics from the vantage of different disciplines ranging from the agriculture policy to the tuberculosis program, demonstrated how academic training and theoretical backgrounds not only influence analysis of issues but also impact intervention strategies. Through the governmental sources I was able to directly explore policy attitudes to 'the native question' and native health care both federally and provincially; by examining the structural placement of Indian Affairs and the Medical Services Branch[9] in the federal bureaucracy I was able to look past the policy language to assess what branch autonomy, affiliation and funding indicated about the approach to native affairs. Examination of the clinical diabetes literature (eg. Hickey & Carter, 1994) and critical social theory (eg. Petersen & Lupton, 1996) strengthened my understanding of the mechanics of diabetes and allowed me to explore underlying philosophies and attitudes of biomedicine and the clinical paradigm. Reading through studies about native understandings and experiences of diabetes (eg. Garro and Lang, 1994), I was able to see how non-natives working in health experienced cross-cultural misunderstanding and conflict (the discussion of these topics occurs in chapter 4). The fact that none of these studies articulated the Innu experience kept fresh in my mind the danger of assuming that all native world-views and community experiences are the same.

[9] There have been various names for Indian Affairs and the Medical Services Branch (MSB) – MSB is now part of Health Canada.

Secondary Analysis: Materials and Purpose

Although some of my review material was written about the Innu, very little was written from an Innu perspective. With respect to the Innu experience of diabetes I found only one reference – a power-point presentation by Renée Bowers, the Innu diabetes consultant (Bowers, 2004). The aim of the secondary analysis was to address this gap and gain a further articulation of Innu experiences and understandings of Type II diabetes, food, health and culture and lifestyle change before traveling to Sheshatshiu to conduct new interviews.

The extant data series is comprised of four data sets which include: two sets of interviews, one on *Ashkui* (open water in the ice), the other on both *Ashkui* and *Innu Tukuna* (religion and medicine); and recordings of the two skill-transfer modules that I participated in as an intern, one on anthropology, the other on eco-forestry. The two sets of interviews are referenced as "series 2 interviews" and "series 3 interviews" respectively, the two sets of modules are referenced as "series 4 anthropology module" and "series 5 eco-forestry module" respectively.

The informants in the interviews are all *Tshishennaut*. As a result, the secondary analysis of these interviews enabled me first, to access the perspective of people who had spent most of their lives in *nutshimit* (in the country/on the land) without conducting new research, and second, to focus new qualitative research on younger generations' perceptions and experiences of food, health, culture and lifestyle change, and Type II diabetes. The modules contain remarks from a variety of people – Innu and non-Innu ranging in age from early twenties to over seventy. In these four data sets I also found invaluable opinions and experiences of research itself. To my own experience as an intern

researcher in Sheshatshiu, then, I added the experiences of Innu who had been both subjects and actors in research, and used these perspectives to shape my approach to being in Sheshatshiu as a Master's student researcher.

Community-based research: Conducting the New Interviews

I) Getting Started: My first aim when I arrived in Sheshatshiu was to find an Innu co-researcher. I felt that drawing on an Innu community member to help me develop an appropriate set of interview questions, contact participants, and create an interview approach and environment that would be comfortable for participants, provided a small degree of community participation. Although I would have liked to engage in the broader, longer-term sort of community-based participatory research recommended by Macaulay et al (1999), such as involving a community board, organizing community meetings and so on, the limitations of conducting research as a Master's student made it untenable for me to do so.

I re-introduced myself to the people working in the Innu Nation offices, explained the research I hoped to do, and asked people to spread the word that I was looking for an Innu co-researcher. In particular, I spoke with Tony Jenkinson who had been a key contact for me throughout the preparatory stages of the research. Jenkinson and I discussed how my research would build on and depart from the work being conducted by Samson and Pretty, in which he was also involved.

II) Recruitment of Participants and Development of the Interview Questions: Over the next few days I spent my time divided between waiting for interested individuals to meet with me at the Innu Nation about the co-research opportunity, and arranging meetings and interviews with representatives from social services, the community health program,

the family resource center, the community youth services center, the Innu Nation, the Band Council, the Mani Ashini clinic, the diabetes program, and Blake's store (which opened soon after Sheshatshiu was officially settled, and had been the only food store in the community until shortly before I arrived in Sheshatshiu (Series 1 Interviews, 2005)).

I met with Louis Rich on my third day in Sheshatshiu. We discussed the research and I conducted a mock interview with him to give him an idea of the topics I wanted to cover and how I wanted to approach them. The hiring process complete, we began to work on recruiting participants and designing interview questions. All of the Innu interview participants were recruited by Louis Rich except for the individuals associated with the community institutions I mentioned above.[10] He also acted as both translator and co-interviewer. Over the period of a week, Louis Rich and I worked together with several Innu participants to design a semi-structured set of interview questions that were deemed relevant both to community members and to the research topics of food, health, and culture-change. The resulting list of questions were organized around the themes of individual and community weaknesses and strengths, and were designed to encourage participants to focus on areas that were of particular interest to them.[11]

III) Interview Approach: The interviews were designed to allow for diabetes be placed within the context of other experiences and concerns. In order to foreground the most basic presuppositions and assumptions about health and diabetes the first question that needed to be addressed was: is diabetes a concern for the Innu of Sheshatshiu? The

[10] One of the factors that non-native researchers must take into consideration doing research in Native communities is the unspoken politics of affiliation – if your research becomes associated with a particular family or political group within the community it is unlikely that you will get participants from outside this group (Series 4, Anthropology Module, 2003); Big Head, R. & Kelly, J., 2005). The fact that Louis Rich provided contacts within the community highly influenced the outcome of this research. Most of the participants he recruited were members of his immediate and extended family. This is clearly revealed in the fact that most of the participants' last names are 'Rich'.

[11] See appendix A for interview questions.

interviews were set up in order to allow the topic of diabetes to arise spontaneously.[12] The interviewers did not know whether informants were diabetic and there were no direct questions asked about diabetes until the participant introduced the topic. When the interviews were introduced to participants the research goals were broadly defined – "health" was not put forward as the main topic of interest. The Innu generally associate the term 'health' with the clinical experience and a biomedical definition of health; the term 'health' was avoided as it would likely have implied boundaries that were not intended.[13] The aim was to allow diabetes to emerge as a concern within the broader context of the lived reality in Sheshatshiu.

IV) Description of Interview Participants and Interview Locations: Over twenty-five interviews were conducted during a three-week period in – December, 2005. Twenty interviews were carried out with Innu participants, men and women, ranging in age from twenty to sixty. Other participants included non-Innu health care providers, community residents, human resources employees, school employees, and youth center employees. Most of the interviews were mechanically recorded, but some were not recorded on the request of participants. The majority of the interviews were conducted by both Louis and I, although we did several separately. The bulk of the interviews with Innu were

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[12] Except in the case of health care worker interviews.

[13] Writing about the Inuit experience of northern health care, O'Neil argues that:

> when health services are transferred from the south prior to local political developments which would ensure local input into the design and operation of health services, a process is established where Inuit social life comes to be defined in medical terms by health care providers. The 'medicalization' of social life and institutionalization of communities is then reflected in the 'medicalized expectations' that increasingly characterize Inuit demands in the Canadians North. (1984, p. 420)

The arguments put forward by O'Neil can be equally applied to the Innu since they revolve around the 'northern medical discourse,' and community level factors that are 'unique to the Canadian North' such as 'the combination of clinical and community health functions that local health personnel practice" (O'Neil, 1984, p. 420).

conducted at the Innu radio station (CJIK), housed in a trailer that used to be the RCMP office. A number of interviews were conducted in participants' houses. Two interviews were conducted in a tent (set up at the entrance to Sheshatshiu in protest of the Band Council's hiring policies). Two were conducted at the Innu Nation offices, one was conducted at the Band Council offices, two were conducted at the Mani Ashini Health clinic, one was conducted at the Community Youth Network center, one was conducted at the Human Resources offices (Social Services).

V) Transcription, Coding and Analysis of the New Interviews: I transcribed, coded, and analysed the interviews in Halifax. In the coding and analysis process I used the tools of the grounded theory approach:

> the term 'grounded theory' refers both to a method of inquiry and to the product of inquiry.... Essentially, grounded theory methods are a set of flexible analytic guidelines that enable researchers to focus their data collection and to build inductive middle-range theories through successive levels of data analysis and conceptual development. (Charmaz, 2005, p. 508)

Because my approach to the data was highly informed by existing theoretical frameworks in the various literature sources that I reviewed, it cannot be described without qualification as a grounded theory approach, which purports to create new concepts and theories inductively from the data alone.

In the first stages of coding I attempted to approach the interview data without discriminating between topics that were relevant or irrelevant to my research topics. Rather, I simply noted every different topic that arose – there were over 200 topics in the interviews. I then grouped these topics into related series, or themes. Although all of these disparate themes could be related to a discussion of "individual and community health", it became clear that there was enough material in the interview to write any

number of theses, or a multi-volume text on health and social issues in Sheshatshiu. At this point, I returned to my research topics, narrowed the focus of my analysis, and began to put aside all of the topics that were not significantly related to issues of food, health and culture-change in Sheshatshiu.

During this process of elimination and prioritization I relied on both the theoretical frameworks of my various literature review sources, and the theories that were emerging from the Innu perspectives contained in the interviews in order to decide what topics were in fact significant to food, health and culture-change in Sheshatshiu. Having selected a range of themes on which to focus, I returned to the interviews and re-read them with specific attention to these themes. Within this new focus, some of the previous topics were amalgamated, others were separated into multiple new topics. Once this review was complete I began the process of analysis. Exploring the relationship among the various themes, drawing conclusions from these relationships, and finally, broadening out the findings specific to Sheshatshiu into the broader context of native health, the health care system, and national and international colonial dynamics. Again, this analysis was defined by both the theoretical frameworks of my various literature review sources, and the theories that were emerging from the Innu perspectives contained in the interviews.

I did not seek input from Louis Rich or any other Innu community members during the analytic and writing stages of the research process. I will be returning to the community in order report the research findings and to meet with community members and develop materials out of the thesis that will be useful to the community.

VI) Structure of the Thesis: The organization of the thesis is designed to prioritize the perspectives of the Innu participants, while at the same time providing information that lends background and context to their experiences. In Chapter 1 the Innu are introduced, and the current distinction between the Québec and Labrador Innu is discussed. The settlement of the Innu, the evolution of the relationship between the Labrador Innu and the provincial and federal governments, and the implications of this unique relationship with respect to native rights, services and privileges in Newfoundland and Labrador are outlined. The Innu relationship to their land, *Nitassinan*, and the effects of the severance of the Innu from the land are discussed in the context of the individual and collective physical, social and political health of the Innu. Finally, the history of health care provision to the Labrador Innu is outlined in order to demonstrate how the jurisdictional ambiguity and administrative complexity has affected the quality of service-provision.

Chapter 2 narrows the focus to the Innu of Sheshatshiu, who are at the heart of this research, and provides a description of the research setting in Sheshatshiu. The aspects of the community discussed include: the settlement of Sheshatshiu, housing, infrastructure, employment, schooling, health-care, the impact of alcohol on individual and community health, and community politics. The discussion of politics is focused around the unsuitability of band council government in a community deeply divided by clan affiliation, and the abuse of alcohol in political proceedings.

Chapter 3 contains the findings from the secondary analysis of the extant four-part data series. The inclusion of these findings provides *Tshishennaut* perspectives on food, health, culture-change, and diabetes.

Chapter 4 brings the focus back to Type II diabetes and native health care. The lifestyle approach to Type II diabetes is discussed as an example of the recent trend towards individualization that began to develop in the mid-1970's in the national and international approach to public health (Petersen & Lupton, 1996). An outline of the emergence of diabetes as a concern for Health Canada (the Medical Services Branch) follows, which culminates in the development of the "culturally relevant approach". The inclusion of measures designed to increase cultural relevance is the main distinction between native and non-native diabetes prevention and care efforts. Through an exploration of existing diabetes prevention programs in native communities, the underlying messages of the culturally relevant approach are explored, and the similarities between cultural relevance and earlier colonial approaches to native health and social issues are discussed. Finally, the diabetes prevention and treatment effort in Sheshatshiu is outlined.

Chapter 5 contains the interview data. It is organized into the following sections: food beliefs across generations; the centrality of land to Innu culture, Innu medicine, and Innu food; cultural validation and diabetes; Innu medicine and diabetes; and responses to the lifestyle approach. The organization of these sections aims to do justice to the interconnected nature of the Innu experience of diabetes, and of the contextual, integrated understanding of health that prevails in the community.

Chapter 1

The Innu

> But all of this is our land, once a hunting land all over. The government never told us in advance what it was planning. It drew a map and marked the places that supposedly belonged to it. It's not very long ago that the Government of Newfoundland first came here. I think it was in 1949 that it first arrived. That's when Newfoundland joined Canada and when a line was drawn on the map to separate us from the [F]rench. Then the government of Newfoundland wrote on paper that they were responsible for us; for the Innu north of the line on that map. But it is all Innu land, no matter which side of the line you look at. It didn't belong to either government long ago, it was and still is Innu land...and the Inuit. I make no mention of White men when I talk about whose land this is, not even one, not a French man or an Englishman. I mention just the Innu and the Inuit. (Andrew, A., 1984)

The current health status of the Innu cannot be understood separately from the political and healthcare history of the Newfoundland and Labrador native people (Medical Services Branch Atlantic Region, 1977-1988; Medical Services Branch, 1961 - 1992; International Grenfell Association, n.d.; Health Labrador Corporation n.d.; Allen in National Round Table on Aboriginal Health and Social Issues, 1993; Wotton, 1984; Joe, 1994; Young, 1994; Backhouse & McRae, 2002). An intimate relationship to the land is crucial to the physical, social, economic and cultural health of the Innu (Series 2 – 5; Hanrahan, 2000; Mailhot, 1997; Sable, n.d.; Tanner et. al., n.d.). Understood in a colonial context, the settlement of the Innu is an instrument designed to break this relationship with the land (Mailhot, 1997; Samson, 2003; Wadden, 1991; Andrew & Sarsfield, 1985; Roche in Wadden, 1991). Thus, the Innu struggle for rights, recognition, and self-determination is simultaneously a struggle for decolonization and for better health among the Innu (Andrew, 1984; Backhouse & McRae, 2002; Benyshek et. al., 2001Coates, 2000; Kelm, 1998; Samson, 2003; Sarsfield, 1989; Wadden, 1991).

The Innu of the Québec-Labrador peninsula comprise a group of approximately 10 000 individuals. The majority live in Québec, associated with communities located along the North shore of the Gulf of St. Lawrence and the St. Lawrence River. The Innu of Labrador, who are the focus of this research, number approximately 2000 and live in two communities – Sheshatshiu and Utshimassit/Natuashish (Davis Inlet/Sango Bay) (Indian and Northern Affairs Canada 2005).[14] The fact that the Innu of Sheshatshiu and Utshimassit/Natuashish live in Labrador has deeply affected every aspect of their lives; both the onset of diabetes and the health care system's approach to diabetes treatment in Sheshatshiu and Utshimassit/Natuashish are prime examples. The political history of the relationship between Newfoundland and Canada, coupled with the Northern geography of Labrador, together have defined the quality of settled life for the Innu in two main ways: on a practical, daily level, jurisdictional ambiguity has resulted in inadequate health care and social services; on a profound and long-term level a lack of treaty rights and a refusal of recognition of the Innu as a sovereign, unique people has deeply damaged the Innu sense of basic goodness, health and empowerment.

Historically, the Innu perceived themselves to be a unified people who called all of *Nitassinan* (the Québec-Labrador peninsula) home.[15] The anthropological perspective corroborates this unity, grouping the Innu linguistically, culturally and ancestrally together as Algonkian (Wadden, 1991, p. 4). Politically, however, the Innu have been divided since 1927 by the boundary line between Labrador and Québec. Although the

[14] As a response to deteriorating living conditions, the community at Utshimassit has recently been relocated inland to Natuashish.

[15] Although the Innu distinguished themselves into groups (Mailhot, 1997), they had not been dichotomized and brought under the jurisdiction of two mutually exclusive provincial systems (economically, environmentally, politically, socially and culturally).

boundary dispute between Québec and Labrador was settled and the lines drawn in 1927, this division was immaterial to the Innu until the 1950's.

It was only when Newfoundland joined Canada that this division became real for the Innu. Government surveillance and programming increased following confederation around issues like tuberculosis, and military and industry interests began to stake claims over *Nitassinan*. Although Innu people, judges, and scholars alike make the point that the provincial boundary is still only a political creation at odds with first occupancy rights and Innu understandings of *Nitassinan* (Andrew, A., 1984; Wadden, 1991; Samson, 2003), the linguistic, spatial, and political entrenchment of this division is undeniable. First, the Labrador and Québec Innu speak different second languages – English and French respectively – and therefore cannot use their second language to navigate the dialectical differences in *Innu Aimun* (Innu language) that have been accentuated as free-flow across the border decreased.[16] Second, they are under the jurisdiction of different political bodies at both the provincial and community level – the government of Newfoundland and Labrador, and the Innu Nation and Band Council preside in Labrador, while in Québec it is the Québec government and the Mamit Innuat that preside.[17]

At the community level the creation of numerous Innu political bodies has weakened the power of a collective Innu voice.[18] The following conversation highlights

[16] The efforts of Mailhot and other linguists to help the Innu establish a standardized lexicon are a result of the difficulty the two groups experience around communication.
[17] Although Mailhot refers to the Innu Nation as the unified voice of the Innu people (1997), and the federal and provincial governments negotiate with the Innu Nation on matters of land claims and self-determination, at the community level people are more invested in the Band Council. To achieve better representation, this disconnect between the Innu Nation and the Band Council needs to be addressed.
[18] With the establishment of permanent settlements it is useful to have location-specific organization bodies. However, considering the magnitude of the obstacles facing the Innu as a colonized people the threat of "divide and rule" (Tuhiwai Smith, 1999, p. 99) is perhaps more significant.

the divisive impact of Band Council government and the governments' form of remunerating the Innu for their losses by offering money and economic deals:

> [The government representatives] wanted the Innu to behave as one total nation, right, and you wanted to negotiate only for the independence of *Innu Aimun* rather than have regular land negotiations according to the laws of Canada...Wasn't it two weeks ago that there was a meeting of Québec and the Labrador Innu at the Aurora Hotel, you had people Gilbert Florer saying "why can't we act as one big nation?"...But it is too late for that it seems. Nobody wants to do that anymore. The Band Councils want to cut their own economic deals on developments...so right now to behave as one nation now would seem unlikely. (Anthropology Module, 2003)

It must be acknowledged that none of these forms of separation – linguistic, jurisdictional, or political – would have had a substantial impact without the federal and provincial governments' aggressive settlement campaign. Underlying these other forms of separation is the fact that settlement ended the nomadic way of life of the Innu – without settlement none of these other concerns would exist.

Native Rights in Newfoundland and Labrador: Jurisdictional Ambiguity and Denial of Sovereignty and Recognition

> Since the Northwest River Band of Algonquians are not treaty Indians, de jure, they owned no land...From their own point of view they once owned the whole area over which they moved, hunted, fished, picked berries and trapped. In the course of time much of this land, including the better fishing and trapping places in the immediate locale of Northwest River, was pre-empted, or in most cases, simply taken over by whites, some of whom are not the least bit bashful about describing how they succeeded in getting the Indians off 'their' land. (McGhee in Wadden, 1991, p. 62)

It was only with settlement, and the coinciding increase of government presence in the North and in Innu lives, that the consequences of the political history and geography of Labrador began to affect the Innu who were now associated with Sheshatshiu and Utshimassit. As government presence in the North increased,

jurisdiction and regulation, which before settlement had merely been abstract government concepts immaterial to the Innu, became enforced realities. The Québec Innu lived, worked, and hunted under a different set of provincial rules and conditions than the Innu of Labrador. In fact, the Labrador Innu – and all the native inhabitants of Newfoundland and Labrador – lived under a set of circumstances different from native people in all the rest of Canada including their fellow Innu in Québec.

The roots of this difference reach back to the confederation of Canada in 1867 and their impact is apparent today. While in the rest of Canada the Indian Act of 1876 and treaty negotiations delineated the special status of native people in a separate relationship between them and the Crown, these provisions did not apply to native people of Newfoundland (and Labrador) due to Newfoundland's status as a Dominion (Backhouse & McRae, 2002; Samson, 2003; Wadden, 1991). Meanwhile, the Dominion of Newfoundland took no special consideration of its native peoples: the Mi'kmaq of Conne River, the Innu of Sheshatshiu and Utshimassit/ Natuashish, the Métis and the Inuit. The fact that they did have a separate political identity as natives is significant because the point of this distinction is first, to acknowledge the sovereignty of the native people over the land now occupied by colonial nations, and second, to delineate the obligations of the colonizers to the native people. In other words, in Newfoundland there was no acknowledgement that in order for settlement to occur, the original occupants of the land had been displaced. Nor was their any recognition of Dominion responsibility for the well-being of the native people.

Although some argue that the special status of Canadian native people in fact prevents them from gaining equal citizenship (Barsh, 2004), the lack of special status for

native people in Newfoundland certainly did not create equal citizenship. On the contrary, the complete absence of governmental support in Innu lives demonstrates that without a special identity as native they did not exist at all in the governmental consciousness. When Newfoundland joined Canada, there was no mention of native peoples in the Terms of Union (Backhouse & McRae, 2002; Samson, 2003; Wadden, 1991). Amendments to the Indian Act in 1951, then, though they were made after Newfoundland's confederation, did not apply to native people in Newfoundland and Labrador.

The conceptual absence of the Innu on a political level has been a main factor in the deterioration of Innu health – physical, economic, social, cultural, and spiritual. The lack of recognition of the Innu as a sovereign group has resulted in un-negotiated takeover of Innu lands and resources. This loss of control over resources and political autonomy has caused the deaths of many Innu and damaged Innu culture. And yet, while the Innu do not exist as sovereign, at the community level they have been extensively managed (The physical lay-out of Sheshatshiu is evidence of this fact – the community is literally ringed by externally introduced institutions that control almost every aspect of community life.) Essentially, they have been the objects of a poorly-managed experiment in modern colonization and the impact on the health of the Innu, ranging from high rates of substance abuse and suicide to the rising prevalence of diabetes, has been disastrous:

> It is the pattern of colonialism everywhere. When you undermine a people, their identity and way of life, you are going to have self-destructive behaviour.... You are going to have alcohol abuse. That then allows for a silent kind of rage that's under the surface to be alive and expressed. All of it is actually quite simple, but the frightening part is, if you accept the answer [native self determination] you know that change is required and it's the change which people most naturally resist. (Father Jim Roche in Wadden, 1991, p. 92 square brackets in the original)

As is typical of colonized groups, the illness caused by colonial practices paradoxically becomes justification for the entrenchment of colonial medicine.[19] Unique to the Innu and all the native people of Newfoundland and Labrador, is the fact that the systematic provision of health and social services has been clouded and delayed by the changing status of Newfoundland. The jurisdictional ambiguity arising from squabbles over federal versus provincial responsibility for health care and social services has resulted in fatally disorganized health care and social services. However, although the obstacles presented by jurisdictional squabbles are prodigious – inconsistency, short-lived programs, high staff turnover, constant changes in management, systems overhauls, lack of communication among three levels of health care stakeholders plus Department of Indian Affairs and Development (DIAND) – they are only obstacles to the achievement of health for the Innu, not the fundamental cause of their loss of health in the first place (Andrew & Sarsfield, 1984; Peter Penashue in Backhouse & McRae, 2002).

It is easier to pin blame on individual health care providers and suggest improvements in their numbers, training, equipment and overall approach than it is to comprehend a dispersed and convoluted history of colonization.[20] But it is this history that the Innu want to be recognized, and the only solutions that they find compelling are

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[19] Tony Jenkinson writes:

> It is a paradox that if one sets aside TB, the spanish flu and measles (all introduced diseases) and if one credits father Franz Peters observation that the Mushuau Innu went from having the lowest TB rates on the coast [pre-settlement] to the highest [after the move to houses and sedentary living]) in the case of TB a "disease of settlement", health worsened and continues to worsen with the provision of greater and greater levels of "health care." Which is not to suggest that more health care necessarily means worse health but it makes one question general assumptions about the answer to ill health being more nurses, nursing stations and medicines. (T. Jenkinson, personal communication, 2005)

[20] Even the approaches of progressive diabetes prevention programs such as the Gila River Diabetes Prevention Model display the tendency to adjust the existing system rather than plunging into a difficult exploration of "decolonizing methodologies" (Tuhiwai Smith, 1999).

those that address the colonial subtext of the Innu situation. In other words, although inadequacies in the health care system contribute to the poor health of the Innu, colonization, through settlement at Sheshatshiu and Utshimassit, is the fundamental cause of individual and community illness.

Settlement of the Innu: A modern colonial project

> In 1951 Canada instituted the Indian Act and shortly afterwards began a program, in their words, to civilize the Innu. In the Labrador part of *Ntesinan* [*Nitassinan*], where the Government of Newfoundland refused to recognize the existence of the Innu people even from a genetic or cultural standpoint, Canada began in 1953 to sponsor the same settlement and 'civilization' programs already underway in more southerly areas of Canada. (Andrew & Sarsfield, 1984, p. 428)

The government-driven settlement of the Innu into permanent communities created by the provincial governments and largely controlled by government institutions has been the defining factor in Innu lives since its occurrence in Québec in the 1950's and in Labrador in the 1960's. Although settlement occurred after the "colonial period" had "officially" ended, the project to settle the Innu and all of the Canadian North must be understood as a colonial project (Brody, 1975; Paine, 1977).[21]

It is likely that the Innu had contact with Europeans as early as A.D. 1000, and likely too that they had regular contact with a variety of different European groups throughout the 17th century (Mailhot, 1997, p. 7). But for the Innu contact did not equal colonization. In fact, into the middle of the twentieth century the Innu were characterized by their independence. With settlement, in the span of fifty years the Innu have come to be seen in an entirely different light – their communities suffer all the worst effects of

[21] O'Neil describes the work of Robert Paine regarding the colonial relationship between southern and northern Canada: "Paine uses the analogy of the nursery with Native people in the role of children and southern bureaucrats, educators, and other professionals in the role of nannies" (1984, p. 420).

colonization and are among the most pathologized in Canada. Understanding the settlement of the Innu as a colonial project, we can situate their current experiences within the broader international context of the struggle of colonized peoples. This is a struggle to place both historic and current responsibility for the myriad difficulties faced by native people where it belongs – on the shoulders of the colonizers – while at the same time empowering native people to take their healing into their own hands to move towards a life-affirming, hopeful future.[22]

For the Innu, settlement must be seen as an act of colonialism, but the fact that this did not occur within the 'colonial' period is significant in terms of the governmental motivations driving settlement, the rubric under which settlement was justified, and the Innu experience of being colonized in the twentieth century. What were the governments' motivations to settle the North? The 1940's saw a drastic increase in government presence in *Nitassinan* due to diverse factors such as World War II, the tuberculosis epidemic and the discovery of resources in the North (Grygier, 1994; Hanrahan, 2000; Wadden, 1991; Samson, 2003). The coincidence of the "civilization" programs with the drive for increased industrialization, surveillance, and military control over the North cannot be ignored. From the perspective of the governments of Newfoundland and of Canada, the Innu clearly were a potential obstacle, or perhaps even just a nuisance, to achieving these goals. Unlike native groups farther South, the need for more land due to the pressure of population expansion cannot be considered a driving

[22] This is not a simple balance to achieve; there is a very reasonable fear that any suggestion of native ownership will be understood by colonizing governments and institutions as the end of their obligation to support the healing process. In Canada, the native outcry against Trudeau's 1969 White Paper, which suggested the obliteration of their special status in the name of establishing native people as equal citizens, is a prime example. Although the White Paper was abandoned, the change in policy position that it symbolized was put into practice in other ways. Demonstrating its characteristic experimental role, health care was the first governmental arm of native affairs to begin transferring responsibility for providing services to native community councils.

motivation to restrict the domain of the Innu and isolate them into segregated communities. Nor did the Innu present a military threat as did the Mi'kmaq, for example, in the early years of expansion (Reid, 1987).

The project of settlement was a military initiative to be sure, but it was the threat of Soviet invasion associated with the Cold War, not the Innu, that was of concern.[23] Similarly, procuring land was also a factor driving the settlement of the Innu, but rather than being an obstacle to expansion, the Innu presented a potential obstacle to accessing resources in the North (Samson, 2003).[24] The development of multiple industrial projects in *Nitassinan* including hydroelectric power,[25] mining,[26] and forestry[27] are ample evidence of this fact.

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[23] The construction of an international air-force base at Goose Bay in 1942 is evidence of this concern (Wadden, 1991).

[24] Past and present government agents and missionaries have exercised authority over the Innu primarily as a necessary accompaniment to the economic development of the Labrador-Québec peninsula. Industrial development of *Nitassinan* has necessarily involved both transforming and relocating the Innu. If industrialization was to succeed and Labrador was to be an actor on the stage of global capitalism, then nomadic hunters had to be both cleared from the lands and made to see the sense behind resource extraction. (Samson, 2003, p. 15)

[25] A small project was developed at Betsiamites in 1948. The much larger Churchill Falls development occurred in 1973 and, despite the increasing international pressure for aboriginal rights recognition, the size of the project and therefore the intensity of associated environmental impacts, the Innu were still not consulted. "No compensation was ever paid to those affected; further they had not even been made aware of the flooding" (Hanrahan, 2000, p. 243). The project resulted in the flooding of ancestral hunting, fishing and trapping grounds as well as burial grounds. The Gregoire family was so unaware of the development that "they left their canoe, traps, tent and other belongings near the dam site; all of it was lost when the waters rose in 1973" (Wadden, 1991, p. 50).

[26] In 1949 iron ore mines began to be developed at Schefferville and Labrador City about which the Innu were not consulted, nor were they welcome to reap even the small returns available to mine labourers. Currently, the Voisey's Bay Nickel Corporation mine (VBNC) – a multi-billion dollar venture – employs both Inuit and Innu people and some percentage of the profits were negotiated as part of the Inuit land claims agreement (Innuat Tapirisat, 2004). The positive and negative aspects of the VBNC are simultaneously starkly opposed and yet difficult to disentangle. The community task force that culminated in Daniel Ashini's keynote speech, "Between a Rock and a Hard Place," (Ashini, 2004) on Innu perspectives of the VBNC development, and the interviews for the current study, reveal the tension between employment and royalty opportunities on the one hand, and the destruction of environmental, social and cultural health and integrity on the other

[27] The forestry industry also began to develop in the forties. By 1950 the QNSPC, an American-owned, Québec-operated company controlled 6000 acres of timberland. In the environs of Sheshatshiu companies like Liner Board have cut massively and indiscriminately, gone bankrupt, and left only wreckage for the area's inhabitants. Currently, for the Innu on both sides of the border forestry is a major contender for Innu

It was the rubric of liberalism – of an egalitarian and unified Canada – that smoothed the way for the anachronistic colonization of the Innu. Settlement is the "politically correct" modern version of colonization in the Canadian North. Despite having typical colonial motives of resource control at its root, "settlement" was portrayed by government agents to the Innu as integration into the "Society of the future" and as the inevitable boon of "civilization" (Rockwood in Wadden, 1991).[28] The Innu did agree to settle due to the power of the liberal promise of quality housing, services, employment and education opportunities (Innu Nation & Mushuau Innu Band Council, 1995; Series 1 Interviews, 2005; Series 2, Interviews, 1998; Samson, 2003; Wadden, 1991). As the years went on, and these promised benefits did not materialize, the Innu began to regret their decision.[29] This regret stemmed out of the fact that their ability to practice their own way of life was being restricted as they were forcibly being made to see the value of

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land, and companies lobby intensively to increase annual allowable cuts and expand operations into old growth forest.

[28] Writing in 1957, government agent Walter Rockwood articulated the liberal promise:

> The Eskimos and the Indians cannot continue to exist as isolated minorities but must ultimately be integrated in to the general body of our Society. A vigorous program in Welfare and Education, particularly the latter, is required to match the Health program already underway, and to prepare these minorities for the Society of the future. (Rockwood in Wadden, 1991, p. 69)

> One fact seems clear, - civilization is on the Northward march, and for the Eskimo and the Indian there is no escape. The last bridges of isolation were destroyed with the coming of the airplane and the radio. The only course now open, for there can be no turning back, is to fit him as soon as may be to take his full place as a citizen in our society. (Rockwood in Samson, 2003, p. 18)

[29] Wadden points out that though in the sixties the Innu looked to the future with optimism,

> Many Innu bitterly argue today that little of what was done for them by the Church and Canadian governments was done in the name of philanthropy. Rather, they feel they were housed and their children schooled so that the colonial governments could move in and develop Innu land. (1996, p. 69)

resource extraction and of all the other norms, practices and values of the non-Innu society and wage economy.[30]

The anticipated Soviet attack never materialized. An international air-force base located in much-used Innu territory did, however, and the consequences of this development have negatively affected the Innu in a number of ways and continue to do so.[31] Settlement did indeed achieve its aim – the Innu were separated from each other and from their land. This separation had a number of consequences. First, it allowed the provincial and federal governments to delay Innu resistance and force the inevitable confrontation over land and resources to occur on the governments' terms – through the courts in the context of land claims and self-determination negotiations.[32] Secondly, the 'successful' development of resources in the North has permanently altered the face of

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[30] Samson describes the government settlement and assimilation policies as "A kind of reckless destruction of the nomadic hunting life" (2003, p.13).

[31] The base was constructed on what used to be a popular feeding ground for *atik'u*. Needless to say, *atik'u* migration patterns to that area are no longer reliable, nor do the Innu have access to an area they once frequented with regularity. Furthermore, the immediate area of the base is only a fraction of the problem. The Low Level flight and dummy bombing exercises associated with the base carry the impacts of the military presence in Labrador into a much larger portion of the surrounding environment. That these exercises negatively affect the land, wildlife, and the Innu who continue to live off the land was forcefully demonstrated by the Innu when they occupied the air-force base runway in protest of the training activities. The base has also had negative social consequences for the Innu – the presence of military men has encouraged the rise of prostitution among young Innu women and to the spread of sexually transmitted diseases among the Innu (of course the conditions that would see Innu prostituting themselves are a consequence of other aspects of colonization besides the base).

[32] The power imbalance inherent in the land claims process is apparent from step one, when the federal government demanded that the native group in question prove their ownership over the land in question. Especially in the case of the Labrador Innu, who were not part of treaty negotiations and never agreed to cede any land in the first place or to be beholden to the Canadian government in any way at all, should it not be Canada who ought to prove to the Innu what right it had to dam Churchill Falls without Innu consent? The power imbalance present at the beginning of the proceedings affects the whole process – for example, when the Innu of Utshimassit (Davis Inlet) resorted to blocking their runway in order that their request be heard to replace a problematic judge, the federal government responded by threatening to end the land claims negotiations process if the Innu continued to refused the judge entry (Wadden, 1991). Although the land claims process has already resulted in land ownership for the Inuit and may also for the Innu, the amount of land under negotiation is less by far than the area proven by land-use occupancy studies to be the domain of the Innu (Samson, 2003, p. 81). Furthermore, land ownership – or resource autonomy – is only one aspect of decolonization. The Innu also require political autonomy – or self-determination – in order to decolonize themselves. Like land claims, the process of attaining self-determination is also a painfully slow one fraught by difficulties most of which stem from the social ills that are a result of colonization.

Nitassinan. The benefit of these projects in terms of Canadian prosperity is short-term; the devastation that settlement has wreaked among the Innu will be felt for generations to come.

The Land is Health: Settlement and the severance of the Innu from the land

Having outlined the context that motivated the governments' 'civilization' program for the Innu, it is necessary to explore the relationship between settlement and Innu health. The project of settlement was to end the nomadic way of life – essentially, to break the Innu relationship with the land. Both the secondary analysis of extant data sets and established literature demonstrate that for the Innu, a relationship with the land is fundamental to every aspect of life – social, political, spiritual, cultural and economic.

Tanner et al. state that "traditional Innu beliefs focus upon the natural and supernatural world of animals, hunting and relationship to the land" (Tanner, McGrath and Bennett, n.d., Traditional Innu Beliefs section, para. 2). Tanner et al. explain that:

> Among the Innu there was no neat and clear separation between spirituality and civil society. The political leaders tended also to be spiritual leaders. Even today the Elders are generally felt to deserve respect, both as civic and as spiritual leaders. The basic every day work in traditional times – hunting – was permeated with spiritual as well as material factors, and because wildlife harvesting continues to be important, to some degree this situation continues. (n.d., Introduction section, para. 6)

Sable points out the significance of Innu conceptions of the land as father, mother, supermarket and medicine chest (*The Labrador Project*). The way the Innu speak about medicine, animals, religion, respect, communal health and the land indicates the interconnectedness of the social, political, cultural, spiritual and economic domains:

> The grandmothers told us not to ever abuse the food...you don't say something to the animals. You don't abuse them...if you say bad things to the animals you

> won't get anything hunting, like maybe run out of food...we don't talk to them, we just respect the animals. And they told us that we never need doctor before. We always have to cure themselves. Like get medication from the trees or...maybe under the ground, sand, or even the...ashes from the stove. (Series 2, Mary Anne Montague Interview, 1998)

Armitage reports that "respect is omnipresent in Innu culture; it is a key operating principle in their religious ideology," and McGrath clarifies that "respect involves maintaining good relations with the spirit world, the natural elements...with physical objects... [and] with the animals they kill" (Tanner et al., n.d., Traditional Innu Beliefs section, para. 5). The following comments show how the land (and animals) were simultaneously the foundation of social conduct, and the source of necessary tools and clothing:

> The people who didn't have so much success in catching caribou or bear would get to eat whatever other people caught. So everything was shared and nobody went without...He talked about the importance of caribou hide to the Innu culture, how every part of the animal was used. The hide was used to make moccasins. The *babish – babish* was used to make snow shoes. The bones were used – every part of the animal was used because the animal was respected...And Sebastien tells us that even today that his wife and he don't eat frozen food from the store or salted meat and anything like that. They still eat wildlife and traditional food but the kids in his family eat sort of the fast food stuff that comes from the store. (Series 4, Anthropology Module, 2003)

Understanding the centrality of the Innu relationship to the land to the healthy functioning of every aspect of life, it becomes clear that the destruction of the Innu relationship to their land will lead to the disintegration of Innu social, political, cultural, and economic health. The current state of individual and community health in Sheshatshiu and Utshimasshit/Natuashish are evidence of this process. The relationship between the destruction of political and resource autonomy, and ill-health is stated by Maura Hanrahan writing about the Métis experience in Labrador:

> The imposition of external politico-economic structures creates a hierarchy of power with Métis [and most Labrador native people] at the bottom. This happens primarily through government regulations, from the 1940's onwards, that restrict resource usage, and through development projects that alter the environment. This hierarchy makes the Métis relationship to the land difficult, if not impossible, to maintain. The threat to Métis health is obvious. (Hanrahan, 2000, p. 233)

Innu ill-health is an embodied outcry[33] against the injustice of the fact that they have been successively edged off land that was once theirs, imprisoned in communities that encourage a lifestyle inimical to the lives they once led, and taught to despise their history, wisdom and social norms.

What must be understood is that culture is simultaneously fragile and powerful. Currently the Innu are struggling to regain perspective, to rebuild a functional understanding of the world. The horrifyingly effective work of assimilation was to erase the familiar points of reference for the Innu – to undermine belief in their individual and cultural basic goodness and resilience. The loss of this belief has profoundly crippled the Innu ability to adapt to the many changes foisted upon them by Canada's discovery of the North. Former Chief Francis Penashue's blunt words reveal the depth of the damage that has been done to the Innu identity: "Nobody likes Innu today. Do you like Innu?...I'm saying that we're all evil here, you know" (Series 2, Francis Penashue Interview, 1998). He goes on to contextualize the confusion and despair of today's Innu:

> Columbus. And the whole discovery thing. With Canada and Newfoundland and all that, you know. And I didn't believe anything I heard, I thought it was crap. You know, there was my thinking. And it wasn't very long, I guess about 10 years ago, I started to know... Indians [are] our people. 500 years ago when everybody was celebrating on Newfoundland, that "John Cabot 500 [celebration]"

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[33] Kelm introduces the concept of embodied resistance as follows:

> If, as Sergai Kan notes, the embodiment of inequality is a powerful tool in legitimizing authority, then we should also remember that that same embodiment also serves to challenge authority by being both an icon of repression and a provocation to resistance. (Kelm, 1998, p. xvii)

> you know...you never mentioned the Innu people here. Couple thousand years ago.... You got to learn how to rewind it, [the] tape. Now in 40's and 50's [it's] 95% Innu, 99% was pure Innu culture was here...And now, you count, 99 maybe 95 [percent] white culture here now...Because they've been told by the priest and government, you don't do it my way. Your way's no good, your culture's no good...Well really now, there's the youngest generation they don't hardly believe their own culture anymore. But they will, but it takes a while. (Series 2, Francis Penashue Interview, 1998)

In summary, while the denial of Innu sovereignty at both the provincial and federal level allowed the governments to destroy the Innu relationship with the land without moral or legal compunction, the liberal policy belief that assimilation would lead to a better life for the Native people allowed the Church's killing of Innu culture, and the deposition of their spiritual leaders, to be considered a necessity to the successful integration of the Innu into modern Canadian society.

The struggle for recognition: Protests, Land-Claims, and Self-Determination

It is important to keep in mind that all of these impositions – political, social, cultural, and economic – were legally and politically legitimated by the constitutional lack of recognition of the Innu. Innu land rights, and even the right to a distinct culture, were overlooked; as Andrew and Sarsfield point out, "in the Labrador part of Ntesinan...the Government of Newfoundland refused to recognize the existence of the Innu people even from a genetic or cultural standpoint" (1984).

In the early years of development and settlement (1940 – 1960), the Innu did not realize what the government and society in general had planned for their land:[34]

[34] Recall that the Innu were largely nomadic until the 1960's. The lack of contact between Innu and non-Innu meant that the Innu did not speak much French and even less English. Even if, therefore, the plans of the governments had been publicly announced, they would have been literally meaningless to the Innu. That the government made no effort to inform, much less consult, the Innu about developments is also clear – a product of the way the Innu had ceased to exist on a political level.

> So that we would abandon our land. The government ran so many things; it built our houses and the school. The government sent their officials, the geologists, to search for certain types of rocks. We didn't know exactly what they were doing because the government never told us...the Innu always knew it was their land where the government workers were searching...The Innu knew this, but there was no one to speak on our behalf. It's like the government is slowly creeping around your bed where you are sleeping to get past you. (Andrew, A., 1984)

And once the Innu began to realize that they were being cut off from their land, unlike other native groups they had no treaties to turn to that acknowledged their rights on the land (Wadden, 1991; Samson, 2003). However, beginning in the late 1970's the Innu began to demand rights:

> And now the people who were told all this history [of the denial of Innu sovereignty, the stealing of Innu land and the outlawing of Innu religion and medicine] want to fight back. The old people now sense that their children who are fully grown want to fight back. And the young people who have learned the White men's ways also want to fight back against the government. The young people have been taught in school and have learned the English language; and now they want to fight against the government. The old people didn't understand the English language – they couldn't communicate with the White people. As a result, White people treated the Innu the way they wanted. But today, we want to hold them back so they can't treat us as badly as before. We knew what was planned for us, but nobody could speak English. It's because of this that there wasn't any struggle against the government for treating us the way they do. (Sylvestre in Andrew, A., 1984)

There are a number of factors that contributed to the Innu realization that they could demand recognition. (1) The rise of the importance of the legal system as an ally (Coates, 2000; Samson, 2003)[35]. (2) The national context: not just treaty rights, but aboriginal rights, aboriginal title, or first occupancy rights, became increasingly respected as a legal reality with the result that land claims settlements cannot be denied (Coates, 2000; "Report to the Canadian Human Rights Commission on the Treatment of the Innu

[35] Samson highlights a number of court cases including the 1970 *Calder* case, the 1980 *Baker Case,* and the1990 *Delgamuukw* case: "Beginning with the 1970 *Calder* decision involving the Nisga'a people of British Colombia, a number of cases affirmed that Natives like the Innu, who had signed treaties or other cessions, possessed unextinguished aboriginal title" (2003, p. 46).

of Labrador by the Government of Canada" Backhouse & McRae, 2002). (3) The international context: the rise of concern for human rights and especially aboriginal people (Backhouse & McRae, 2002; Samson, 2003; Wadden, 1991).[36]

In 1976 the Innu inquired about registration under the *Indian Act* (Backhouse & McRae, 2002, The Innu and the Government section, para. 8). In 1977 they submitted a Land Claim (Backhouse & McRae, 2002, The Innu and the Government section, para. 9) and began to collect land-use and occupancy data to support their claim. In 1987 the Innu openly defied Newfoundland game laws by hunting in the Mealy Mountains. With lawyer John Olthius[37] acting in their defense, the accused stood trial on April 29 in Goose Bay. "Although the Mealy Mountain protest did not cause the Newfoundland government to change the legislation, it...encouraged the Innu to keep fighting back until their rights are recognized" (Wadden, 1991, p. 95). The Innu carried this new resolve into protests against the low flights and bombing exercises practiced by the department of national defense out of the air-force base at Goose Bay (Wadden, 1991).

The Innu occupation of the base runway, John Olthius' defense strategy,[38] and the ruling offered by Judge James Igloliorte,[39] demonstrate a significant shift both in the external perception of the Innu and in the Innu awareness of their ability to demand rights. The Innu defense offered by Olthius was summed up by Judge Igloliorte as follows:

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[36] To clarify their identity as first occupants native people begin to define themselves at this time as "First Nations" (Coates, 2000, p. 77).

[37] Olthius is known for his work in the 1975 Mackenzie Valley Pipeline hearings, with the Dogrib Dene (now known as the Tlicho), and with the Ojibway people of Grassy Narrows (Wadden, 1991).

[38] Olthius used 'The colour of right', which hinges on the accused proving that they felt their actions were in the right. In the case of the Innu, this meant they had to prove they believed that the land of *Nitassinan* – including the Department of National Defense 'property' on which they were allegedly 'trespassing' – belonged to them (Wadden, 1991).

[39] James Igloliorte is an Inuk from Hopedale and Newfoundland's first and only Native judge (Wadden, 1991).

> Canadian law is founded on the English common law and here the Innu are saying they have never agreed to accept this kind of law as theirs. English and Canadian law has...omitted to include those who were without a written set of laws. That includes not only Innu people but a large part of aboriginal people in Canada...There is absolutely no question that the Innu have been left out of decisions made which affect their lifestyle and adversely affect their unique society. (Wadden, 1991, p. 138)

The fact that the government had no legal right to be regulating Innu people, or using and occupying Innu land, was becoming recognized in the socially accepted forums of politics and law. Confirmation of this shift came in 1992 when the federal government formally recognized the Innu as a unique people and agreed to work towards Innu self-government. However, as noted previously, the incarceration of Nympha Byrne and Utshimassit chief Katie Rich in 1995 demonstrates that land claims and self-determination negotiations unfold on the governments' terms.

Land claims and self-determination negotiations for the Innu have yet to be settled. Although it appeared as if the government was prepared to by-pass issues of Indian and Reserve status and carry on with land-claims and self-determination negotiations regardless, this position was reversed (Backhouse & McRae, 2002, The Issue of Registration section, para. 5). On the contrary, far from moving quickly towards self-determination, the government is clearly indicating that it has no faith in the Innu ability to manage their own affairs – for example, in the crucial area of education where the Innu could not do much worse than the provincial government (see chapter 2).

The provision of health services is another example. Although the Innu have begun to take part in health care provision, the terms of transfer[40] and the resulting administrative labyrinth and jurisdictional hydra are not a satisfactory solution:

[40] 'Transfer' refers to the transfer of responsibility and control of services from provincial and federal governments to native communities.

> Ironically, health care frequently runs in opposition to community health, with one of the major problems in northern health being the northern health care system. Thus, aboriginal peoples have been caught in a dilemma; they risk losing basic health care in any attempt to change the system to better meet their needs. (Sarsfield et al., 1988, p. 385)

For native people, regaining health will occur only through self-determination, land claims agreements and a process, not of assimilation or even integration, but of incorporation[41] whereby native people take only what works from the colonial systems, re-form it, and reject the rest. The role of incorporation is nowhere so important as in the crucial area of self-government:

> At the most fundamental level, the Royal Commission saw a key role for Aboriginal self-government as providing "the affirmation and conservation of Aboriginal cultures and identities as fundamental characteristics for Canadian society." The vision of self-government set out by the Royal Commission was not, however, the municipal council model that the Innu fear the Government wishes to impose on them. Rather: it should be understood that self-government does not mean bringing Aboriginal nations into line with predetermined Canadian norms of how people should govern themselves. It is the reinstatement of a nation-to-nation relationship. It is the entrenchment of the Aboriginal right of doing things differently, within the boundaries of a flexible *Canadian Charter of Rights and Freedoms* and international human rights standards. The issue of self-government remains one of the key outstanding issues to be resolved in the new relationship that is evolving between the Government and the Innu. (Backhouse & McRae, 2002,

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[41] In her 2004 paper, Wilp Wa'ums: colonial encounter, decolonization and medical care among the Nisga'a, Kelm introduces the Nisga'a strategy of incorporation as:

> neither a particular 'post-colonial moment' nor a capitulation to the downsizing agenda of the Canadian government...Incorporation is about drawing into indigenous life certain foreign ideas, practices, material culture...[which] had their meaning reassigned by indigenous peoples... incorporation functions paradoxically through a process, described by Sahlins, as one where strategic cultural change encourages political resistance which, in turn, ensures cultural survival. By taking on some parts of colonial culture, indigenous people evince agency and in so doing refuse the inert, subordinated self-image ascribed to them by the dominant society. (Kelm, 2004, p. 336)

Kelm qualifies that, in the context of the colonizers' intentional assault on Native culture, incorporation is an "ambivalent mechanism". The Labrador project is characterized by this ambivalence. Although the goal is 'integration of Innu knowledge and western science,' in practice 'integration' is often an unequal process of making Innu knowledge fit in with western science where appropriate. With respect to diabetes, in the same way that the fundamental tenets of science are not challenged by integrating Indigenous Ecological Knowledge, similarly diabetes prevention programs that propose to integrate Native culture do not challenge the medical paradigm and only include Native medicine "when appropriate" (Hickey & Carter, 1994, p. 467).

> The Implications of the Recommendations of the National Round Table on Aboriginal Health and Social Issues section, para. 10)

What is required of the rest of society is support for fundamental changes to entrenched systems of economics, education and health because such systemic changes will lead to the decolonization of the Innu. In the words of former Innu Nation President Peter Penashue, "Innu health and ill-health is determined largely by factors such as social and economic considerations, rather than the health care system itself...improvement in Innu health can only occur alongside the development of health socio-economic and cultural systems" (Backhouse & McRae, 2002, Health section, para. 6)

It is in this light that the approach to diabetes must be examined. Benyshek et al. state that

> A reappraisal of the fundamental causes of chronic illness such as diabetes (and long-term, broad-based strategies to prevent them) is long overdue.... [N]ew epidemiological approaches are now warranted – approaches within which socio-political factors such as poverty are investigated as fundamental, rather than as superficial, causes of disease. (2001, p. 47)

Diabetes, as only one of many symptoms of colonization, will only be effectively reduced by challenging the status quo upheld by current colonial institutions:

> Intervention programs that would seek to reduce diabetes prevalence rates in Native American communities by reforming the economic and political arrangements that underwrite poverty, poor nutrition, lack of educational and employment opportunities and resources, and despair – all of which contribute to the disease process – would require unprecedented political support and commitment of resources. Simply stated, the political and economic support required to begin to ameliorate these problems is not likely to emerge out of the existing organization of institutional interests. (Benyshek et al., p. 47)

Although these remarks focus on Native Americans, the point that real change requires profound systemic changes is equally relevant to Native Canadians. Benyshek et al.'s remarks about the difficulty of making such changes are not intended to be pessimistic,

but realistic. Their paper offers an interim strategy focusing on pre-natal nutrition, and he is careful to assert that, despite the limitations of the current clinical approach to diabetes, these efforts should not be abandoned. Their point is that even culturally relevant diabetes prevention programs will not be effective until economic and political reform is effected.

The same qualification applies to the discussion in the next section of jurisdictional ambiguity in Innu health care. Sarsfield et al. point out that:

> it has become painfully evident that 'health' cannot be achieved through the present medical 'diagnosis and therapy' methods favored by the dominant non-aboriginal culture. In spite of this, many physicians and many communities adhere to the illusionary counter productive image of health care being the major influential agent.... The reality is that [health care]...is the 'last and least' in importance. (1988, p. 385)

And yet it cannot be denied that Native people require health care services. Sarsfield et al. argue that a balance can be achieved by transferring control to Native communities over the "structure and function of health care, often to a degree and in a manner which might not be necessary or appropriate in urban Canada" (1988, p. 387). The health care system is not the key to achieving Native health but "it is essential...that the health care divisions of services, education and research be supportive of community strength and self-determination, rather than an oppressive reactionary force" (1988, p. 385).

Hence, although Innu health and ill-health are not primarily determined by the structure of the health care system, nor can the solutions to diabetes or ill-health generally be found within the bounds of the health care system, it is necessary to track the history of service provision in order to understand the current Innu experience of diabetes, and to see how issues of jurisdiction and control continue to impede Innu health.

National, Regional and Provincial Health Care: Jurisdictional Ambiguity, Inconsistent Service-provision, and the Erasure of the Innu from the Federal View

> In 1992, the Innu Nation brought a complaint to the Canadian Human Rights Commission (the Commission) alleging that the Government of Canada (the Government) had failed to exercise direct constitutional responsibility in respect of the Innu. Instead, the Innu Nation claimed, the Government had left the Innu to be dealt with by the Province of Newfoundland and Labrador (the Province) under an agreement with the Government. The Innu claimed that the refusal of the Government to recognize its constitutional obligations had resulted in a continuing governmental failure to provide them with the level and quality of services received by other Aboriginal people in Canada.... The Innu sought compensation for the failure of the Government of Canada to recognize their Aboriginal constitutional status, and for breach of fiduciary duty.... The Report, delivered in 1993, concluded that the Government had failed to acknowledge and assume constitutional responsibility for the Innu as Aboriginal people of Canada with a consequent impact on the level and quality of services received by the Innu and on their ability to achieve self-government. (Backhouse & McRae, 2002, Background section, para. 1)

The breakdown in jurisdictional responsibility is most evident with respect to the provision of health care. While in the rest of Canada Native health care is the responsibility of the federal government, in Newfoundland and Labrador health care services were first sporadically provided by private institutions, and later by the provincial government. The federal government has never been directly involved in health care provision in Newfoundland and Labrador, and only after Newfoundland joined Canada did the federal government begin to contribute financial support. The detrimental effect of jurisdictional ambiguity affects Innu health in the broadest sense because it is not only the provision of health care specifically, but also of social services in general, that is impeded. The situation with respect to the Innu has been described as "a jurisdictional nightmare" (Backhouse & McRae, 2002, Health section, para. 5). The chaos emanates from the friction and confusion of four levels of involvement in Innu health care – national, provincial, private, and community – compounded by the

dysfunctional relationship between the health care sector (Health Canada) and the social services sector (DIAND)[42] over key environmental/health issues such as water, sewage and garbage disposal. In the "Report to the Canadian Human Rights Commission on the Treatment of the Innu of Labrador by the Government of Canada", the differing treatment of children from Sheshatshiu and Utshimasshit (Davis Inlet) who were sniffing gas illuminates how the problems of jurisdiction play out on the ground in the two Labrador Innu communities:

> The Innu leadership in Sheshatshiu...called on the provincial authorities to apprehend the children in that community under child welfare laws. In Davis Inlet the leadership took the matter to Health Canada and the children were dealt with under voluntary care arrangements. The children of Sheshatshiu were treated in Goose Bay and the children from Davis Inlet were sent to Grace Hospital in St. John's...The 2000 incident demonstrates the jurisdictional nightmare that exists in respect of Innu health. The differing arrangements with the two communities led to serious difficulties over which level of government should be paying for which service. Health is a provincial responsibility, exercised in respect of the Innu through the provincial Health Labrador Corporation. Health Canada nevertheless funds health care programs and DIAND provides funding for health as well. The Innu manage health issues through health commissions in each of the communities. Coordination between these groups is a major problem. Within the Government an interdepartmental committee was established...to try to bring some coordination at the federal level. This has resulted in better communication but it has not prevented each department from carrying out its mandate as it sees fit, and friction between DIAND and Health Canada continues. The problem between the two departments is described by officials as a "national problem". (Backhouse & McRae, 2002, Health section, para. 5)

In this quote the lack of coordination between all of the key players is apparent – Innu community-level health care, provincial health care, federal funding sources and the problematic relationship between DIAND (responsible for social services) and Health Canada. That in 2000 an effective response to a pressing health issue was hampered by ambiguity about whose responsibility it was to provide services and to pay for them is the

[42] DIAND = Department of Indian Affairs and Development.

direct result of a convoluted history of passing responsibility for the native people of Newfoundland back and forth among the government of Canada, the Dominion, private and community organizations. In fact, far from being resolved, the jurisdictional issues continue to be exacerbated today by constant changes in both the nature of the relationship among all the players and in *who* is providing services from *where.* The most recent shift was in 2005; Health Labrador Corporation and the Regional Grenfell Association were *re*-amalgamated after having only been created as separate bodies in 1994. Contemporary health services, including those pertaining to diabetes, are a product of this complicated jurisdictional history and it continues to shape both the population-level epidemiological studies upon which treatment policies are formed, and the individual and community-level experiences of the Innu at the clinic in Sheshatshiu, hospitals in Goose Bay, St. John's and Halifax (Series 1-5; Samson, 2003; Royal Commission on Aboriginal Peoples, 1993).

Who Provided What When?: History of Health Care Provision and Financial Agreements

For native people of Newfoundland and Labrador (both Indian and Inuit) health services are not and never were provided by the federal government.

> Both the provincial and federal governments were content to leave the medical, educational, and social services for the Northern Peninsula and Labrador in the hands of Moravian Brothers and the Grenfell Association, both of which were essentially privately funded, foreign-based institutions. (Grygier, 1994, p. 165)

From 1914 to 1981, services were provided to the Innu by the International Grenfell Association (the IGA, a private, philanthropic institution) with funding from the government formally beginning in 1954 and increasing to almost full support in the seventies. In 1981, the *provincial* government took over from the IGA, not the federal

government, and has continued to provide services through a variety of bodies since that year (IGA, n.d., introduction section).

There are a number of factors that contributed to the jurisdictional nightmare that exists with respect to Innu health care. First, the laborious renewal of federal-provincial agreements; second, the successive multiplication of committees and groups responsible for different native communities; and third, the disintegration and amalgamation of provincial health service bodies. The difficulties arising from these three factors were all exacerbated by the constant tension between the federal and provincial governments regarding the extent of responsibility and obligation to Native people.

From 1914 until 1949 the IGA provided health care services funded only by privately garnered foreign funds. "Following union, the Government paid costs incurred by Newfoundland in respect of the Aboriginal people of Newfoundland and Labrador, although the nature and extent of its responsibility or obligation to do so was the subject of substantial internal discussion" (Backhouse & McRae, 2002, The Innu and the Government section, para. 1). Post-confederation negotiations between the federal and provincial governments saw the implementation in 1954 of a 10-year federal-provincial health agreement.[43] These negotiations did not include the Native groups in question. In fact, as there is no direct discussion of the Native people it is difficult to tell from reports

[43]Backhouse and McRae offers the following description of the first agreement:

> In 1954, the Government and the Province entered into an agreement by an exchange of letters...designed to delimit, on a long-term and more satisfactory basis, the areas of responsibility of the federal and provincial governments with regard to the Indian and Eskimo population of Northern Labrador.... The agreement provided that the Government would assume 66.7% of costs in respect of Eskimos and 100% of costs in respect of Indians relating to "agreed capital expenditures...in the fields of welfare, health and education," assume the full costs of hospital treatment for Indians and Eskimos of northern Labrador during a 10-year period, and "undertake an aggressive anti-tuberculosis program" during the same period. For its part, the Province was to assume all other "financial and administrative responsibilities for the Indian and Eskimo population of Labrador" excluding such federal benefits as family allowances and old age pensions. (Backhouse & McRae, 2002, The Innu and the Government section, para. 2)

whether the agreement pertains to all of the Mi'kmaq, the Innu and the Inuit. The nature of federal and provincial responsibility was entirely financial – the federal government provided funds to the provincial government, which in turn funded the activities of the IGA. For example, using federal funds the IGA hospital at North West River was enlarged; the federal government began subsidizing hospital stays for tuberculosis patients at a rate of $22/patient/day; and four nursing stations were built for the IGA at Nain, Davis Inlet, Makkovik, and Hopedale (Wadden, 1991, p. 65). This ten-year federal-provincial agreement was renewed in 1965 as a five-year agreement,[44] again without input from the Native people of Newfoundland and Labrardor. The basic structure of the agreement did not change – the federal and provincial governments continued to provide funding, the IGA continued to provide services.

In the mid-seventies there was a shift in the approach to the negotiations around Native health services, which is apparent in the national and regional Medical Services Branch (MSB) reports. The 1974 MSB Atlantic report was the first to contain a clear definition of the relationship between the federal and provincial governments and the IGA, and the native communities of Labrador are for the first time enumerated:

> During the year, our financial involvement with Health Services in Labrador increased substantially. There are approximately 2000 Indians and Inuit people in Labrador located in six isolated communities widely separated from each other. The Newfoundland government provides the health services through the International Grenfell Association, and through a Federal-Provincial agreement

[44] Backhouse and McRae offer the following description of the second agreement:

> Ten years later a new agreement was entered into between the Government and the Province, again by an exchange of letters. This agreement renewed the 1954 agreement in respect of medical and hospital costs and the anti-tuberculosis program, but included a new arrangement under which the Government would "reimburse Newfoundland for 90 percent of the province's expenditures on Indians and Eskimos" up to a maximum of $1 million per year. This agreement provided the financial basis for capital developments, particularly housing, in both communities. (Backhouse & McRae, 2002, The Innu and the Government section, para. 3)

> we provide financial assistance based on the ratio of Native population to general population. The current agreement with the province expires April, 1975 and discussions have already been held to re-define programs and responsibility prior to the completion of a new Health Agreement. There is evidence that the Native association will press for services to the Micmac Indian population of Newfoundland. (MSB Atlantic, 1974, p. 9)

The enumeration of six Labrador Native communities is significant, as it likely includes the Innu of Sheshatshiu and indicates that they are finally appearing on the federal radar screen. The fact that the Native Association *can* 'press' for any kind of demand at all is also significant – it indicates the shift towards greater Native involvement in health care services. This trend is reinforced by the fact that the signing of a new agreement was stalled in 1975 and 1976 because of a lack of Native consent. In 1975 "a new agreement has been drafted but had not been signed up to the end of the year due to a delay in obtaining Native approval of the terms of the agreement" (MSB Atlantic, p. 6). In 1976 the agreement had not been renewed because "we are waiting for a health study to be completed by the Native Associations of Labrador and their concurrence in the agreement before the document is signed" (MSB Atlantic, p. 4). It is apparent from this quote that by 1976 the Innu and Inuit also have Associations to represent their interests. By 1978, the health agreement is to be established by a committee that will "liase with the province and Native people to ensure the objectives of the agreement are met" (MSB Atlantic, p. 8).

Hence, by 1978, there were four levels of involvement in Innu health care: federal, provincial, private (IGA), and community (Innu). Insofar as the Innu were more involved in what services were provided and how, this is a positive change. However, as the example offered by the Human Rights Commission demonstrates, the complexity arising from having so many stake-holders and middle-men cripples the system from

providing adequate care. The fact that it took so long for agreements to be finalized throughout the seventies is an indication of more difficulties to come in the eighties. The following description of the renewal of agreements over several decades reveals the fragmentation of previous agreements into smaller, more specific agreements and the creation of specific committees to deal with specific Native groups:

> The 1964 arrangement, which was to last for five years, was extended in 1970 and 1976. In 1981 it was again renewed as two separate agreements, one as the Native Peoples of Labrador Agreement and the other as the Comprehensive Health Agreement.[45] The latter has been renewed on an annual basis, but the Native Peoples of Labrador Agreement was subsequently divided into two agreements, one relating to the Inuit and the other to the Innu communities of Sheshatshiu and Davis Inlet. The Innu agreement was renewed regularly and exists today as the Contribution Agreement Between the Government of Canada and the Government of Newfoundland and Labrador for the Benefit of the Innu Communities of Labrador, 1991–1996. (Backhouse & McRae, 2002, The Innu and the Government section, para. 4)

Although it is the nature of such agreements to be continually renewed and therefore their constant renewal does not in itself demonstrate a lack of continuity, the reference in MSB Atlantic reports to complications and conflicts and the consequent necessity of extended interim agreements implies the underlying tension and struggle around health care jurisdiction. The following comments about the third tripartite agreement reveal both the logistical difficulty in coordinating so many levels of involvement and that there have been long-standing disagreements, which have clearly detracted from the improvement of health services in Labrador. After two six-month

[45] In 1981 the Canada/Newfoundland/Native Peoples of Labrador Organizing Committee was divided into two meeting sections: one with the people of Conne River, Newfoundland; the other with the Innu and Inuit representatives from Labrador (MSB, 1981, p. 20). This split is significant in that the Mi'kmaq were clearly making an effort to separate from Labrador *and* Newfoundland to some degree and align themselves with the Mi'kmaq of the Maritime provinces. This alignment is demonstrated in the organization of Community Health Representative training programs and other programs as well. For example, while the Innu and Inuit take their training in Happy Valley-Goose Bay, the Mi'kmaq take theirs in Nova Scotia at St. Francis Xavier University (MSB, 1981, p. 17).

interim agreements and other delays, a new tripartite agreement was finally signed during the 1985 fiscal year:

> After a delay of over two years, a meeting of the Coordinating Committee was convened on 17 February 1986 in Goose Bay. Some old causes for dispute have been cleared away and there is now an opportunity to take initiatives in a cooperative manner to improve health services in Labrador. (MSB Atlantic, p. v)

Even after such a long delay, the terms of this laboriously developed agreement were not uniformly acceptable. According to the MSB Atlantic, the Innu were of the view that "the level of funding is totally inadequate," while "In contrast, the arrangements with the LIHC [Labrador Inuit Health Commission] are more positive and this group is going ahead with considerable action and in a good planning process" (MSB Atlantic, p. v).[46]

To further complicate matters, in 1981 the provincial government took over the provision of services from the IGA. By the late 1970's the IGA reported that it was essentially a funds manager for the provincial government and sold its assets and responsibility to the province for $1 in 1981 (IGA, n.d., introduction section, para. 7).[47] Although the removal of a privately-run organization from the range of stake-holders involved in providing Innu health care could have simplified health provision, and was intended to increase local input into health care services, this was not the case. Once the province took over from the IGA responsibility for the health care of Labrador native

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[46] The Inuit are often perceived and portrayed by the MSB as a more reasonable and capable group than the Innu. However, the fact that the MSB see the Inuit as more 'positive' and as having a 'good' planning process only means that the Inuit are more willing to work with the colonial agenda, not that they are inherently more positive and capable than the Innu. For example, the tone of the MSB statement "some Indian bands are grasping the idea of a board of health" (MSB, 1964, p. 98) reveals that, if a band did not *approve* of a board of health and preferred some other method of meeting and discussing health concerns and making decisions, the MSB would likely consider that band to be 'uncooperative' and 'lacking in modern understanding'.

[47] The IGA changed its focus "and became essentially a private foundation whose sole purpose was to award grants for the benefit of people of that region" (IGA, 2006). The IGA continues to support health education and community projects today in the area originally served by the IGA (Town of North West River, 2006).

people began to be passed back and forth among a number of different organizations. In 1981 the provincial government created the Regional Grenfell Association, which had responsibility for the "entire region" of the Labrador coast, including the Innu of Sheshatshiu. In 1994 the Regional Grenfell Association's jurisdiction was limited to Southern Labrador and yet another organization, Health Labrador Corporation (HLC), was established by the province to provide services in Northern Labrador, which includes Utshimassit and North West River (and Sheshatshiu). This distinction between Northern and Southern Labrador is significant to the Innu of Sheshatshiu because, although they were not overlooked by the HLC, in some cases they are not included in regional conceptions of 'Northern Labrador' (Wotton, 1984; Backhouse & McRae, 2002). In 2005 the Regional Grenfell Association and the Health Labrador Corporation were re-amalgamated.

Iris Allen, writing in 1993 on behalf of the Labrador Inuit Association (LIA) highlights the degree of fragmentation in Labrador health services:

> The product of the jurisdictional confusion is that there are currently four different groups that define health policy for the Labrador Inuit: (1) the federal government through Indian and Inuit Health Services, Medical Services Branch, Health and Welfare Canada; (2) the provincial government of Newfoundland through the Department of Health; (3) Regional Health Services – Grenfell Regional Health Services (which operates the nursing stations and the public health program); and (4) the Labrador Inuit Association membership through the Labrador Inuit Health Commission. These groups do not work well together, despite efforts on everyone's part. (Allen in National Round Table on Aboriginal Health and Social Issues 1993, p. 133)

This fragmentation necessarily translates down to the individual level. Allen gives the following example:

> A mother whose child has a serious ear problem attempting to fit into the confused health care system can often find getting appropriate medical care difficult and frustrating. The referral policy of GRHS is such that the child must

> be sent to their secondary care facility in St. Anthony. The parent is not given the right to choose where the child could be seen – i.e., a specialist in St. John's...we must use services provided within the Grenfell region. (p. 134)

The inconsistency in who was providing services from where and under what management structures exacerbated the already prodigious systemic problems that characterize health care in remote native communities – high turnover rates and short-lived programs with constantly changing parameters.

The Innu Are Invisible: Jurisdictional Ambiguity and Documentation

The inclusion of the opinions of the Naskapi Innu Health Commission and the Labrador Inuit Health Commission in the 1985 report demonstrates the increasing level of involvement of the Innu (and most native communities across Canada) in their health care. This degree of detail is a marked contrast to the indifferent and basic enumeration of native people and communities in 1974. It was not until after the details of the 1978 agreement were finally agreed upon that the MSB Atlantic reports begin to provide details about Newfoundland and Labrador's native people. The shift towards greater surveillance coincided with the greater financial involvement of the federal government (which began in 1974), and the provincial government's takeover from the IGA. The lack of clarity about the situation of native people in Newfoundland and Labrador is likely a product of the purely financial nature of the relationship between the provincial and federal governments – because the MSB is not responsible for providing services or making records, it would not have a clear understanding of the status of health. Regardless of the reasons behind it, however, the absence of the Labrador Innu in the Atlantic Region MSB reports is yet another indication of their lack of existence on a

federal level. Although purely conceptual, this non-existence has concrete results in terms of policy-making and the approaches to health care within communities that are informed by these policies. The "trends" observed in native communities under the jurisdiction of the MSB are used to inform what kinds of programs and services are funded. Because the Innu are not observed, not only are their specific needs not taken into account in the development of services and programs, but they cannot even be located within the broad trends established throughout the region or in other settings.

The organization of health services is such that gaps are created into which the Innu consistently fall. Epidemiological studies and the policy decisions that follow from them are often applied to broad geographical categories. Canada is often divided longitudinally into east, prairie, and west, and latitudinally into Southern, Sub-Arctic, and Arctic (or Northern). Although such broad generalizations are problematic because they obscure a finer level of detail, it cannot be denied that the health concerns of people living in the north, for example, are quite different than those of people living in the south, and that taking these differences into account can lead to improved services. For the Innu of Labrador, due to the political history outlined above, the problem is that they cannot be found anywhere on the map created by these east to west and south to north divisions.

When there are discussions and policy decisions made about 'northern' or 'sub-arctic' communities, although Shehsatshiu and Utshimassit/Natuashish ought to be included by geographical terms, the definition of 'northern' for Health Canada means 'Inuit' in the context of Labrador. Although the "northern health service" was created to

serve "indigent Indians and Eskimos residing in the Arctic" (MSB 1963: 81), there is no recognition of the fact that there are "Indians" in Labrador, only "Eskimos":

> There are about 12, 000 Eskimos. They are the particular concern of Northern Affairs Branch of the Department of Northern Affairs and National Research except on the Labrador Coast where the provincial government assumes obligations. (MSB, 1961, p. 19)[48]

It is clear from this quote that neither the Inuit nor the Innu of Labrador were provided for by the northern health service and this is a result of the terms of Newfoundland's entry into Canada. Although the division of health care into Indian health services and Northern health services was partly a political move to separate the Inuit from First Nations, it was also practical – the point of making these broad distinctions between north and south was to better design health care services to meet the needs of people living in particular environments. The exclusion of the Innu from 'northern' health services, then, is problematic because being left out of the 'northern' category means that when special measures are made for 'northern' communities, those measures will not necessarily be implemented in Sheshatshiu or Utshimasshit/Natuashish.

With respect to the division of the country from east to west, similar kinds of policy decisions and special measures flow from regional analyses. For example, according to MSB, "Canadian Indians...show three quite distinct health patterns and problems each requiring special measures" (MSB, 1966, p. 98). Essentially, in 1966 the trends in Native health across Canada were portrayed as follows: in Eastern Canada there is a low birth rate, moderate death and infant death rate; in the Prairies there is a high birth rate, high fertility rate, and high infant death rate; while in British Columbia and Nova Scotia particularly, there is a high adult death rate possibly due to engagement in

[48] Unless a region is specified, "MSB" means national-level MSB.

"maritime pursuits". We might assume that Newfoundland and Labrador are included in "Eastern Canada", but this seems unlikely when it is considered that the national percentage-population-by-province breakdown that precedes this account of regional trends clearly excludes Newfoundland and Labrador:

> Almost a quarter of all Canadian Indians reside in Ontario, 20% in British Columbia, Manitoba and Saskatchewan each have 14%, Alberta and Québec each 11%. Over 2% of Indians reside in the Northwest Territories and a little over 1% in the Yukon. Nova Scotia and New Brunswick each have Indian populations comprising some 2% of all Indians. (MSB, 1969, p. 97)

It is somewhat reasonable that MSB would not report on health trends in Newfoundland and Labrador because it would not have access to detailed statistics for that province. Population statistics, on the other hand, should be more easily accessible. Furthermore, to make a statement about "all Canadian Indians" which excludes an entire province is simply erroneous, and very telling. The Innu, and all native people in Newfoundland and Labrador, are literally not on the map.

This absence, though it has its origins in Newfoundland's status as a Dominion at the time of confederation, continues to affect the Innu today in terms of various epidemiological studies (from which many health care programs are derived). The Innu experience of diabetes is no exception. In his 1994 epidemiological overview of diabetes among Canadian Indians and Inuit, T. Kue Young suggests the need to detail the particularities of Canadian native experiences of diabetes and notes the challenges inherent in such a project. The challenges are first, that there is a paucity of information about Canadian native diabetes – data are "scanty" (p. 21) and "statistical data indicating time trends in diabetes prevalence are not available for Native Canadians since it is only recently that baseline data have been collected." (p. 28). And second, that "Canadian

Indians are genetically heterogeneous and they live in environments that differ markedly from those U.S. tribes who have been extensively studied from the perspective of diabetes" (p. 29). Young notes that, in fact, "these U.S. tribes have contributed a disproportionate share and may have even distorted our knowledge about the North American Indian diabetes "epidemic"" (p. 29). In other words, the factors that contribute to the highly variable prevalence rates across Canada are not well understood. Because it is precisely an understanding, or misunderstanding, of these factors that determines the approach of prevention and treatment programs, more detailed studies that attend to geographical, cultural, historical and political particularities are crucial to the creation of diabetes care that is effective for native Canadians.

However, though data for native Canadians generally may be scanty, for the Innu it is largely unavailable (Wotton, 1984; Samson, 2003)[49]. In Young's by-province breakdown Newfoundland and Labrador are not included. We are told that the highest rates were found in the Atlantic region, but this refers only to Nova Scotia, New Brunswick, and Prince Edward Island (p. 25). We are told that "rates were considerably higher in the southern latitudes compared to the rates in northern latitudes" and that "among the Algonkians, who are distributed across 20 degrees of latitude, the prevalence also declined towards the north." (p. 27- 28) We are told that the among the Algonkians in the Subarctic there is 2.3 % prevalence, while in the Northeast the prevalence is 4.3. Although all of these categories potentially apply to the Innu – they live in the north latitudes, could be characterized as subarctic Algonkian, and could be considered to live in the Northeast – since none of the data Young is working from refer to the Innu, one cannot assume the Innu fit into the trends Young describes. In fact, even the widely

[49] See also discussion in Chapter 2 "health care "section.

accepted statement that native Canadians experience rates of diabetes that are two to six times greater than non-native Canadians (Macaulay et.al., 1997) cannot be assumed to apply to the Innu.

The fact that Young does not include Newfoundland and Labrador (and therefore the Innu) is not an oversight on his part, but the result of the paucity of data that stems from the fact that the federal government was not, and never has been, responsible for the health care of Newfoundland and Labrador native people. Hence, when a "national review of case registers maintained by the Canadian government's Indian and northern health services" was conducted in 1987, and a total of "5, 324 known cases [of diabetes] were ascertained from Native communities *served by the federal government*" (p. 25 emphasis added) these data do not apply to Newfoundland and Labrador native people.[50]

The absence of the Innu persists even beyond the regional MSB reports and into the organizations within the province of Newfoundland and Labrador. Again the lack of special status is at the root of their absence: the constant bureaucratic reorganization that resulted from the passage of responsibility for native health in the province from one organization to another has resulted in a dearth of information on the Innu communities. Wotton's 1984 study of Innu and Inuit mortality, speaks eloquently to the results of this history:

> Many of the facts and figures about the health of Canada's Native people have been displayed often and widely. One group of Native people for whom the statistics have not been available is the Innu and Inuit of northern Labrador. When Newfoundland joined Canada in 1949, the special status of its Native inhabitants was not recognized. Because of this historical quirk, Native statistics in Newfoundland continue to be pooled with those of the rest of the province

[50] Young acknowledges the partial coverage of these registers, noting that they constitute 76% of the total registered Indian population of Canada. However, he never directly states the absence of Newfoundland and Labrador Native people.

> where their relatively small numbers are rapidly diluted and hence easier to overlook. (pp.139)

To assess trends in mortality over a ten year period, Wotton had to "go first to the communities for a list of deaths over the past 12 years and then search out details and verification from hospitals, nursing stations, vital statistics, and community members." (p. 139)

Furthermore, Wotton's paper does not address the Sheshatshiu Innu, only the Mushuau Innu. In other words, even when the 'Labrador Innu' *are* considered, the Innu of Sheshatshiu are overlooked. The separation of the Mushuau Innu and the Sheshatshiu Innu also occurs at the federal level. The human rights report points this out:

> The 1993 Report recommended that the Government "formally acknowledge its constitutional responsibility to the Innu".... Despite initial indications that acknowledgement would be forthcoming, in fact the Government has never made a single acknowledgement of its constitutional responsibility to the Innu people. Instead, it has made separate acknowledgements about the status of the Mushuau Innu and the Sheshatshiu Innu. (Backhouse & McRae, 2002, Implementation of the 1993 Recommendations by the Government of Canada section, para. 1)

In attempting to do diabetes research among the Labrador Innu there is not even any baseline data to begin from. Although Wotton's paper was written twenty years ago, the process of establishing rates and trends over time remains the job of the individual researcher, who must compile these statistics from patients' files held by the Sheshatshiu and Natuashish Band Councils (Samson, 2003)[51]. The hair-splitting division of responsibility among the three members of the early tripartite agreements continues

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[51] Samson points out both the lack of statistical records and the problematic nature of such records:

> The few and somewhat fragmentary health and mortality statistics that I have been able to collect...generalize and agglomerate the family breakdown, abuse, drunkenness, and alcohol-related diseases, violence, accidents and self-harm. Even though no detailed figures are kept in Sheshatshiu or Utshimassits, at the hospital in Goose Bay, at the Health Department in St. John's, or with Health Canada in Ottawa, it is obvious to the local health workers that life and death for the Innu are not what they are for people in other parts of Canada. (2003, p. 229)

today: although Health Labrador Corporation is responsible for diagnosing Labrador Innu with diabetes, they do not keep records of "ethnic populations" (personal communication HLC records manager).

In summary, the changing relationship of Newfoundland and Labrador to Canada has resulted in overly complex and inadequate provision of health care and social services to the Innu (Backhouse & McRae, 2002). From the administrative point of view there is constant tension over who is responsible for paying for and providing which services. From the patient perspective, the experience of trying to get one's health care and social support needs met is fraught with confusion, complexity and inconsistency. Finally, the conceptual lack of existence of the native people of Newfoundland and Labrador has resulted in their exclusion from national-level epidemiological studies that are often the foundation upon which approaches to community-level programs and services are developed. The way towards health for the Innu lies primarily with land claims and self-determination, and secondarily with improvements in the administration and provision of health care and social services. Land ownership and political freedom will allow the Innu to rebuild their relationship to the land, their history, social structure, culture and to each other in the context of the current realities of life in Labrador and specifically in the community of Sheshatshiu.

Chapter 2

Sheshatshiu: The research setting

Again and again, the interviews conducted in 2005 revealed that housing, employment, schooling, registration, health care, alcohol and community health, and community politics were the issues of greatest concern for the Innu of Sheshatshiu. Having discussed the political and health care history that has shaped the current conditions in Labrador, we can now turn our focus to the community of Sheshatshiu and understand the Innu residents' concerns in light of the broader regional and national context. The description of the research setting begins with a brief discussion of the liberal vision of settlement that convinced the Innu to settle in Sheshatshiu (Wadden, 1991; Samson, 2003; Mailhot, 1997; Innu Nation & Mushuau Innu Band Council, 1995). A discussion of historic and current living conditions follows (Paddon and McGhee in Wadden, 1991; McGillivray, 1988; Series 1 Interviews, 2005; Backhouse & McRae, 2002; Innu Nation & Mushuau Innu Band Council, 1995; Tanner et. al., n.d.; Samson, 2003; Government of Newfoundland and Labrador, 1996; Hanrahan, 2000; Paddon in Grygier, 1994; Health Labrador Corporation, n.d.; Series 4 Anthropology Module, 2005). The Innu interviewed in 2005 suggested that alcohol and substance abuse, and community politics are the most fundamental problems that Sheshatshiu is facing. According to the participants, alcohol and substance abuse and community politics are closely related, and they are at the root of most of the individual and community health issues in the community (Interviews, 2005; Series 2 Interviews, 1998; Mailhot, 1997; Samson, 2003; and Francis Penashue in Wadden, 1991).

The current community of Sheshatshiu is located (N 03 95 15) (W 59 32 12) approximately forty-five minutes North East by road from Goose Bay. It must be kept in mind that the community is neither very old nor is it the traditional stopping place the Innu frequented before the arrival of settlers (Wadden, 1991).[52] House-building began in earnest in Sheshatshiu only in 1962[53] upon the request of a Roman Catholic priest, Father Pirson. The settlement of the Innu at Sheshatshiu at this time was a shared effort of the provincial and federal governments and the Roman Catholic Church; while it was the Church's influence that convinced the Innu to settle in Sheshatshiu (Mailhot, 23; Innu Nation & Mushuau Innu Band Council, 1995), the governments' financial involvement provided the physical incentives to keep the Innu settled. Without funds for houses, the school, the hospital at North West River, and family allowance,[54] the exhortations of the missionaries would have lacked the immediate power to keep the Innu permanently in

[52] The traditional summer gathering place where the Innu used to camp for several months before returning to the interior of Labrador for the winter was in the area now occupied by North West River. In 1930, the settlers pushed the Innu off of this land and claimed it as their own, forcing the Innu to relocate to the current environs of Sheshatshiu (Wadden, 1991, 61). In fact, to this day, the town of North West River dubs itself as 'Central Labrador's Oldest Community' (the NWR sign at the entrance to the town and the town website both share this claim to fame (Town of North West River, 2006)). And in the web-based 'town history' there is not one single mention of the existence of the Innu, much less of the fact that the Innu were the original inhabitants of the site of North West River. Rather, the French are credited with establishing a trading post at North West River in 1743 and the English are portrayed as rightfully claiming the territory 'as spoils of war in 1763' (Town of North West River, 2006). The waves of settlement and development encouraged first by the fur trade in the 1800's, then by industrial and military expansion in the 1900's are not noted as having any negative impact on the Native people of Labrador or the environment – only as contributing positively to the economy of settler households and the Labrador region (Town of North West River, 2006).

[53] The first few houses for the elderly and the disabled were constructed in the late 1950's, but it was not until the sixties that "fourteen houses were constructed, ten of which were inhabited" (Wadden, 1991, p. 65)

[54] With the decline in the fur trade, cash was in high demand; the introduction of family allowance was an important contribution to Innu families' well-being (Samson, 2003; Wadden, 1991). Receipt of family allowance, however, was contingent on sending one's children to school – "Innu who persisted in taking their children to the bush were told they would lose their family allowances, the small amount of cash many now depended on to provide them with some necessary staples" (Wadden, 1991, p. 65).

Sheshatshiu (Wadden, 1991; Samson, 2003). An Elder in Sheshatshiu described the way the Innu were "convinced" to stay in the community:

> The Innu were told that houses would be built for them and they had to school their children in return. It's like bribing the Innu. The Innu were not to leave the community while their children were schooled. Not even to go into the country while their land was being destroyed through exploitation. That was the idea the governments must have had. And many Innu were led to believe all this. We were told the children would eventually find proper jobs once they finished school. It was never like that . All those promises. (Maniaten in Wadden, 1991, p. 65)

A better life: The Liberal Promise

The community of Sheshatshiu, then, is only forty-odd years old. And although it was conceptualized by policy-makers and missionaries to be the way of the future for the Innu, the key to their successful integration into modern Canadian life (Rockwood in Wadden, 1991), by all the typical standards the community has failed to live up to this dream. Joseph Pokue reveals that the governments' promises were empty, and that far from bringing a better life, community-living has been worse than prison for many Innu and has resulted in a variety of mental, social and physical illnesses including diabetes (Louis Rich translates):

> Like my father used to say I feel useless when I'm in the community because there's nothing I'm qualified to do. But if you put him in nushimit – he knows how to hunt he can tell you a lot about animals and water. This is the knowledge he obtained from his parents for so many years and taught his children up till now. And this is like a prison, if a person have knowledge about cultural things and then come in the community they become imprisoned because can't do anything – immobilized. That's the sad thing about trying to change the Elders that have no knowledge of the English language or anything. These are the savages. That's what they used to talk about in the early twenties.
>
> Moving around, doing a lot of exercise in the bush they didn't catch such sicknesses [as diabetes]. This is what they believe like moving around in the bush – because they're doing stuff. Now back in the community, all you're doing is sitting in the house getting drunk every weekend. That's it. This is the life that the government promised us – the good life (laughter) (Joseph Pokue translated

by Louis Rich 2005)

The components that were to make Sheshatshiu the vehicle of integration for the Innu were houses, jobs, school, and access to health care and social services (Innu Nation & Mushuau Innu Band Council, 1995; Wadden, 1991; Samson, 2003). In each of these areas the current situation in Sheshatshiu is problematic for many residents.

Housing, Infrastructure, Employment (or Unemployment)

On the most basic level, although the government built houses beginning in 1962, they were substandard. Each one cost less than $2000 to construct, and electricity, running water, sewer and garbage management were lacking (Wadden, 1991, p. 65). The negative impact of settlement on the health of the Innu was noted by Dr. Harry L. Paddon, who came to work with Sir Wilfred Grenfell in Labrador and was responsible for establishing the cottage hospital at North West River in 1915 (NWR, n.d., history section). According to Paddon, settlement – rather than decreasing the need for health care services – contributed to health problems:

> People suffered new health disorders. Sanitation is not a problem when small numbers of people frequently move camp, but it becomes a serious problem when hundreds of people live in the same spot year-round in shacks with no water or sewage facilities...*gastroenteritis, impetigo, and related infections were rampant in the Indian village at North West River. Paddon said the Innu needed a clean water supply (this nine years after the first homes were built there.)* (Wadden, 1991, p. 67 italics in original)

By 1988 there were 103 residential homes, 21 of which had running water. There was still no community sewage disposal system (McGillivray, 1988, p. 501) Currently, many of the water and sewer-related infections reported by Paddon continue to be a concern: "nurses speak of 'epidemics' of impetigo, skin diseases and gastric problems"

(Samson, 2003, p. 229).[55] Funds for housing continue to be provided by the government while the allocation and construction of houses and repairs are managed by the Band Council. Although running water is now the norm, the sewer system continues to be a work in progress (Interviews, 2005; observation of construction, 2005) and the quality and availability of housing is the central concern for many people in the community (Series 1 Interviews, 2005).[56] Although these basic components of settled life are still sub-standard, there are a variety of other social services available in the community: a women's shelter, a group home, a family resource center[57], social services (family workers), a RCMP station, the Mani Ashini health clinic, and the Charles J. Andrew youth treatment center. Many Innu view these services, excluding social services[58], as one of the few positives of community life (Series 1 Interviews, 2005). It is evident in the nature of these services that they are designed to treat a sick community.[59] Innu and non-Innu observe that the sickness of the Innu keeps these organizations in business (Interviews, 2005; O'Neil, 1984)[60]. The fact that many of the jobs offered by these organizations are filled by *akaneshau* (white people) is a chief complaint of many Innu

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[55] The recent rash of water-related illnesses on Mohawk reserves in Northern Ontario demonstrates that the basic amenity of clean water is still not a given for Canadian Native people living on reserves.

[56] Kelm argues that it was not until the 1940's that the perception of native bodies as having "a 'natural' tolerance for and even a predisposition to dirt.... gave way to environmental perspectives that reversed the flow of cause and effect, seeing poor housing, for instance, as the cause of weakened Aboriginal bodies and not vice versa" (1998, p. 39). From the earliest days of colonization right up until today the importance of environmental/infrastructural management to community health has been demonstrated all over Canada in the form of various water, sewer and housing-related illnesses in Native reserves (Shkilnyk, 1985; Kelm, 1998; Waldram et al., 1995).

[57] Primarily Innu-run, for families struggling with addictions and relationship breakdown (see chapter five).

[58] Some Innu feel the work social services does is necessary, but many Innu are suspicious of social services because they have removed many children from their families, rarely tell the truth about how long children will be gone for, and rescind financial support without cause (Series 1 Interviews, 2005).

[59] O'Neil states that "the most fundamental aspect of contemporary northern medical ideology is that northern Native societies are defined as sick societies." (Circumpolar Health, 1984, p. 420)

[60] O'Neil points out that "the bureaucratic and economic interests of health services and the various research industries are to certain extent dependent on a perception that Native societies are sick societies. If more sickness can be discovered, more resources are necessary and the future growth of these institutions is assured" (1984, p. 420)

residents of Sheshatshiu (Series 1 Interviews, 2005). Those who appreciate these services look forward to a time when they are not necessary.

With respect to employment, the assault on *nutshimit*-based economies forced the Innu to look to local industry and government to find waged work. However, though the Innu had been discouraged from continuing an Innu way of life, they were invited to participate in the cash economy only in the most limited sense and, as stated by Hanrahan, only at the bottom of the hierarchy of power (Hanrahan, 2000, p. 233):

> Innu men tried salaried work, and some even moved to Goose Bay to live, but language and training were big barriers to their success in these ventures. 'Most of these Indians do not know enough English to understand supervisors or bosses' observed John McGhee. 'Even for very simple jobs, where the principal requirement is brawn...for this reason and others, they rarely last as much as a couple of months on the same job.'" (Wadden, 1991, p. 66)

McGillivray describes the community economy as "based on social welfare programs, either directly through social assistance or through government job creation programs which allow people to work for a set number of weeks and then collect unemployment insurance benefits" (1988, p. 501). Currently, the majority of jobs within the community continue to be provided by the Band Council. Unemployment rates in Sheshatshiu (and Utshimassit) in 2001 were approximately 80% (Samson, 2003, p. 150). The processes surrounding getting and keeping a job are stressfully vague, most work is short-term – often just long enough to keep employment insurance coming in – and entrenched clan and familial factions make obtaining work a frustrating prospect (Series 1 Interviews, 2005). Work opportunities outside the community are largely associated with industrial ventures such as Voisey's Bay Nickel Company (VBNC); although these jobs pay well, the work schedule and commute are disruptive to family life and some

Innu struggle with the conflict of interests presented by working for a company that is damaging the environment (Interviews, 2005; Samson, 2003).

Schooling

The central role of schooling to economic and social success is tantamount to a physical law in the ideology of North American society.[61] With settlement the Innu of Sheshatshiu have come under the influence of this law. The Sheshatshiu school was built in 1961 and run by the Catholic School board until the late 1980's when the provincial government took over. Schooling was provided by Church personnel – often individuals considered unfit for duties elsewhere (Series 1 Interviews, 2005). Many students experienced physical and verbal abuse at the hands of these individuals and some teachers were eventually convicted of sexual abuse crimes (Innu Nation & Mushuau Innu Band Council, 1995; Series 1 Interviews, 2005):

> The dominance of the Catholic church...has waned significantly in recent years, not because people are returning to their traditional beliefs, but because too many Innu suffered sexual, physical and psychological abuse at the hands of religious workers and teachers. Innu testimony at the People's Inquiry of 1992 indicates that the current perception is that while the priests suppressed the drum, dancing, and *mukaushan* [feast for all Innu], all they offered in exchange were certain social services that in most Newfoundland and Labrador communities would normally have been supplied by the government. (Tanner, n.d., The Roman Catholic Church section, para. 4)

Unfortunately, the situation with respect to education has not been significantly improved by government involvement:

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[61] Neil Postman states that:

> Schools are to fashion Americans out of the wretched refuse of teeming shores. Schools are to provide the lost and lonely with a common attachment to America's history and future, to America's sacred symbols, to its promise of freedom. The schools are, in a word, the affirmative answer to the question, Can a coherent, stable, unified culture be created out of people of diverse traditions, languages, and religions? (Postman, p. 14)

> At the time that the 1993 Report was completed the state of education in the Innu communities was little short of disastrous. Attendance at schools was irregular, the drop-out rate was high and few Innu ever completed high school. Today the situation is generally regarded as the same, if not worse. Attendance at the high school level can be as low as 10% - and not always the same 10%. Students who do stay in school suspect that their education level is not the same as those at the same grade in other schools in Newfoundland and Labrador. Remuneration of teachers in the provincial system is structured in such a way that the Innu schools are unlikely to attract experienced teachers, and once they gain experience, they are likely to leave. Some years, it is difficult even to obtain a full complement of teachers.
>
> The schools in both Sheshatshiu and Davis Inlet are in extremely poor physical condition...There is agreement that it is necessary to construct a new school in Sheshatshiu, but there is no consensus as to who will fund the construction, nor whether the new school will be built to federal or provincial standards. No one claims that the schools provide any kind of effective mechanism for conserving and revitalizing Innu language and culture. Some Innu parents have lost faith in the capacity of the schools to offer education in either the Innu language and culture or in the basic skills offered under the provincial curriculum. A number of Sheshatshiu parents have responded by sending their children across the bridge to the school in North West River. (Backhouse & McRae, 2002, Education section, paras. 1 & 2)

Innu dissatisfaction with the school curriculum is not new. Sixteen years ago in 1990 "angry Innu parents padlocked the doors to the school and kept their children home until Newfoundland government officials agreed to give them a more direct say in how their children are educated" (Wadden, 1991, p. 69). Although work has begun on increasing Innu content, the cultural content is confined to "culture days", which trivialize the role of culture and miss the fundamental point, since activities are restricted to the class-room and do not take students into *nutshimit*. Relevance of the "core" curriculum to the Innu students continues to be negligible; the only subjects current students mentioned as useful were English and Computers, while older people expressed disgust at the fact that they were taught about John Cabot and nothing about their own history, or even that of Labrador (Series 1 Interviews, 2005). The teachers are all non-

Innu except for one Innu teacher responsible for *Innu Aimun* (language), and a handful of Innu teacher-aides (Interviews, 2005; Samson, 2003; Wadden, 1991).

Even in the subject of music, which is marginalized in public schools across the country, non-Innu standards of certification are required to teach music in Sheshatshiu (Series 1 Interviews, 2005). The following exchange with David Penashue, an accomplished musician and one of the participants for the current study, encompasses issues of provincial control, certification, lack of cultural relevance, and historical and cultural disempowerment. He suggested that with reserve status, and the subsequent transfer of education out of "the system in Newfoundland," the lack of accreditation for going into *nutshimit* would be reversed and other issues with education would also be improved:

> Because you will learn more about cultural stuff. When I went to school they teach me how John Cabot arrive! (laughter) and my dad teach me in the bush how the Innu arrive...but they give you credit about John Cabot – how the native people were here – they don't give you no credit. It's how the system works...I hope it will all change and I will look for a job there...in teaching music. I heard some people teaching the kids music – *akaneshau* [white people], it's more English. I would love to see more kids singing their own language. For me that's what my goals are. Innu music. But right now I cannot do that I have to have a degree, a teaching degree. That can also be changed, only the people they can change it are our leaders in the Band Council. They [will] have the power, but right now they can do nothing – they still in the Newfoundland [system]. (Series 1, David Penashue Interviews, 2005)

Registration for the Innu of Labrador:

The above quote demonstrates that Innu control in key areas such as education is conditional on reserve status. Although the government appeared willing to transfer education into Innu control without these measures, this did not turn out to be the case:

> Paragraph 2 of the 24 1999 Agreement in Principle provided that "Canada and the Province will work together with the Innu to transfer control for [education]

> programs to the Innu." This has not happened...in fact, there is a widespread view among federal and provincial officials that the Innu do not have the capacity to manage education in their communities.... If it is expected that the Innu are to come up with a plan to solve the problems of Innu education – something that the Government and the Province have been unable to do – before they are given responsibility for Innu education, then this is tantamount to a refusal to devolve education to the Innu.... It is difficult to see how the continuation of a system that clearly does not work will improve education in the Innu communities. And it is difficult to understand why giving the Innu the opportunity to take responsibility for the education of their children could make anything worse. (Backhouse & McRae, 2002, Education section, paras. 6-8)

The human rights report describes the process around registration and reserve status of the Innu as a "saga".[62] The following chronology is adapted from the human rights report. The Innu inquired about registration in 1976; in 1977 they applied to be registered under the Indian Act. The province of Newfoundland and Labrador objected to this move and no registration occurred. However, in 1978 the federal government recognized the Innu land-claim based on occupancy rights. In the late 1980's the government was prepared to offer the Innu registration, but the Innu no longer wanted to be registered under the Indian Act. They considered the act outdated and paternalistic and, since their land claim had been recognized, felt registration was an unnecessary step in the process towards self determination. Instead, during the 1990's the Innu argued for equivalency with other registered Native groups without registration. In 1992 the government recognized the Innu as a unique group and conceded to working towards

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[62] The 'saga' is

> an unfortunate one that does not reflect well on the Government. The Innu were offered registration. The offer was subsequently withdrawn and then re-offered. The Innu were told they were getting equivalency without registration, but then told equivalency only applied to programs and services and not to taxation. They were then told they could get taxation exemption if they became registered. When a parallel was drawn with Conne River, the Innu were told that they were different from the Aboriginal inhabitants of Conne River, although an internal government memorandum provided to the Innu under an Access to Information Act request appears to indicate that the only real difference between the Innu and the Mik'maqs of Conne River was that whereas the Mik'maqs had sued the Government, the Innu had not. (Backhouse & McRae, 2002, The Issue of Registration section, para.16)

Innu self-government. The 1993 human rights report recommended that the government move forward with land claims and self-determination negotiations without requiring Indian and reserve status. The government seemed prepared to proceed. In 1997 the offer of registration was withdrawn:

> and this was the position taken by the Deputy Minister of DIAND, who wrote to the Innu on 12 December 1997, stating: "[W]ith self-government currently under negotiation, it appears that registration and reserve creation is an unnecessary step to take and then undo under a self-government regime." In short, the approach appeared to be that the Innu would receive all of the benefits to which status Indians on reserve were entitled, that land claims and self-government would be negotiated, and that in this way the Government would have fulfilled its constitutional responsibilities. However, it did not work out that way. The Government, it turned out, was not prepared to grant the Innu all of the benefits to which status Indians on reserve were entitled. The sticking point appears to have been tax exempt status, which the Government was not prepared to provide to the Innu. (Backhouse & McRae, 2002, The Issue of Registration section, para. 3)

In 1999, Innu leadership held a referendum to discern whether Sheshatshiu and Natuashish community members were prepared to go through with registration (and eventually the creation of reserves) if it were the only way to achieve equivalency. Both communities voted in favour of "doing whatever was necessary" including agreeing to registration (voter turn-out was 49% in Sheshatshiu with 78.5 % in favour; in Natuashish there was an 88% voter turnout with 88.2% in favour). It was not until 2001 that the Cabinet formally approved the registration of the Innu under the Indian Act. "Thus, for the Innu, registration will be the culmination of a long and tortuous process. In the words of Peter Penashue, "it should have been just so simple. Eight years later [since the 1993 Report] they are starting to do what they should have done in 1949" (Backhouse & McRae, 2002, The Issue of Registration section, para. 17).

What the process of registration will achieve is unclear since, in the absence of reserve status, it will not remove the province from Innu affairs:

> Even after registration is complete, the Province will continue to be involved. The Government views the Province as continuing to provide education, and possibly other services, with a transfer of federal funds to cover the costs. The Government takes the position that the Innu have yet to develop the capacity to administer such programs on their own. Federal officials claim that substantial "capacity development" is required before the Government will move towards the devolution of such programs directly to the Innu. The long-term goal, concedes the Government, is to have the Innu assume control. (Backhouse & McRae, 2002, The Continuing Role of the Province section, para. 2)

Health Care

As was discussed earlier, the International Grenfell Association was responsible for providing health care services in Sheshatshiu until 1981 and in that year the provincial government took over from the IGA. The quality and availability of these services was likely sub-par. Maura Hanrahan offers the following description of IGA work with the Métis:

> The IGA and Western medicine did not figure prominently in the health narratives of Métis Elders. There was in fact only one spontaneous mention of these subjects even when informants were asked about 'health': this was an Elder's mention of how and IGA doctor said his community was the healthiest in Labrador. This man also reported that another IGA doctor used Métis medicine...to cure rash when his own methods failed. When asked about the IGA in particular, one informant described the Association as 'parental' and remarked:
>
> > Do not ask me my opinion of Dr. Grenfell himself because I will not express that. But I will say that Dr. Grenfell had some wonderful people working for him. (Hanrahan, 2000, p. 238)

Throughout the whole area of Labrador where the Innu traveled before settlement, health care services were intermittent and available largely along the coast as the main mode of transport to the interior was by dog-sled. Paddon reports that:

> Until the end of the Second World War...the total resources of the area consisted of a ten bed hospital at North West River, and the care of the outlying settlements was restricted to a patrol of the coast by summer in the small hospital boat 'Marval' and a visit to parts of it by dog-team in the winter. The territory, even using modern air transport, is over four hundred miles long, and over eight hundred as the dog-team travels. (Grygier, 1994, p. 161)

Furthermore, according to Grygier, Grenfell's "efforts in preventive medicine [1920-1930], and the hospital facilities of the mission, were available mainly to the predominantly white fishing communities of southern Labrador and northern Newfoundland" (Grygier, 1994, p. 161).

Once the Innu were settled at Sheshatshiu only limited health care services were available to them there.[63] Residents of Sheshatshiu supplemented the North West River hospital services with those of the Melville hospital in Happy Valley Goose Bay, which opened in 1953 and provided acute, primary and secondary care to residents of northern Labrador (www.releases.gov.nl.ca). After the 1970's, when the base was opened to civilians (McGillivray, 1988), some Innu used the base hospital (Series 1 Interviews, 2005). In 1983 the North West River hospital was closed. A small health clinic was operated within Sheshatshiu during this period (Series 1 Interviews, 2005). In 1996 construction began on a new hospital in Happy Valley Goose Bay to replace the ageing and insufficient Melville hospital (www.releases.gov.nl.ca). The new Labrador Health Center opened in September, 2000 (www.hlc.nf.ca). In December of 2000, the North West River clinic and the Sheshatshiu health clinic were combined and relocated (www.hlc.nf.ca). The new Mani Ashini clinic opened in April of 2001 and it provides community health care for the Innu of Sheshatshiu and the residents of NWR.

The Mani Ashini clinic is located on the edge of Sheshatshiu – at the boundary between the Innu community and the settler community of North West River. In fact, the building itself is divided in half. The wing closer to the road and to North West River is operated by Health Labrador Corporation and is referred to as the North West River

[63] Though they were employed at the North West River hospital as early as 1963 (Wadden, 1991; McGillivray, 1988),

health clinic. The wing farther in toward Sheshatshiu is operated by the Band Council. A third wing extends back from the midpoint between these two; it houses the diabetes program offices which are administratively and physically separate from the Health Labrador portion and Innu health portion of the clinic. There is no permanent doctor stationed at the clinic. A nurse-practitioner works at the clinic full-time and a doctor from the Labrador Health Center schedules visits to the clinic every few weeks. To see a doctor, or for emergencies, residents of Sheshatshiu (and NWR) travel to the Goose Bay hospital. For special services, such as children's care, heart conditions, and dialysis (treatment for kidney failure, one of the complications arising from diabetes) people have to fly to St. John's or Halifax (Interviews, 2005; Anthropology Module, 2003).

As discussed earlier, health care among the Innu is a jurisdictional nightmare and the negative impact on people's health of having to navigate this complex and constantly shifting maze of providers and services is undeniable (Innu Nation & Mushuau Innu Band Council, 1995; National Round Table on Aboriginal Health and Social Issues 1993). With respect to diabetes specifically, a patient who comes into the clinic with symptoms is referred to the Labrador Health Center to be diagnosed by a doctor. From this encounter one stream of records is produced. The patient is then referred back to the clinic-based diabetes program. The patient's interactions with the diabetes program generate a second stream of records. Because the diabetes program is not run by Health Labrador Corporation, the diabetes workers do not have access to the computer system containing the patient's first set of records (Series 1 Interviews, 2005). A health care worker explained how the gap between these two sets of records directly detracts from the continuity and quality of care that the patient receives. She described an experience

where a patient came in to the clinic with elevated blood sugar levels. As it was the health care worker's first encounter with the patient, she advised closer attention to sugar levels and counseled the individual on blood sugar management strategies. After the patient had left that she discovered that since diagnosis (with Type II diabetes), the patient had in fact managed to lower their blood sugar levels significantly. Hence, despite the sugar levels being elevated, the patient had effected some improvement. The health care worker was frustrated and regretful, pointing out that had she been aware of this improvement she would have congratulated and encouraged the patient to keep up the good work – a key form of support in managing a lifelong disease like diabetes.

In the following quote, the social and psychological nature of the illnesses and deaths afflicting the Innu is apparent – Samson describes the typical portrait of a group suffering the effects of colonization:

> The frequency of infant deaths, alcohol-related deaths, and suicide does not tally with the figures for most of Canada. Significant numbers of Innu die in what are called accidents when they have been drinking heavily...The local doctors and nurses say that diabetes, heart conditions, respiratory conditions, skin diseases, arthritis, ulcers, obesity, alcoholism, and accidents are also very common. Many diseases occur at younger ages than are usually found in other populations; [Type II] diabetes for example, affects some teenagers. (Samson, 2003, p. 229)

He refers also to the problematic record-keeping – a product of jurisdictional ambiguity – that contributes to the confused and fragmented approach to Innu health:

> The few and somewhat fragmentary health and mortality statistics that I have been able to collect...generalize and agglomerate the family breakdown, abuse, drunkenness, and alcohol-related diseases, violence, accidents and self-harm. Even though no detailed figures are kept in Sheshatshiu or Utshimassit, at the hospital in Goose Bay, at the Health Department in St. John's, or with Health Canada in Ottawa, it is obvious to the local health workers that life and death for the Innu are not what they are for people in other parts of Canada. (Samson, 2003, p. 229)

The scanty statistics and the fact that the method of recording deaths generalizes, agglomerates, and cites only immediate causes (such as "accidents") obscure the profound impact of alcohol and despair on Innu health.[64] And yet, the underlying role of alcohol and despair in the high mortality rates in Sheshatshiu must be acknowledged if an effective approach to health is to be achieved.[65] This fact is revealed, despite the statistics or lack thereof, through both community health care workers and the Innu saying that alcohol and suicide are the primary and inextricably related health concerns in the community (Interviews, 2005; Wadden, 1991; Samson, 2003; Innu Nation &

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[64] The problematic elements of epidemiological analyses, which stem from statistical records, are discussed by Lupton and Petersen, who make specific reference to death certificates as a prime example of the socially-constructed nature of epidemiological "data":

> The format of the death certificate, which by law must be filled in by a medical practitioner when someone dies, implies several rules: death is a product of pathology and is a physical event; and the cause of death is visible at postmortem, is always a singular event, is proximate to the event of death and makes sense in the context of assumptions about natural and normal death (that is, it should be a likely event given the dead person's age, medical history, and so on.) (Petersen & Lupton, 1996, p. 40)

Lupton and Petersen go on to talk about alcoholism as a prime example of why the causes of death are *not* singular, precise, and proximate. The fact that they, like Samson, link statistics and epidemiology, death-certificates, alcoholism, and the exclusion of factors like poor housing and nutrition, and poverty into a problematic constellation, reinforces the need to understand the colonial roots of ill-health in Sheshatshiu:

> For instance, doctors are aware of the social need to cite liver disease rather than alcoholism as a cause of death because the former diagnosis is more precise and linked to a specific organ failure For similar reasons, social conditions such as poor housing, poor diet, or poverty are generally not considered appropriate to cite as reasons for death on certificates. (Petersen & Lupton, 1996, p. 40)

In the case of the Innu, the "need" may in fact be to cite alcoholism, poor housing, poor diet, and poverty as causes of death rather than the medically circumscribed singular, physical event of liver failure, for example. The arguments offered by Lupton and Petersen demonstrate the politically, historically, economically, and socially evacuated character of the biomedical and clinical approach to health and illness. It is the very lack of acknowledgement of these embedded, systemic and dynamic factors, that has enabled the individualistic, lifestyle-oriented approach to dominate the provision of health care since the mid-1970's (Petersen & Lupton, 1996).

[65] Wotton reports that in the 1980's the suicide rates for Northern Labrador (including both Innu and Inuit) were twice the national Native rates and five times the national non-native rates (Wotton, 1984, pp. 141). Samson states that "in Sheshatshiu there is at least one suicide attempt per month" and at times associated with heavy drinking – around elections, when people return from *nutshimit*, and on pay-days (Series 1 Interviews, 2005; Samson, 2003; Andrew & Sarsfield, 1985) – "there can be several in any given week" (Samson, 2003, p. 227).

Mushuau Innu Band Council, 1995; National Round Table on Aboriginal Health and Social Issues 1993).

Although health care workers and the Innu agree on the priority of alcoholism, suicide, and other self-destructive behaviours, they reach different conclusions about the implications of the importance of such issues. While health care workers focus on Innu individuals and culture, overlooking wider community and social circumstances, the Innu understand health and ill-health to be the totality of experience formed by history, politics, economics and social relationships in the community (Series 1 – 3 Interviews). Samson summarizes the perspectives of a variety of health care workers he interviewed in Sheshatshiu (and Utshimassit) as individualistically-oriented:

> Both doctors and nurses working in the Innu villages commonly locate the underlying causes of physical illness and disease in the conduct of the Innu themselves, particularly in their inability or unwillingness to teach their children basic safety requirements, their lack of coping skills, aversion to washing, their drinking, poor nutrition, and sexual promiscuity. (Samson, 2003, p. 237)

This individualistic perspective and approach is reasonable considering that the overarching biomedical and clinical approach to health care adopted internationally has been geared towards the individual since the mid-1970's (Petersen & Lupton, 1996). Nonetheless, its power to effect improvements in Innu health is limited because the fundamental sources of Innu ill-health lie in precisely the areas overlooked by the individual, lifestyle approach to health care. Let us take an example from one of the interviews conducted in 2005 to elucidate the Innu perspective on the effect of alcohol on individual and community health.

Alcohol and Individual and Community Health

Katie Jack was one among many participants who cited alcohol-abuse, alcoholism, and alcohol-related social problems as a number one concern of community life. Although Katie Jack sees her own role in overcoming her addiction to alcohol as centrally important, she does not blame herself for being an alcoholic, nor is she convinced that even successful participation in an alcohol treatment program will provide a long-term solution. In other words, in contrast with the individualistic focus of health care workers, although Katie Jack understands her individual effort to battle addiction as key, this view does not lead inexorably to an individualistic understanding of the sources of alcoholism. On the contrary, implicit in her explanation of *why* she suffers from alcoholism are the community-wide, politically and socially constructed factors that lead to a dependency on alcohol:

> **L**: I asked her what was one of her worries...or problems that she encounters. She said one major problem was alcohol. She likes her beer and she do drink...Like when she raised her children – children that aren't belonging to Ben, from another marriage fifteen years ago...and since then she's played the role of mother and father – this guy has left. She's had a hard time raising child trying to be both parents raising children.
> **Z**: And have a job on top of it.
> **L**: Yes. And this was hard for her. There was lots of stress involved...She been stressed out in the past and whenever this occurrence happens she turns to alcohol just use it to sooth her mind I guess. And also in the past she has thought about suicide as well – so much stress. (Series 1, Katie Jack Interview, 2005)

In other words, Katie Jack turns to alcohol as a form of stress-relief. I will take the next few pages to outline the various kinds of stress that Katie Jack is under, the point being that as long as these stresses exist, so will alcohol abuse, and alcoholism will continue to impede the effectiveness of the self-care practices so crucial to the individualistic,

lifestyle approach to health care generally and diabetes specifically (Hickey & Carter, 1994; Jack et al., 1999).[66]

For Katie Jack, the sources of intense stress range from issues of family support, as discussed above, to community-wide issues of insufficient and unevenly distributed housing and social programming. She views the political and family favouritisim practiced by the leaders in the Band Council as the source of this unevenness and insufficiency:

> **Z**: So how do you feel about living in Sheshatshiu?
> **K**: Innu Aimun
> **L**: They don't like being here because of all the fighting that's going on and the lack of assistance people receiving from the leaders. Favouring others friends or relatives. (Series 1, Katie Jack Interview, 2005)

A similar experience of the negative impact of political favouritism was described by Lea Rich:

> **Z**: Is there – what do you feel like about living in this community? Is it a good place to live?
> **Le**: No. the way everything is going now I don't think so. Fights. Chief. Councilors.
> **Z**: Do you see any way the situation could be improved?
> **L**: if the chief was related to everyone! (laughter)
> **Le**: I don't think people should get PO's [Pay Orders] they should pay their own stuff. Usually pays for the festival in summer and stuff. BC [Band Council] pays for them. They should pay their own way if they want to go there. If I want to go somewhere I pay my own way.
> **Z**: If it were up to you what would you have the BC spend money on?
> **Le**: housing, water, health, school. (Series 1, Lea Rich Interview, 2005)

[66] There are both physical and psychological elements of alcoholism that make it a significant obstacle to diabetes prevention and management. The physical factors are the high carbohydrate, high sugar content of alcohol, which destabilizes blood sugars (Canadian Diabetes Association, 2003), and that drinking binges often lead to malnutrition (Shkilnyk 1985; interviews 2005). The psychological factors are that the depression and self-loathing that undergird alcoholism also impede the self-care practices recommended to diabetics (Hickey & Carter, 1994; interviews 2005; The diabetes Educator 1999;). Hickey and Carter state that alcohol use, which they contextualize as a response to the poverty and despair of acculturation, can lead to "less effective self care" (1994, p. 458).

Long delays in housing repairs is one way in which the political favouritism affects Katie Jack. In response to a question about her health she replied:

> **L**: Physically she's fine but she also have other worries as well because of...when she was working here she had to leave her job and work at Voisey's for a while. While they were, both of them were working at Voisey's, while they were gone the house – some kids had broken into the house, to the house – beat it up. Just the way it is today.
> **Z**: How long has it been since that happened to your house?
> **L**: It's been over a year now...She requested on several occasions...she herself has went to the Band office and talked to the people who look after the housing. They told her that there is no funds available for that. And they told her when they become available in April...now where are they supposed to live between now and April? They said there is no funds. But there are. Houses are getting fixed as we're sitting here talking so...(Series 1, Katie Jack Interview, 2005)

Others, including Greg Penashue, also experience discrimination in housing issues. In response to a question about the Band Council's contribution to the community Greg Penashue said:

> G: I don't know, there is so much trouble within their own self and that's the saddest part. I guess Band Council is so much different now these days the way it was. The place that you used to you could go if there was a need. Now it's almost like...you almost have to lick somebody else's shoe to get anywhere these days! It almost makes you feel almost like a dog right! In order to get anywhere with anything, yeah. I've been told that once they were supposed to do some work with my house seven years ago! Still haven't done anything yet. They only put that ramp – the one that they have outside – only recently. More than a week ago now I think, because I'm sick [in a wheel-chair from a recent stroke]. It almost make you feel like you have to get sick in order to get something. That's sad. It doesn't have to be. I used to have a kid here that lived with us more than ten years and we used to need a ramp like that. Social Services took him because I drink too much. Placed somewhere else. Still doesn't have a ramp. But he'd been with us a good many years and we never used to have a ramp. (Series 1, Greg Penashue Interview, 2005)

Both for Greg and for Katie, the political determinations of housing issues are most troubling, not in terms of their own needs, but for their children's needs. Although having her house "beat up" beyond habitability was stressful for Katie because all of the

family's possessions were stolen,[67] and living with her mother removes all privacy,[68] what makes it most intolerable is that her children are negatively affected:

> One of the things she encounters living outside her home where she can't live her home because of the damage that's in the house...she's moved in with her mother. Children feel uncomfortable there – sleeping other than their home, their rooms. And because of this, they're discouraged to go to school, to attend school regular. (Series 1, Katie Jack Interview, 2005)

As well as in relation to housing, political favouritism also affects youth directly through limited accessibility of social programming. Katie Jack explains the importance of social programming for youth in the community as follows:

> L: there are other problems as well like teenage pregnancy right. It's because...she believes it's because of the lack of things to motivate children. For instance to stay in school, or just to be happy and stay out of trouble. (Series 1, Katie Jack Interview, 2005)

That motivational programs are not equally available to all families in Sheshatshiu is apparent:

> L: because we find out program has been started long ago and you cannot just take person and...get her take part in program already half gone right. She said they should be more open about it and should be like, for instance announce it on the radio. There are people here that are aware that the programs are being offered and these are the people that have their children in the program. It's open for everybody right, why just them right? Happens all the time right, with other programs right. If there's exchange program going on, they'll make sure these leaders children will go first. Rather than having someone like me – someone on welfare for instance. Usually it's someone they know – their children will go. (Series 1, Katie Jack Interview, 2005)

In sum, Katie Jack's primary sources of stress living in the community are issues with housing and social programming resulting from political favouritism. Her main

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[67] Louis Rich translates for Katie Jack: "When this happened...the kids were stealing stuff from the house – all the household items and the young girl lost all her belongings from her room right. [*Innu Aimun*] And even the bed was taken from her home" (Series 1, Katie Jack Interview, November 2005).

[68] Louis Rich explained: "I've asked her one of the discomforts she's having right now. One of the things that she don't like that she's going through right now. She's living with her mother right and there isn't enough room for the whole family and not only that there's no privacy" (Series 1, Katie Jack Interview, November 2005).

form of stress-relief is to drink alcohol. However, although alcohol is Katie's form of stress-relief, her addiction to alcohol is itself of deep concern to her. Hence, the result of house-related stresses cause Katie to turn to alcohol, but then alcoholism in turn becomes a source of stress parallel to housing issues. Katie Jack's closing interview statement captures this frustrating relationship:

> What would she ask the chief if – in terms of support. She said she would ask to assist her to go to treatment as well as one of her children to go with her. And while she's gone she would like to come back to her home all repaired. (Series 1, Katie Jack Interview, 2005)

Although there are programs to help people manage alcohol addiction, the situation outlined above demonstrates that staying away from alcohol is not primarily a matter of individuals' ability to quell addiction, but of removing the sources of stress that lead people to drink in the first place. In other words, treatment programs do nothing to diminish the community-wide issues of problematic political structure and family break-down, and hence their power to engender profound, long-term improvements in substance abuse in the community are limited. The following quote from *The People Named the Chippewa* highlights this issue:

> The federal government collects revenue from the sale of beverage alcohol; the funds that are returned to tribal communities are used to establish new treatment bureaucracies that focus on individuals rather than on larger social problems. (Vizenor in Samson 2003, p. 269)

Joseph Pokue's remarks (translated by Louis Rich) articulate the need for structural community-oriented approaches, rather than individually-oriented approaches to alcoholism (and, other diseases including diabetes):

> What's the most negative social problem we encounter in the community? Number one I would have answered would have been alcohol. That was exactly the answer he gave me. He said because of it there's a lot of disrespect among the community members overall. People are reluctant to help themselves although

> they have this problem. And the other thing is the leadership. When there's an election goes on for instance, this causes broken relationships – families are separated. All this as far as this road goes down goes back to alcohol right – leadership, broken relationship, people not helping themselves, people disrespecting one another – this all starts from this here, from alcohol. So he said if there is abuse of alcohol being distributed during the elections then he don't want to see any more elections if this is how it's going to be he don't want to see any more elections. (Series 1, Joseph Pokue Interview, 2005)

The wide-ranging impact that alcohol has on all aspects of community life is apparent in this quotation. Joseph Pokue describes the chain as beginning with politicians – alluding to the fact that alcohol is distributed during elections in order to secure votes. Another informant further explained the connection between alcohol and elections:

> L: I hate politics (laughter). When there's an election then they do some kind of campaign – they buy beer for people. Let's say if I wanted to be president of the Innu Nation and there was an election, I would...I would have to have a lot of money to campaign for the election and I would have to buy forty-dozen of beer sittin' there and I'd tell people to come in and vote for me and ok drink some beer – or I'll give you twenty dollars. That's what they do here, when there's an election there they buy beer, they give money away so the person who wants...so the person can be voted. If the person wants to try some kind of – like the president's position, they just buy beer and give money away and they drink and all that. It's kind of like buying votes for residents of this place. They like...I don't know how to explain it...it's just beer, money...beer and money that's all you gotta say if you want to be voted, gotta have that. If you don't have it, I don't know, you wouldn't get any votes I guess. That's just one...one opinion. There's all sorts of...there's a lot them, there's a lot of people. I mean like every elections they buy beer so they can be voted. They buy beer for people so the person can be voted. I don't know what to say to that. Is it wrong or is it...because...I don't know. It's a hard question though. (Series 1, Louis Rich jr. Interview, 2005)

Without further analysis, these statements suggest that alcoholism in Sheshatshiu is the fault of corrupt politicians. However, such an analysis overlooks the historical context and, like the individualistic lifestyle approach to diabetes, alcoholism, and health care generally, this type of superficial analysis and individualistic blame for political dysfunction leads to superficial solutions.

Politics in Sheshatshiu: Band Council Government and Alcohol are Introduced Ills

The historic context of the current political situation in Sheshatshiu is that the Band Council governmental structure, like alcohol, was introduced by the colonizers.[69] It was at the outset, and continues to be, at odds with the Innu way of leadership and group organization as it was practiced before settlement. José Mailhot clarifies that the Innu pre-settlement were indeed organized into "bands", but the band structure of the nomadic Innu is markedly different from the settlement-induced "band" of Sheshatshiu and other communities. The most important difference is that nomadic "local bands" were "close-knit groups of fewer than a hundred individuals occupying a river basin...They were subdivided into hunting groups during the greater part of the year" (Mailhot, 1997, p. 39). The family unit, therefore, was autonomous for the greater part of the year – a situation which demonstrates the appropriateness of the Innu approach to *utshimau* (leaders and leadership). The local bands are referred to by many Innu as "clans" (Mailhot, 1997; Series 1 Interviews, 2005), and the hunting groups were even smaller groupings ranging from a single family to several. Clan divisions and family autonomy and loyalty were, and are, profoundly important to social interactions and organization. Mailhot argues

[69] Band Councils and elections were forced upon Native communities all across Canada by the colonizing government. In many cases political/legal charges were fabricated by government officials in order to provide a way to depose strong leaders and undermine an already existing political structure less conducive to assimilation (Carter, 1990). A Mi'kmaq man from Eskasoni I spoke to scoffed at Canadian pride in the fact that our Nation has never upheld a puppet government in a foreign country – he pointed out that multiple puppet governments were put in place within Canada in Native communities in the form of Band Councils. From his perspective, the social breakdown and high rates of unemployment on the Eskasoni Reserve are a direct result of the introduction of Band Council government (V. Doucette, personal communication, June 2005). Stuart Myiow of the Mohawk Nation described Kahnawake as being involved in a civil war – the introduced Band Council government against the pre-colonization government (Myiow, 2005).

against the misconception that the Innu are egalitarian; she points out that the clan divisions form the basis of hierarchy in settled communities and that Sheshatshiu, more than any other Innu community, has to contend with this hierarchy:

> Sheshatshiu is unique among the community of the peninsula in that it includes four [clan] subdivisions. Not only do its subdivisions have a more complex history than one finds elsewhere but, more importantly, they constitute a strictly organized hierarchy that plays a critical role in the community's social and political life. (Mailhot, 1997, p. 40)

The agglomeration of four different clans in Sheshatshiu makes the single-chief governance structure of the Band Council highly problematic because although family groups were self-sufficient in *nutshimit* (see footnote 69), within the community the four clans "do not enjoy the same status" (Mailhot, 1997, p. 48) and the egalitarianism of *nutshimit* is lost. Many of the interview participants painted a dismaying picture of how family autonomy and loyalty and clan divisions have, in the context of the Band Council government, chiefs and elections, been transformed into nepotism and corruption in the form of familial favouritism and clan factionalism. With respect to the Band Council structure and the so-called election of chiefs, Samson writes

> While the introduction of the state and institutionalized authority has altered Innu society, the colonial origins of these changes...signify that the policies of an already established state brought them about...Innu "chiefs" do not derive their power from "the group" in the throes of social change, but from the state that has imposed and legitimized such positions. (2003, p. 35)[70]

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[70] That the whole concept of chiefs was foreign and in fact inimical to the Innu approach to leadership is noted by various researchers who have studied Innu social organization, and is apparent in the secondary analysis data (Mailhot; Wadden; Armitage; Series 4, Anthropology Module, 2003; Series 2, Interviews). In *nutshimit* the *utshimau* takes charge, takes the lead, for a specific voyage or task; when the task or journey is finished, the role of *utshimau* is open. The leader does not "have the main say" (Series 4, Anthropology Module, 2003), he does not preside over all decisions, and he is only leader for a limited period of time:

> Each family could produce all the technology it needed and a generalized exchange ensured the fair distribution of goods among individuals. Deference was shown not to chiefs endowed with privileges and authority but to leaders who were respected and listened to for their experience and

Samson provides statements from former President Katie Rich, and others, like Penote Michel, who became involved with Band Council politics:

> One of the hardest things that I find in being a leader is that I have a lot of responsibilities for the people. As a leader you have to live on both sides, both the Innu and non-native way. You have to follow the white man's way of living; you have to be able to understand their ways...You have to choose which path you will go for the people. Because people depend on you a lot, you want to take the steps towards what the people want, but the government also pressures me to do things their way. It is dividing the leaders not in the sense that there is division amongst the leaders, but dividing us personally. (Katie Rich in Samson, 2003, p. 35)
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> Those of us drawn into positions on the councils find ourselves expected to act in ways which are not only counter to norms of Innu behaviour but which amount to serving as proxies for our colonizers in administering the government villages...Here we are expected to preside over little empires of chronic financial dependency, watching the foreigners' welfare money flow in while our People and culture disintegrate around us. (Penote Michel in Samson, 2003, p. 35-36)

The experience of Francis Penashue, who was hand-picked by Father Pirson in 1958 to receive an *akaneshau* education, and who was "elected" chief in a typically alcohol-soaked election in 1980 (Wadden, 1991), demonstrates that the use of alcohol as leverage is a form of corruption that is also used by non-Innu parties with a vested interest in Innu compliance:

> Businessmen from Newfoundland or Goose Bay wanted to get their hands on some of the government money allocated for new housing and services in Sheshatshiu, but in order to do so they need the chief to sign construction contracts.[71] Francis says he was often invited to meet people at hotels in Goose

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wisdom. In Innu society before contact with Europeans, individuals, groups and probably even the sexes were on an equal footing. (Mailhot, 1997)

[71] The large proportion of jobs allocated to non-Innu individuals and contractors from outside the community was raised as a major concern by many of the interview participants. In fact, while I was in Sheshatshiu there was a protest against Band Council hiring policies which was sparked by the hiring of an *akaneshau* at the Family Resource center, an Innu-run healing center for families struggling with addictions and family break-down. A significant amount of the government money that comes into the community is then spent on non-Innu working in jobs ranging from advisors to the chief and council, construction, health care, and child care. Louis Rich is disgusted by the fact that a significant amount of money that comes in

> Bay, and inevitably a bottle of booze would be put on the coffee table in front of him. The liquor eased his nervousness and enabled the businessmen to get what they had come for – his signature. Instead of enjoying the prestige that should have come with the chief's job, Francis' self-respect was further diminished and he became more depressed. (Wadden, 1991, p. 86)

This account suggests that in Sheshatshiu, not only Band Council government but also the connection between alcohol and leadership through the use of alcohol as a political bribe was introduced by colonization.

Although it can be argued that alcoholism, corrupt leadership, and the role of alcohol in elections are the fault of the colonizers and not of the individual Innu politicians, this kind of argumentation does not do justice to the complexity of the lived experience of politics in Sheshatshiu. Joseph Pokue illuminates the complexity of navigating between individual, collective, Innu, and non-Innu responsibility for alcoholism in Sheshatshiu (Louis Rich translates):

> L: He said every individual has problems and somehow or another it's always related back to alcohol. Alcohol is always there as a negative thing. For instance if both spouses are fighting, one of them will have some excuse to turn to booze. So all alcohol is doing is hurting the community. Nothing good about alcohol. No matter where you talk about *akaneshau* was involved in there somehow. They introduced to alcohol for instance, *akaneshau*. Even before beer or liquor came out there was home-brew and this came from *akaneshau* some years earlier. (Joseph Pokue, Interviews 2005)

That alcohol was introduced by non-Innu is apparent, but what to do about the current state of addiction in the community is less clear – many informants clarified that the Innu do not believe that blaming *akaneshau* will solve the problem. Joseph Pokue articulated this common position as follows:

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from the government is spent on paying non-Innu to manage this very money through what he called "co-management agreements":

> Band Council spends 250, 000 on co-management. Works to about twenty-grand a month just so people will look after the funds, other peopole than ourselves. 250 000 could build a lot of houses, fix a houses, or create programs. (Series 1, Louis Rich in Lea Rich Interview, November 2005)

> L: He said...Joseph said we're always blaming other...*akaneshau* for instance, we're blaming them when the problem lies within us. A lot of people are reluctant to take the blame, the prefer blaming somebody else. Although he said everything is surrounded with alcohol there's going to be a negative result. He said he wouldn't normally blame anybody else for his drinking or the causes or the problems created by drinking only himself, he said. And a lot of people don't realize this he said. They'll always want to blame somebody else. (Series 1, Joseph Pokue Interview, 2005)

There are a number of aspects to the healing that must occur around alcohol on the individual, familial and community level. Some of the changes that need to happen cannot be made by anyone other than the Innu themselves, as Greg Penashue attests:

> G: You know the biggest problems we always have is that we are the problem. We gotta remember that. That's one of the hardest things that doesn't sit well to anybody...[Not giving people booze or money] this is where I said it's going to be really, really hard you know to be able to make a change. We have to say no to everybody no matter how much you love them! It's going to be hard because they'll come back and say things to you like you don't like them, you hate them, you don't love me and everything else, you don't care for me and everything else. Like, the guilt will come up, try to make you feel guilty. (Series 1, Greg Penashue Interview, 2005)

Alcoholism, like diabetes, is only one of many symptoms of a larger disease of colonization brought upon the Innu by settlement and community life – which, as Father Jim Roche put it, undermines a people, their identity and way of life. Altogether, settled life for the Innu has not brought them into the modern world in the way that was hoped for. The majority of community members do not have secure jobs or adequate housing. Most of the school-age Innu do not enjoy school at Peenamin Mckenzie and do not think it provides good quality education. A small fraction of students complete school, and most young Innu feel uncertain that they have the qualifications to get work outside of Sheshatshiu. The registration of the Innu has not moved them towards self-determination despite government assurances that registration would expediate the process. Health care provision in Sheshatshiu is hampered by jurisdictional ambiguity and administrative

complexity, and the clinical approach to achieving health does not comprehend the range of factors, such as alcohol and substance abuse, affecting Innu health. Alcohol and substance abuse are the number one health concern for the Innu, and the health care system's approach to these afflictions fails to address their fundamental causes. Finally, in addition to invalidating the Innu conception of leadership, the introduction of elections and Band Council government among the Innu has transformed the long-standing, healthy and valuable familialism among the Innu into corrupt and dysfunctional nepotism.

Having listed many of the negative aspects of life in Sheshatshiu, it is crucial to note that many community members are devoted to the community and to making it a better place to live (Series 1 Interviews, 2005). Their efforts to achieve this goal revolve around rebuilding relationships with one another and re-instating the *Tshishennaut* in positions of authority and respect so that the community can be guided into the future based on a solid foundation of history and experience. In the following chapter, the *Tshishennaut* perspectives on food, health, culture and lifestyle change, and diabetes provide a sense of what life was like for the Innu before settlement and how settlement has corroded Innu values, social structures and health. Also, the *Tshishennaut* reveal the integrated nature of Innu conceptions of health and medicine, demonstrating the differences between the Innu and biomedical approaches to health.

Chapter 3

Secondary Analysis of the Extant Data Series

The intent of this chapter is to allow the reader to become further acquainted with the voices of the Innu. The placement of the secondary analysis of extant interviews and modules before the exploration of the clinical conception and approach to diabetes (chapter 4), is intended to allow the clinical approach to be understood in the context of Innu conceptions of health and medicine. The analysis prepares the reader for interpreting the new interviews (chapter 5) in the same way that conducting the analysis prepared me to carry out the new interviews in Sheshatshiu.

Purpose of Secondary Analysis

In undertaking a secondary analysis of several extant data sets I had two aims. First, I wanted to get a sense of Innu perspectives on diabetes, food, health, lifestyle and culture change in preparation to carry out interviews focused on these subjects, and to further assess the depth of Innu interest in the research topics. Second, I wanted to explore how people saw the *connections* between food, health, lifestyle and culture change, and *whether* people saw diabetes as related to any of these topics.

The secondary survey revealed a rich variety of information about food, health, lifestyle and culture change and the relationships among them. Any concern that food, health, culture and lifestyle change were not of pressing interest to the Innu was allayed. The presence of significant references to these topics in a series of data sets not originally intended to draw out this kind of information indicated substantial interest in them. Furthermore, it was apparent that food, health, culture and lifestyle change are critical components of a profoundly important dialogue unfolding in Sheshatshiu about the past,

present and future of the Innu. Innu of all generations are working to understand why settlement occurred, why it has unraveled Innu social and physical health, and what they can do to regain their social and physical health within a new way of life that encompasses both community living and life in *nutshimit*.

Another significant discovery was that there were various references to diabetes in the data series. Had no one mentioned diabetes, the distinction between diabetes – originally included in order to access funding – and the research areas suggested by the Innu, would have been further demarcated. Diabetes would have remained an add-on connected to the other topics by means external to the data: I would have relied solely on relating clinical models of the role of diet, exercise, and stress in diabetes to Innu perceptions of food, fitness and well-being. Instead, diabetes *was explicitly* connected to food, health, lifestyle and culture change, and comments about Innu remedies for diabetes testified to the inclusion of the disease in the Innu world view. Hence, the data demonstrated interest in the research topics *and* indicated that they belong together in a single research project. The existence of an Innu perspective on the place of diabetes validates the inclusion of diabetes among research topics of interest to the community, and not simply as a source of funding.

Data Analysis: The whole picture – an integrated conception of food, health, culture and lifestyle change, and diabetes

Contrasts between country and community life contain and unify all of the research topics – diabetes, food, health culture and lifestyle change. The following is an

Innu Environmental Guardian's summary of many *Tshishennaut* perspectives regarding the relationship between food, health, culture and lifestyle change, and diabetes:[72]

> I've been listening to the older people talking about when they were in the past and when they were young they were traveling with their parents. They're talking about country food and what they eat I guess it was more healthy and they were strong and they never had any kind of disease like we have now, like diabetes and cancer and the kind of disease people are getting now. And they said that ever since the people have changed their food habits, then they're starting to get those kinds of [diseases]...because they ate a different kind of food, the kind of food they ate before the food they bought from the store, you know. Because, I understand, [Joachim] said there was candies and stuff, bars – before they didn't have that, 'til he came into Sheshatshiu with his parents back in the 1950's. That's the time they seen those foods I guess. (Series 5, Eco-forestry Module, 2003)

Another Innu added to this translation of Joachim Nui's remarks:

> He said that he remembers – wanted to see more Innu medicines used to treat the Innu, because before in the country – because [non-Innu medicine] that's part of too what's making them sick. (Series 5, Eco-forestry Module, 2003)

These comments suggest that there is a connection between "country food" [wild food], *Innu Tukuna*, health and strength, on the one hand, and between community life, store-bought food, non-Innu medicine and diabetes on the other. The common perspective that emerged from the secondary analysis is that the move away from eating wild food, sedentary community lifestyles, and relying on Innu medicine caused a decline in Innu health in the form of diseases like diabetes.

The *Tshishennaut* approached the topic of food comparatively – contrasting wild food, or *nutshimit mishum*, with store food[73] – and the properties of *nutshimit mishum* and

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[72] As previously noted, the eco-forestry modules were co-taught by *Tshishennaut*. The modules were primarily developed for, and attended by Environmental Guardians. Sometimes, one of the guardians would translate from *Innu Aimun* so that the English-speakers present could understand what had been said.

[73] Although "store food" implies the full range of food available in stores, this definition does not accurately describe the Innu store food diet. The Innu store food diet is comprised primarily of meats, canned prepared foods, bread, pasta, and rice. Fast food items – such as deep fried chicken – soda, candy-bars, and potato chips are also widely consumed; fresh fruits and vegetables are not commonly purchased.

store food were related to health and ill-health respectively. For example, in the quote above it is stated that in the country people were "healthy" and "strong" because they ate "country food." In the community people are sick because they eat "food they bought from the store" – "candies" and "bars". Joachim Nui also seemed to suggest that community life did not even provide security against the threat of starvation (the following two quotes are Joachim's remarks translated by two different people):

> People had run out of food because there was not much wildlife in there [in the community] I guess and you know, in the country they didn't run out of food because there was always the fish. (Series 5, Eco-forestry Module, 2003)

> What Joachim was saying, is we're better off living in the country in terms of food in the country – country food. Living on the coast in the community he finds there's nothing to do and nothing to eat...there's not always enough food to go around. (Series 5, Eco-forestry Module, 2003)

Because Joachim did not mention community stores running out of food or an inability to purchase store-food, this remark is best understood to mean that, for him, store-bought food hardly counts as food. When Joachim says "there's nothing to do and nothing to eat" he means that since there is a shortage of wild food near the community and store-bought food is not worth eating, there is nothing to eat. That many *Tshisheannuat* do not consider store-food worth eating is demonstrated in the following quotes:

> She feels, they both feels weak. Because they don't eat the traditional food. Like, you know, porcupine, partridge, rabbit, beaver, and she feels, they feels weak. They always want to have it. Or she have a freezer, she always wants to keep some fish. (Series 2, Mary Adele Penashue and Louis Penashue Interview, 1998)

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Essentially, the Innu have adopted a typical Settler diet (Samson, 2003; Series 1 Interviews, 2005). Despite appearing as a poor diet in relation to diabetes, logistic and economic factors make this diet a necessity for many residents of North West River and Sheshatshiu, non-Innu and Innu alike. The availability of fresh food is not as much of an issue as it is in communities not accessible by road; the issue with fresh food is its cost (see discussion chapter 5).

> Old people...these days they can get [but] doesn't like to eat the food that they bought from the store. But he likes to eat fish and things that they can get in *nutshimit*, and they feel better after eating it. (Series 2, Josephine Abraham Interview, 1998)

These statements suggest a clear connection between diet and health from the *Tshishennaut* perspective – in their experience, wild food is healthier than store food. However, despite their preference for wild food many *Tshishennaut* articulate a growing concern about environmental contaminants from long-range airborne pollution, and the impact of local industrial development negatively affecting the quality of wild food and therefore their health:

> The land is destroyed, the animals are going to grow weak. And because they [Louis and Mary Adele] eat the food, then they're not going to feel well...Some of the stuff that they know that it's not as good as it used to be at one time – the animals. Sometimes they saw and they experienced animal die all of a sudden, for no reason. That's very unusual, she said that never happened before. (Series 2, Mary Adele Penashue and Louis Penashue Interview, 1998)

Although there is debate about the degree of impact that development and pollution have had on Northern ecosystems, fears about contamination and decline of wild-life are wide-spread and are deepened both from within the Innu community and from without – coming as they do simultaneously from scientists and from the peoples who have been eating wild foods in the North for centuries. Hence, regardless of the accuracy of such perceptions, the stress that these fears cause is significant.[74]

Another major difference between store food and *nutshimit mishum*, and between community life and *nutshimit* life, is that while in the community food and exercise can be separated, in *nutshimit* demanding physical activity is required to procure food. Joachim's comment that "Living on the coast in the community he finds there's nothing to do and nothing to eat" points to another crucial aspect of country life – its physical

[74] See discussion of environmental contaminants in chapter 4.

demand. Descriptions like Simeo's[75] of routines in the country demonstrate that a high level of exercise was intrinsic to the way of life – fitness was a product of daily activities. Comments like those made by Joachim ("Living...in the community...there's nothing to do") and Elizabeth Penashue ("These days in the community that is all people do is driving around in their vehicles and skidoo")[76] suggest that community life is empty of both meaningful and strenuous activity. The impact of skidoo use on exercise and fitness levels is clearly stated by Joachim:

> One thing that [Joachim] said when he talked about snowmobiles over when the dogsleds were used. He finds that without using anything, just traveling with your sled instead of a skidoo, though it's faster, that way [with a sled] you see more of the country, you experience more of the country. I just asked him the difference between traveling skidoo and dogsled – which is better? He said that the skidoo is a lot better these days because you get there faster! [laughter] No, but seriously, he said that the old way is better. He agrees that it's healthier – people get more...it takes a lot of exercise. (Series 5, Eco-forestry Module, 2003)

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[75] Simeo said:

> Innu had a hard life in the country. They didn't have any modern motors...They would walk or carry the canoe on their heads. Now he sees that everything is changing...Sometimes you [had] to go look for food on an empty stomach. With no food. Even in those days they were very, when they set up camps they were fast at it in the evenings. They didn't really feel tired, or they were very in condition – healthy in the country...Innu work very hard in the country. Sometimes in the evenings you would check on the beaver trap in the night. (Series 4, Anthropology Module, 2003)

[76] The following retrospective offered by Elizabeth Penashue reveals the high level of integrated activity in *nutshimit* and the lack of meaningful activity in the community:

> The only time Innu people don't go hunting is when the weather is bad, the Innu man go get wood for time the weather will be bad, and the family stay in the tent. The kids stay inside the tent. The kids would look out the tent, when they see blue skies somewhere, they are really happy and the kids ask her or his mom or grand mother to have a look – the weather has improved. The child would be really happy because they want to go out and play outside...The father would take the older kids hunting, and the mother would stay home, looking after the young kids, cooking, doing laundry, cleaning the animals, and cleaning the tent. When I went to the country, I took my caribou hide and I cleaned it in the country, sewing and stuff like that. My mother used to go in the country and do more stuff than I do, because there are only a few things that I can do. These days in the country, we have skidoo that people never had in the country. It was harder in the country in the old days. These days in the community that is all people do is driving around in their vehicles and skidoo. The only time that whole family used to take a break is when the whole family goes in the canoe...Going for a boil up, once we see a nice spot, we make fire and start cooking and after we all ate, we go fishing and the children are really happy being together and stuff like, they play in the sand with one another. (Series 2, Elizabeth Penashue Interview, 1998)

The fact that nothing was said in the data sets about exercise springing from community life – on the contrary it was characterized as devoid of activity – coupled with personal observation of community activities[77], support the conclusion that the community "lifestyle" is intrinsically less active than country life.

If we take the drive to procure food to be the primary factor necessitating a high level of activity in country life, the increased food-security of community life can be seen as key to declining activity levels. Because food can be bought, it does not need to be chased down. Because food does not need to be chased, houses can remain stationary and do not require transport and rebuilding. Because there is no need to be constantly engaged to provide food and shelter, there is nothing to do. And because there is nothing to do, people fight boredom by driving vehicles and skidoos and engaging in self destructive behaviours such as substance abuse, gambling and fighting (Series 1 Interviews, 2005).

It is clear that for these *Tshishennaut*, country life is healthier than community life because of better food and greater levels of exercise. This interrelationship points to an even broader relationship between food and the entire way of life in *nutshimit*: food is a central component not only of physical health but also of socio-cultural and spiritual health. Studies regarding food quality that quantitatively measure the nutrients in wild versus store-bought food have been carried out for the Innu wild food diet specifically (Samson, & Pretty 2005). However, perceptions of how store-bought food affects health

[77] For children bicycling provides some exercise but the community's one bike repair shop closed down because its operator was fed up with vandalism and political tension. For men, the Goose Bay hockey league provides a form of exercise. Some women used to play hockey, but there was not enough financial and other community support to keep the team going (V. Courtois, personal communication, November 2003). In 2003-2005 new recreational facilities are being constructed in the community, including a hockey arena, and there are plans to start up a girls' hockey team

are broader than quantitative measures can convey. As noted in chapter 1, attitudes towards food and methods of procuring food are defining facets of Innu life and food is central to social and spiritual function as well as physical health. The transition to eating store-bought food is not simply a matter of trading one group of nutrients for another and one form of exercise for another, but of trading one way of life for another. The fact that *Tshishennaut* continue to eat wild food while the younger generations eat store-bought food is not only a concern because the nutritional value of 'frozen', 'salted' and 'fast food' is seen to be less, but also because as hunting and preparing wild food wanes so will various modes of understanding, communicating and being in relationships.

We are left, then, with a plethora of comments about the drawbacks of store food, and very little direct commentary about its benefits. And yet, we cannot take this to mean that *Tshishennaut* recommend a return to *nutshimit* as a solution to the Innu struggle. Remarks about how hard life in *nutshimit* was, adamant statements like Simeo's[78] disparaging romanticized portrayals of country life, and appreciative references to social services and assistance, suggest that community life has some benefits.

Here we confront the underlying motivation driving spontaneous contrasts of country versus community life. The desire to understand what has happened and move

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[78] Simeo critiques unrealistic portrayals of life in *nutshimit*:

> Innu had a hard life in the country. They didn't have any modern motors...They would walk or carry the canoe on their heads. Now he sees that everything is changing...Sometimes you [had] to go look for food on an empty stomach. With no food. Even in those days they were very, when they set up camps they were fast at it in the evenings. They didn't really feel tired, or they were very in condition – healthy in the country. Everybody had to – even if one partridge was killed in the bush, one – they got to share it too...Kept on saying it was a hard life in the country. Our tents were really freezing in the winter. Innu didn't give up. Innu work very hard in the country. Sometimes in the evenings you would check on the beaver trap in the night. He doesn't really believe the other – sometimes the other Innu – when they don't say they don't have no hard life in the country 'cause he knows it himself, he said that's where he came from. (Series 4, Anthropology Module, 2003)

towards a better way of life seems to be at their root. In drawing conclusions about people's views of how lifestyle and culture change have affected Innu health, it is important to acknowledge the ambiguity of these views. No one, not even the *Tshishennaut*, believe that the Innu should return to freezing away the winter in canvas tents, slogging through mountains of snow on foot to find food, relying on the unpredictable movements of caribou herds for the bulk of their sustenance, and storing meat in underground caches in defense against shortages. In the face of electric heat, gasoline, and long-range food transport, to choose this lifestyle would be extreme. In the same way, although there are problems with the health care system, and some Innu feel that non-Innu medicine makes them sick, no one suggests rejecting all that biomedicine has to offer. For many, including those with advanced diabetes, to make this choice would be a death-wish.

It is crucial to consider that there is not necessarily an ultimate solution; the purpose of this research is not to reveal the middle way, the liberal ideal of integration and mutual co-existence. Kathleen Nuna's remarks reveal the truly complex nature of the relationship between the Innu and non-Innu society – priests, educators, researchers, health care workers, government people, television, and substances – and capture the ambiguity of the Innu position:

> In 1951 everything changed. That was the last year that she didn't go in the country anymore because the priest was here and the priest had a job for her father. Her father was a prospector. And so they were stuck in the community, and she said that her family started having more children and so they started going to school...She feels bad that things have changed because of change from country life to Sheshatshiu life. Because she says that before in the country they didn't have T.V. and alcohol or smoking. They all were – had – good health, good food, good relationships, and communication between people. And she says that doesn't exist anymore. She says she likes to work with *Akaneshau* – white people – because she says they taught her. She learned some good things from

> some white people – like from the doctors and the nurses and teachers. (Series 4, Anthropology Module, 2003)

Kathleen Nuna refers to priests, doctors, nurses and teachers as *Akaneshau* figures who she appreciates. Other Innu disparage these same figures. What is important to acknowledge is both the variation in views, and the intertwined relationship of these figures.

Inseparability of medicine, spirituality and culture (vs purely pharmacological approach)

One can speak of Innu medicine and refer only to the various plant and animal-based remedies, striving to match Innu and Western orthodox medicine on a pharmacological level.[79] But the larger spiritual and cultural context within which these remedies exist emerges through the language the Innu use to describe them (see discussion of Innu relationship with the land chapter 1).

The flow of Mary Anne's comments demonstrates the inseparability of respect for the land and animals generally, and in the use of them for medicinal purposes. That this respect is integral to Innu culture as it was practiced before settlement is clear in the following remarks:

> She used to, when she collect all these bundles of different medicine, they had to have a ceremony. They had to say a prayer. They have to say a prayer before they collect...And they used to gather the medicine, different types of plants. Combination of things that are useful for medicine. So I asked her how do you collect a whole lot and she responded she's more respectful before she collect them, she don't just pick them up...asking the creator...She said before you picks the plants, you have to concentrate why you want to pick them. You have to ask in whoever you believe in. Give thanks you know, before you pick them. Yeah, that's why you have to think straight before you pick them...That was the purpose

[79] *Tshishennaut* knowledge of plant and animal remedies can be analytically compartmentalized to corroborate and contribute to biomedical research in the same way that *Tshishennaut* knowledge of the land can be made to support and advance biological and ecological research, but to do so diminishes the significance of *Innu Tukuna*.

> of the ceremony. Years ago used to respect all the animals, especially the caribou and the geese and ducks. Right now, all of that change and it's very disrespect...The new generation have not respect the animals, have not respect on the bones of the animals. The old people who are here now, maybe they have a lot of respect, I think of maintaining their culture, wise of maintaining the bones. (Series 3, Mary Madeline Michel Interview, 2000)

When Joachim says non-Innu medicine is "part of too what's making them sick" (eco-forestry module 2003), the problem is not only that medication and hospitals make the Innu sick, but that losing respect for the animals, healers and shaman is deeply disturbing on a psychological and social level.

Mirroring the distinction between pharmaceutical healing and the spiritual cultural context of healing, in the literature a separation is often made between healers and shaman – the former are knowledgeable in the use of plant and animal remedies, the latter deal with illness of the soul and spirit, bad medicine and speak to the animal masters and dead or distant relatives (Tanner et al., n.d.). The distinction between healers and shamen is an active, functional distinction for the Innu. While people talk about using plant and animal remedies on a daily basis with friends and family members, healing ceremonies and procedures are performed only by specific individuals.

Priests and the Church played a crucial role in undermining both the use and the perception of Innu and non-Innu medicine. The relationship between the Innu and the Church is complex (Tanner et al., n.d.; Innu Nation & Mushuau Innu Band Council, 1995) Although church personnel facilitated relations between the Innu, the HBC and the government,[80] they simultaneously undermined Innu belief in *Innu Tukuna* and the validity of *Innu Eitun* (Innu skills/way of life) and traditional Innu leadership.

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[80] For example, Father O'Brien, who began working regularly with the Innu in the 1920's,

As discussed in chapter 1, the Church portrayed shamen as agents of the Devil (Series 2 & 3 interviews; Tanner et al., n.d.) and suppressed religious practices. The following description reveals the corrosive impact the church had on peoples' relationship with, and respect for, Innu religion – and therein shamanistic political leadership (Tanner et al., n.d.):

> A very strong shaman can also heal a person. If they're very seriously sick. My mom told me about a shaman. In, you know, Grand Lake there was a woman. It was...who almost got drowned eh...she was pregnant at that time and she fell in through the water – ice. And it look like that she was going to be drowned. So some people went to the shaman and said would you please save her, she's having a baby. And he told everybody to go inside. Spiritually, he went over there and hauled her out from the water. But because he was a very strong Catholic, and shaman, he came down here to Sheshatshit and he said he told the priest he wanted to talk about it. Because he had heard what the priest said about shamanism, you know, being evil. And he asked – he wanted to be forgiven. (Series 2, Matthew Penashue Interview, 1998)

The fear that was instilled by the priests has stretched across generations and continues to operate today:

> My father don't respect the animals, you know like now if my father had to do the shaking tent now, I think he's scared to do because [the priest] scared...people
>
> Say in 3000 – or 5000 – years ago my people living the way...believe in the shaking tent and the way that leads to heaven...And those people might...I'm saying we're all evil here, you know...If that person is evil, we're all evil here. You angel. Because you have a past. And everywhere it's just always trying to take people away from the past.
>
> But the second [generation] is the way where you got me afraid not to do anything, not to touch this, and wanting to do it my way and all that...Elders [first generation] is the knowledge but like I said they're scared of evil. They got to go by their – by their priests tell them. (Series 2, Francis Penashue Interview, 1998)

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took numerous photographs of his flock, produced the first censuses available to us, and repeatedly sought the material help of the Newfoundland government for the Innu...For some 20 years the Innu were to remain under the authority of European missionaries speaking the Innu language – missionaries would obtain houses, schools, and government services on their behalf. (Mailhot, 1997, p. 23)

Currently, priests no longer have an active role in medicine – they have been replaced in that arena by nurses and doctors. The decline in the profile of Innu medicine as a result of religious and regulatory barriers coupled with a greater availability of doctors, nurses and non-Innu medicine is apparent in the following quote:

> One time they used to collect a lot of medicine in the country before there was any doctor around right now in this modern society. They usually depend on the doctor now because some of the Elders they still use the Innu medicine, their knowledge of medicine is ongoing still. A little bit, they still use it...because a lot of changes she seen in her lifetime...They're not collecting more Innu medicine now because of that, and they're much more dependent on the doctors because of the changes...Well, the changes in the plants [due to pollution and disturbance] and also the way of life...The way of life is much more gradually degrading, I guess – not depending on the medicine in the country. Especially the young people who are much more dependent on the doctor. (Series 3, Kathrine Pastitshi Interview, 2000)

Considering the interconnectedness of medicine, spirituality, health and culture for the Innu, it is clear that the move to greater dependence on non-Innu medicine is a significant disintegrative force on Innu culture, health, and community relationships.

With the rise of biomedicine and the medical profession new disincentives to practicing native medicine were established (Twohig, 1991; Kelm, 1998). Madeline Michelin's remarks suggest the effect of professional/legal regulations on Innu practice:

> **JS**: She only use plants on her own purpose. She don't give it to anybody else, just for herself.
> **MM**: I don't have a license for that. I can only kill myself <laughter>. Never have people poison themselves, never kill themselves. Always get better when I...(Series 3, Madeline Michelin Interview, 2000)

Although health care leads the way in transferring responsibility and ownership from non-native to native hands,[81] the taboo against practicing *Innu Tukuna* remains a powerful disincentive. Matthew Penashue takes on the role of a healer of sorts in the

[81] See discussion of health transfer in chapter 4.

country and in the community, but he keeps his practice hidden. His cautionary note to the young man not to say anything indicates that people still perceive doing medicine the Innu way to be dangerous:

> He said when he brings his kids, his grandchildren out to the country, and when they get sick – any kind of sickness – Matthew doesn't send them to the hospital. What Matthew does he use some kind of medication and he blows on them. Because he does have special power to heal them. And sometimes he can do it. He's got the special power to do that...A lot of people come to Matthew during trouble, if they're worried about something, they go to Matthew. Matthew doesn't do anything, but in his mind, he thinks he wants to get rid of stuff. So he does it. There was a young fellow, a teenager...which had a lot of trouble in the community...he followed Matthew around in the community, he always come to Matthew. And Matthew told him, if I do anything to help you, I don't want you to say anything to anyone about it...and don't call anyone. I don't want you to touch gas anymore. And he's fine now, the young fellow. 'Cause Matthew told him what to do, eh? (Series 2, Matthew Penashue Interview, 1998)

The prevalence of suicide, violent and accidental deaths, substance abuse, vandalism, and political unrest[82] in Sheshatshiu demonstrate that regaining health for the Innu is not simply a matter of managing physical afflictions; there is a need for spiritual healing in the community. But in Sheshatshiu, as in many other Native communities, spiritual healing is inextricably linked to political healing. The government and the medical system together need to acknowledge their shared oppression of the Innu way of life. The only meaningful way to redress the assault against *Innu Tukuna* is to make it expressly legal. As Kelm argues, the statutory legal restrictions indicate the need for greater flexibility in licensing regulations in order to facilitate the re-emergence of native medicine across Canada (Kelm, 2004). In Sheshatshiu, which is not yet a reserve, discussions about self-determination in areas of education and medicine inevitably

[82] For example, recently there was a protest against Band Council policies in which the new Band Council buildings were damaged, community records were burnt, and RCMP vehicles were demolished. And this past winter of 2005 (while I was in Sheshatshiu) Jerome Jack staged a smaller-scale protest against Band Council hiring policies.

revolve around reserve status. However, there is debate among the Innu about whether reserve status will achieve the hoped-for goals of Innu-driven education and medicine (Series 1 Interviews, 2005).

Considering the continued taboo around practicing, it is not surprising that while a number of *Tshishennaut* and their children continue to use Innu remedies (Series 1 Interviews, 2005), shamanistic practices such as the shaking tent or blowing have, to a large degree, been lost (Tanner et al., n.d.).[83] The continuance of medicinal healing is in part explained by the fact, discussed above, that Innu plant and animal remedies can be understood *and validated* on a pharmaceutical level. The following two quotes display the way in which Innu medicinal remedies can be slotted into a Western biomedical understanding, and even into use in the medical system:

> That's the kind of medicine it is. They met some crazy Germans when they were traveling around. They introduced the medicine to them...The guy was the doctor and they give him the cranberry parts to try out...It's very good medicine. Everybody's buying it in Germany now.
>
> That's the medicine...For breathing asthma. It's good for the asthma, it works in a half hour...Takes from the ground and, what it's called "Northern Lights"...She would have died a long time ago, she said, if it wasn't for the medicine she discovered it...the plants. The doctor was very helpful with the plants and experiments, in other words. (Series 3, Mary Anne and Shimun Michel Interview, 2000)
>
> With respect to diabetes in particular, a number of *Tshishennaut* mentioned *Innu*

[83] The following quote is from an interview conducted by Trudy Sable and Rose Gregoire: "TS: do they do sweat lodges out in the country? RG: It almost died out...he has seen it as a young boy. But now it is coming back" (Series 2, Philamena and Dominic Pokue Interview). Ceremonies like sweats that used to be practiced by the Innu are currently being reconstructed from within the pan-Indian spiritual movement. Pan-nativism also introduces new rituals, such as sweetgrass ceremonies. New techniques, such as acupuncture, provide alternatives to clinical and biomedical approaches to health (R. Gregoire, personal communication, 2003; Tanner et al., n.d.). Although some Innu welcome introduced rituals, others feel that: "we gotta maintain our own culture – what we've been taught by our grandfathers. We don't have to be forced to use sweetgrass. We got our own ways, medicine" (Series 5, Ecoforestry Module, 2003).

Tukuna remedies for diabetes. Mary Madeline Nuna (translated by Jack Selma) said: "there's some kind of plant, a red plant...red leaves. You boil them. It's good for the diabetes. You drink the tea" (Mary Madeline Nuna: Anne Swiatonowski/Jack Selma; 2000). Madelin Michelen spoke about boiling *uatnaniss* [hemlock]: "just stick it in the water and you strain it and – when you're diabetic – you drink it and it's a good drug.... Diabetic take only the brand and put it in the water" (Madelin Michelen: : Anne Swiatonowski/Jack Selma; 2000). The fact that these women articulated an *Innu Tukuna* remedy for diabetes suggests that diabetes has become a serious concern for the Innu and places diabetes within the integrated nexus of *Innu Tukuna*. Although these diabetes remedies are primarily medicinal, the spiritual, socio-cultural dimensions of *Innu Tukuna* are implied even with purely medicinal remedies. Recalling Joachim's articulation of the relationship between food, health, culture and lifestyle change, and diabetes,[84] this contextualized understanding of diabetes is reinforced.

In sum, the secondary analysis of the extant data series reveals that from the *Tshishennaut* perspective, there is a highly integrated relationship between food, health, culture and lifestyle change, and diabetes. While *nutshimit* life was conducive to health and happiness, community life gives rise to diseases like diabetes and a multitude of social ills such as substance abuse, family breakdown, and suicide. The group cohesion,

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[84]Joachim's view translated by an Innu student:

> I've been listening to the older people talking about when they were in the past and when they were young they were traveling with their parents. They're talking about country food and what they eat I guess it was more healthy and they were strong and they never had any kind of disease like we have now, like diabetes and cancer and the kind of disease people are getting now. And they said that ever since the people have changed their food habits, then they're starting to get those kinds of [diseases]...because they ate a different kind of food, the kind of food they ate before the food they bought from the store, you know. Because, I understand, [Joachim] said there was candies and stuff, bars – before they didn't have that, 'til he came into Sheshatshiu with his parents back in the 1950's. That's the time they seen those foods I guess. (Series 4, Eco-Forestry Module, 2003)

physical fitness, and diet of wild food necessitated by *nutshimit* life are the elements that made the Innu healthy before settlement. The influence of the Church and education, the lack of meaningful activity, a diet of store food, the environmental impact of industrial development and pollution are the factors that detract from Innu health today. Diabetes is included as a pressing concern.

The *Tshishennaut* suggest that the Innu effort to regain health and rebuild healthy community depends on cultural validation in the form of increased support for *nutshimit* norms, skills and activities, and the legalization of *Innu Tukuna*. The focus on cultural validation, the ultimate aim of which is the rebuilding of individual *and* collective health, and which hinges on reconnecting with the land, differs markedly from the clinical approach to diabetes treatment explored in the following chapter.

Chapter 4

Diabetes: The evolution of the individualistic "lifestyle" approach and the native-specific "culturally relevant" approach

The Innu experience of diabetes in Sheshatshiu cannot be fully appreciated without an understanding of the biomedical, clinical perspective that shapes the treatment process in the community. In this chapter the exploration and critique of the lifestyle and culturally relevant approaches to diabetes demonstrates how medical research, policy positions, and community-based health care delivery are related, and how native cultures and individuals are implicated in the disease process.

Diabetes is a new disease among native people, but has rapidly become a primary concern for native people, clinicians, medical researchers and policy-makers alike (Benyshek et al., 2001; Harris, 1997; Jack et al. 1999, p. 775; Joe & Young, 1994; Macaulay, 1997; Thompson & Gifford, 2000; West, 1974; Young, 1994; MSB, 1961-1992; MSB Atlantic, 195- 1988). The lifestyle approach to diabetes is part of the broader trend towards individualization that defines the conception of public health that began to emerge in the mid-1970's (Douglas, 1992; Petersen & Lupton, 1996; Tesh, 1988; Thompson & Gifford, 2000). As a result of the ineffectiveness of the lifestyle approach in native communities, additional measures towards cultural relevance began to be developed (Hickey & Carter, 1994; Joe & Young, 1994; MSB, 1971-1992). Through an exploration of existing diabetes prevention programs in native communities (Garcia-Smith, 1994; Gittelsohn et. al., 1995; Hickey & Carter, 1994; Joe & Young, 1994; Macaulay et. al, 1997), the underlying messages of the culturally relevant approach are explored, and the similarities between cultural relevance and earlier colonial approaches

to native health and social issues are discussed (Benyshek et. al., 2001; Kelm, 1998; Kelm, 2004; Tuhiwai Smith, 1999). A discussion follows of how the lifestyle and culturally relevant approaches actually work – or do not work – on the ground in Sheshatshiu (Bowers, 2004; Innu Nation & Mushuau Innu Band Council, 1995; Samson, 2003; Series 1 Interviews, 2005).

Diabetes in the North American Aboriginal Population

Diabetes did not emerge in the North American aboriginal population until the 1940's (West, 1974) and in some communities, such as the Tlicho (formerly Dogrib Dene), even as late as 1981 (Young, 1994). And yet, in many aboriginal communities diabetes has rapidly reached alarming proportions and now spans the full range of generations. Rates continue to climb (100 million diagnosed in 2001 in North America expected to increase to 215 million by 2010 (Benyshek et al., 2001, p. 26)) while the age of diagnosis falls, and the severe and costly late-stage complications are beginning to take their toll (Benyshek et al., 2001; Joe & Young, 1994).[85] Rates for aboriginal Canadians are 2-6 times higher than for non-aboriginal Canadians, and some of the highest rates are found in the Atlantic region (Young, 1994).[86]

Diabetes in Sheshatshiu

Although no statistics are available for Sheshatshiu, the statements of health care providers and Innu community members demonstrate that diabetes affects a significant portion of the population and has become a familiar part of life in the community (Series

[85] For example, the Pima spend "$1.6 million annually on dialysis treatment of community members in a climate of severe budget limitations" (Garcia-Smith, 1994, p. 473).
[86] Where the Innu fit into this picture is uncertain due to their exclusion from national statistics and their invisibility among non-natives in provincial statistics.

1-5). Because Sheshatshiu was settled less than fifty years ago, diabetes is in its early stages in the community. Health care workers report that amputations, blindness, and removal to St. John's hospitals for dialysis treatment are not yet the norm, but that there is every indication that these kinds of outcomes will soon become familiar in Sheshatshiu (Series 1 Interviews, 2005).

The research conducted in Sheshatshiu in 2005 reinforced the indication that diabetes is a significant concern for the community. Out of twenty interviews, nine contained comments relating to diabetes. Of the nine participants who discussed diabetes, eight were themselves diabetic, and one was not herself diabetic but had multiple family members affected by the disease. Of the participants who did not discuss diabetes, eight were in the youngest age bracket (20 – 29), three were in the middle age bracket (30-50).

The fact that just under half of the participants introduced a discussion of diabetes and are themselves diabetic, suggests that diabetes is a significant concern for many Innu of Sheshatshiu. In the absence of comprehensive surveys and stringent statistical analysis the extrapolatory power of these numbers is limited; however, the contents of the discussions about diabetes reinforce the quantitative indication that diabetes is a familiar part of the lived reality in Sheshatshiu. People's comments demonstrated that diabetes is understood as a family, community, and nation-wide issue. Some individuals perceived Sheshatshiu as suffering particularly high rates of diabetes.

Many people, some with diabetes and some without, referred to other family members having diabetes; as well as expanding the occurrence of the disease beyond the interview participants, this awareness implies the familiarity of the disease. Often, as for

David Penashue, awareness of family members' diabetes led people to recognize their symptoms and be diagnosed themselves:

> **Z**: How did you realize that you had [diabetes]?
> **D**: Because my mom had it, so my mom have it a long time and I thought I would never get it. I didn't understand what diabetic means. My mom wasn't on her pills all the time – her diabetic pills. Gotta take care of yourself – sugars. I never thought I have diabetic. (Series 1, David Penashue Interview, 2005)

David Penashue also stated that in Sheshatshiu, "we have highest diabetes" (Series 1, David Penashue Interview, 2005). The perception of high rates of diabetes in the community was common. Touching base with the Sheshatshiu Band Council, I spoke to an advisor to the Chief. He was not himself a diabetic, but diabetes in the community was one of his personal concerns – he went to the health clinic to find out how many people in the community had been diagnosed. The answer he received was 100, a number he believed was far too low to be truly representational (Series 1 Interviews, 2005). Lionel, who was one of the first interviewees to raise the topic of diabetes and who has been diabetic for eleven years, cited an extremely high rate of diabetes in the community:

> Li: Well, it was mentioned on TV one time when they talk about diabetes they find it very strange in this community why people in this community – why 94% of diabetic is here in community. None of it where the reserves are. They never seen that happening. But why here in community you know. Like I said it's very strange. (Series 1, Lionel Rich Interview, 2005)

Vanessa Rich, who Louis Rich introduced as one of the only *Tshishennaut* we would interview, contextualized diabetes as one of the many problems inherent in community life. She talked about the high rates of diabetes in the community and across Canada, as well as referring to herself and her family:

> **L**: Healthwise she's a diabetic and of course, nobody likes being a

> diabetic and this is one of the problems she encounters too. There are a lot of diabetics in the community.
> **Z**: You said there's a lot of people in the community that have diabetes. Do you talk about other people...with other people about having it?
> **L**: Yeah, frequently and there are a lot in her family that have it, probably most. Across Canada there's a big problem with diabetes for Native people. (Series 1, Vanessa Rich Interview, 2005)

Taken together, the number of interviews including references to diabetes and the specific content of the remarks about diabetes demonstrate that for the Innu interviewed, diabetes is understood to be a common concern among families, in the community as a whole, and in native communities across Canada. The secondary analysis of extant data sets and the statements of health care workers (Interviews, 2005; Samson 2003) also support this understanding. The Innu experience of diabetes is shaped both by the racially-oriented biomedical search for genetic causes and the culturally-oriented clinical lifestyle treatment. In order to best understand the Innu articulations of this experience it is necessary to discuss the evolution of the lifestyle approach to diabetes and the strategy of cultural relevance that characterizes the lifestyle approach to diabetes among Native people.

The Lifestyle approach to diabetes

> One of the most common chronic diseases is diabetes mellitus. To improve health outcomes for people with this disease, it is critical that we understand why some people adopt and maintain self-management techniques and others do not. The rate of compliance with self-management skills is alarmingly low.... About one half of all patients with chronic disease comply with healthcare provider recommendations.... Treatment regimens for diabetes can involve dietary changes, medication adherence, stress management, foot care, appointment scheduling, and clinical attendance. (Jack et al. 1999, p. 775)

There is one approach to diabetes that is applied by health care providers (doctors, nurses, nutritionists, and diabetes consultants) to all diabetics regardless of their ethnicity,

cultural background, socio-political economic status and geographic location. The current approach distinguishes Type II diabetes as "characterized by 'insulin resistance', i.e. although insulin is present in the blood stream, a post receptor defect in the cells inhibits the insulin-cell receptor interaction that facilitates cellular uptake of glucose. Prevention and treatment strategies are focused around lifestyle issues and self-management techniques such as medication adherence, diet, exercise, and weight-loss – the key elements of the 'lifestyle approach.' The lifestyle approach to diabetes is the product of a shift, beginning in the 1970's, towards an approach to public health that places the burden of responsibility for health upon the shoulders of individuals – even in areas clearly beyond individual control – without consideration of their circumstances:

> Since the mid 1970's there has been a proliferation of new knowledges and activities focusing on health status; particularly the health status of 'populations'. While the increasing attention to body shape, diet and exercise is perhaps the most obvious manifestation of this concern (the 'lifestyle' focus), there is also a new consciousness of risks that are believed to lie beyond the individual's control but which are viewed as, ultimately, a result of human activity (for example, pollution, hazardous chemicals, global warming, the greenhouse effect, loss of bio-diversity and so on). (Petersen & Lupton, 1996, p. 1)[87]

With respect to the approach to diabetes specifically Thompson and Gifford point out that:

> Epidemiologists looking for the causes of non-insulin dependent diabetes mellitus (NIDDM)... are faced with a research discipline that itself is out of balance. In contemporary epidemiology the scales are tipping towards the study of factors at the individual level and away from variables that operate at the group and population levels. (2000, p. 1458)

It is *hypothesized* that high rates among native population are the result of genetic susceptibility. It is *hypothesized* that diabetes may share a common pathogenesis with

[87] Lupton and Petersen call this individualistic approach to public health the "new public health" (1996). From this point forward, I will use the term "new public health" to refer to Lupton and Petersen's portrayal of this mid-seventies shift towards individualistic, consumer-oriented definitions of citizenship and public health care.

cardiovascular diseases and conditions (such as stroke), hypertension (high blood pressure), dyslipidemia (high cholesterol), and obesity (overweight) – a cluster of disorders that have been referred to as "diseases of modernization" or "Western diseases", "metabolic syndrome" and "syndrome x" (Benyshek et al., 2001; Joe & Young, 1994). Although the gene theory and the relationship between diabetes and the other metabolic disorders remains to be proven, approaches to diabetes prevention and management are nonetheless highly defined by these hypotheses. Studies of the trends associated with these disorders (epidemiological research) suggest a set of shared risk factors including: positive familial history (diabetes runs in the family), obesity, low levels of physical activity, and a high calorie/high fat diet (Benyshek et al., 2001, p. 27). Efforts to prevent and manage diabetes focus on reducing these risk factors through diet changes, weight loss, increased exercise, and for diagnosed diabetics, taking oral blood-glucose normalizing medications – in other words, through lifestyle changes. It is the focus on reducing these risk factors through encouraging people to change their lifestyles that has led to the conceptualization of diabetes as a "lifestyle disease".[88]

Looking at diabetes from within the clinical paradigm (accepting the assumptions of the lifestyle approach for the sake of argument) there are two experiences of the lifestyle approach to be considered – the patient's and the health care provider's. What makes diabetes a difficult disease for a patient to have is also what makes it a difficult disease for health care providers to treat:

> Non-Insulin Dependent Diabetes Mellitus (NIDDM) [Type II diabetes] is one of the most frustrating diseases for a physician to treat. First, there is no direct cure. Second, the medications used to treat it may lose their efficacy after a period of

[88] For a typical articulation of the lifestyle approach in Canada see Canadian Diabetes Association, 2003, p. s131-134).

> time. Third, the two regimens, diet and exercise, that have the most long term success in controlling the disease require significant behavioural changes on the part of the patient. Fourth, the pathophysiology is very complex and not well understood. Finally, the symptoms of the disease are extremely subtle, such that the patient has little internal reinforcement for adherence to the treatment and behaviour changes required for control and complication prevention. (Hickey & Carter, 1994, p. 453)

Diabetes is a difficult disease to manage for both patients and providers because it is a total disease – requiring a complete re-structuring of lifestyle; a silent disease – the symptoms are subtle so patients don't "feel sick"; and a life-long disease – it will never be "cured". Hence, although patients are required to make significant changes in the way they live, there is little physical incentive for them to make these changes and no end-point in sight at which "normal life" can resume.

The burden of care is placed on the individual to effect these changes and remain committed to them, and on the health care provider first to convince patients to make changes, then to support them in sustaining these changes for the foreseeable future. The only tools that health care providers can use to reinforce their recommendations are medications, nutrition and exercise advice and regimes, and fire and brimstone articulations of future risks such as blindness, loss of limbs, and kidney failure. The only resources for patients are nutritionists, food guides, and supportive activities (such as walking clubs or diabetic dinner-making sessions). The solution for the patient is to understand the long-term risk, and on the power of this purely conceptual understanding, commit to making lifestyle changes. The implications of non-compliance are, therefore, that the patient lacks mental acuity or discipline, or both of these qualities. The solution for the provider is more training in long-term patient support, more evocative food guides, more attractive food samples, more appropriate and consistent diet and exercise

regimes, and a more comprehensive team of providers (Interviews, 2005; Hickey & Carter, 1994). In other words, the defining moments of management success or failure are located in the one on one relationship between the provider and the patient. There is growing recognition that both the reliance on individuals to effect healthful changes (the new public health) and the reliance on patients' risk-perception are not effective in preventing and managing diseases of all kinds, including diabetes (Douglas, 1992; Petersen & Lupton, 1996).

The failure[89] of the biomedical and clinical approach to diabetes stems from the fact that while diabetes is recognized as a demanding disease, the true difficulties facing health care providers and diabetics remain invisible. In fact, the barriers to effective management of diabetes are much more significant than those described by Hickey and Carter, and the conceptualization of diabetes as a "lifestyle disease" continues to keep these barriers hidden (Benyshek et al., 2001). For diabetics the main barrier is limited choice – due to economic, family, community and environmental realities "good" choices for immediate life issues may not be "good" choices in the light of diabetes. When situated in the broader lived experience, "non-compliance" often becomes logical – a good choice for patients given their circumstances.[90] For providers, then, the main barrier is that their suggestions are not necessarily either good or even realistic for their

[89] Garcia-Smith states that the biomedical approach to diabetes has been a failure: "The DPM [diabetes prevention model] was developed in response to the basically western biomedical approach to treatment that has not changed the course of this disease after twenty-five years" (Garcia-Smith, 1994, p. 471).

[90] The following situation, related to me by a nurse who formerly worked at the Mani Ashini clinic, is an example of how patients' logical and necessary choices can be reduced to a simple refusal to follow treatment suggestions when they are dubbed 'non-compliance'. A non-native diabetic man explained that he was not monitoring his blood-sugar levels because he could not afford the test strips – all his available money was being used to pay for his wife's medications. This individual, given his wife's condition, did not really have the choice to comply with treatment suggestions due to financial restrictions. Although his decision to prioritize his wife's condition over his own health is perhaps a good decision under the circumstances, it would nonetheless be seen as "non-compliance", and hence portrayed simplistically as unwillingness to follow treatment suggestions (D.B., personal communication, 2005).

patients. The reasons behind this are impossible for any health care provider to resolve because they are the product of forces more powerful than a health care provider can overcome through clear instructions and effective patient support and motivation. Both the patient and the health care provider, then, are done a disservice by the lifestyle approach to diabetes, which places all responsibility with the patients and providers and none with the [societal] context within which patients and providers live.

> A *public* health policy that consists mainly of exhorting individuals to change their behaviour appears at best to be shortsighted. At worst it seems less a policy directed at attaining health for the public than one bent on protecting the institutions (whether they are sexism, particular workplaces, or the political economy itself) threatening that health. The issue, however, may be more complicated. If advocates of personal prevention hope for really effective disease prevention, they do have a responsibility to prescribe social prevention as preeminent and to put individual action in a context that indicates its surrogate role. The very notion that individual people can be conceptually separated from the society in which they live needs examination. In other words, the individual-social dichotomy itself is questionable. (Tesh, 1988, p. 82)

The fact that the approach to diabetes in the 21st century is characterized by a *lack* of consideration of economic factors demonstrates the entrenched tendency of our society to avoid examining fundamental inequalities and to look instead for superficial, quick fix solutions that do not challenge the status quo. When this tendency is applied to native people the uselessness of these "band-aid" solutions becomes glaringly apparent; that diabetes has reached "epidemic" proportions among the native population is one example. And yet rather than acting as a touch-stone and catalyzing a widespread paradigm shift, the situation in native communities is seen as an anomaly – as a particularly *native* problem inherent in native bodies and native cultures.

Diabetes among Native people: the culturally relevant approach in Canada

> Type II diabetes, or non-insulin dependent diabetes (NIDDM), is devastating the health and contributing to the early death of many indigenous peoples all over the world. (Joe & Young, 1994, p. 1)
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> * * *
>
> The overwhelming majority of physicians, biomedical researchers, and medical ecologists continue to explain the astoundingly high prevalence rates of diabetes among Native Americans and other high prevalence populations in terms of *yet-to-be-identified genetic factors*. (Benyshek et al., 2001, p. 25 emphasis added)

When it is reported that rates of diabetes are 2-6 times higher among native Canadians than among non-native Canadians (Macaulay, 1997; Young, 1994; Harris, 1997), the response of policy-makers, scientists, medical researchers and most health care workers is to assume that a biological mechanism particular to native bodies, exacerbated by cultural idiosyncrasies and environmental factors, must be the cause of this discrepancy.[91] As discussed in the introduction, the colonial tendency to locate the root of native illness first in native bodies and native cultures and second in the environment (understood as an objective and neutral scientific reality), rather than in the socially and politically constructed circumstances in which native people exist, has characterized the medical and governmental approach to native health since contact (Kelm, 1998; Tuhiwai Smith, 1999). That the theory of genetic susceptibility, despite remaining unproven, is widely accepted as fact even by the most progressive Diabetes Prevention Programs (Macaulay et al. 1997; Joe & Young 1994; Gittelsohn et al. 1995), and that only cultural and racial modifications are made to the lifestyle approach to make it effective among native diabetics, demonstrate the power of this embedded history and the continued tendency to

[91] Genetic theories take root in the 'thrifty gene' hypothesis: "To account for the rapid rise in the prevalence of type II diabetes in some populations, Neel postulated the existence of a 'thrifty gene'.... environmental factors play the significant role in the expression of the gene or genes that contribute either directly or indirectly to the disease process" (Joe & Young, 1994, p. 4).

ignore socio-political and economic circumstances and focus instead on native bodies and cultures and on the blameless environment.

Writing in 1994, Joe and Young state that "the diabetes problem in native peoples in Canada is a decade or more behind the epidemic now occurring in the United States" (Joe & Young, p. 9). T. Kue Young calculated that in 1987 there were 5324 cases of diabetes among native peoples in Canada[92] as compared with 72 000 cases in the United States according to a 1989 Indian Health Service Factsheet (Joe & Young, 1994, p. 9). Diabetes among Native Canadians began to emerge as a significant concern for MSB/Health Canada in 1985.[93] This was the first year that diabetes was mentioned in the national Medical Services Branch reports (MSB, 1985, p. 20).[94] It was also the year that the pivotal Canadian Diabetes Association conference, "Diabetes and Diabetes Education among the Native Population" (CDA 1985), was held. Acknowledging the changing and emerging policy positions on nutrition, chronic disease, community-based initiatives, and the transfer to native control of responsibility for providing services is key to understanding the approach to diabetes that was articulated in 1985.

Although diabetes itself does not emerge as a concern for the MSB until 1985, the foundations for the health care system's response to diabetes are rooted in the concern with nutrition that emerged as early as 1965. The early MSB policy position on nutrition

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[92] As discussed in chapter 1, this number does not include the native people of Newfoundland and Labrador.

[93] Because Health Canada (or the MSB) is responsible for native health care, while provincial governments are responsible for non-native healthcare, native diabetes is the particular concern of Health Canada.

[94] Diabetes is not mentioned in the Atlantic region MSB reports in the eighties. The late emergence of concern about diabetes, and the fact that even the universally approved NNADAP program was put on hold in Sheshatshiu, demonstrate how jurisdictional squabbles have retarded the development of functional health care services in Labrador. The1985 report states that in Sheshatshiu: "The [NNADAP] project has had inadequate leadership and has not been effective recently" (MSB Atlantic, p. iv). And in the 1986 report the government of Newfoundland refused to cost-share on the program until the difficulties were resolved.

is key to understanding diabetes prevention efforts for a number of reasons. Firstly, because the physical properties of food are currently a key factor in diabetes. Secondly, because the focus on patients changing their diet-behaviours places responsibility with the patient for achieving his or her own health, a move which characterizes the approach to diabetes specifically and health care generally in the new public health. Thirdly, because policy positions on non-native and native diets reveals the continuation of the view that native cultures detract from native health.

In 1965 "faulty nutrition" was stated in the MSB reports as a significant factor in native ill-health. By 1969, the concern with nutrition had developed into a "nutrition education program" as part of the MSB mandate. But it was not until 1983, under pressure from native people demanding more "culturally sensitive" nutrition education materials, that nutrient bar graphs of "traditional"[95] native foods were published. The implication is that *native* diets are the source of "faulty nutrition" (and nutrition would be improved by a settled lifestyle with three regular and balanced meals a day). A second demonstration of the negative policy attitude towards native foods is apparent in the response to concerns about environmental contaminants which began to arise in the mid-seventies. In the nutrition program section of the 1977 MSB report it was stated that, "it is paradoxical that the Indian and Inuit desire to follow traditional eating and living habits increases their risk of exposure to environmental contaminants" (MSB, p. 11). The response to this "paradox" was to establish an environmental program to "alert people to the dangers of consuming natural foods having high toxicity levels" (MSB, p. 11).

[95] MSB uses "traditional" but I avoid that term because Innu acquaintances and co-workers have explained that it connotes static sterility – if something is 'traditional' it is no longer a living, vibrant facet of life.

The policy to warn people away from wild food on grounds that it might be contaminated rather than looking into preventing contamination, and without first assessing the risk relative to the degree of contamination necessary to actually cause harm, has a number of implications. First, it is further evidence of the prioritization of non-native food and an unwillingness to acknowledge the multiple positive aspects of native diets.[96] Second, it reveals the tendency to place the responsibility for preventative measures upon individuals rather than upon governmental institutions and industry. Third, it raises questions about the removal of power into the hands of experts/technocrats and the reliance on scientific expertise that is assumed to be objective and true rather than changeable and socially constructed.[97]

The heart-breaking situation among the Grassy Narrows people demonstrates that environmental contamination, such as mercury poisoning, is undeniably a serious concern

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[96] Counter to the approach taken by the MSB, many scientists suggest that especially in light of the high rates of diabetes in Native communities the amount of toxicity in wild foods is a lesser threat than is posed by eating a diet of carbohydrates, sugar and processed food. For example, Kuhnlein concludes that the various benefits of fats contained in traditional foods "need to be considered and these should be balanced against advice to avoid traditional fats that contain particular contaminants, and especially when they are consumed in small quantities. In fact, it seems that there are so many benefits for Indigenous People from using traditional Arctic food fats that their use should be promoted for a variety of cultural, economic and nutritional reasons." In other words, "recommendations for reducing dietary fat...would most effectively meet dietary goals if changes were made to reduce intake of market sources of food fat rather than traditional food sources of fat" (Kuhnlein, 1993, p. 287). Middaugh states that, "of special importance is the need to obtain more information on the beneficial health effects of subsistence foods. Whereas the results of monitoring for environmental pollutants will have little immediate benefit to human health, further understanding of omega-3 fatty acids in seafood and marine mammals may provide many benefits to the health of all" (Middaugh, 1993, p. 381).

[97] Lupton and Petersen articulate the problematic nature of the technocratic construction of risk:

> Risk identification is increasingly regarded as the preserve of those who have access to technology and expert knowledges, for example scientists and members of the medical profession. These experts are responsible for constructing a web of knowledges around environmental hazards, and for interpreting risk for members of the lay population. It is difficult for lay people to know how much trust they should invest in these experts, however, given the constantly shifting state of scientific and medical knowledge. (Petersen & Lupton, 1996, p.98)

Grondin et al. point out that specifically in the North there is a "growing resistance to resource development and... scepticism as regards politicians' and even the scientific communities' environmental goodwill and know-how in the Arctic" (Grondin et al., 1993, p. 368).

in some communities (Shkilnyk, 1985). However, it is suggested by a number of researchers that among some Native groups the rejection of wild foods due to the exaggerated and ill-defined spectre[98] of environmental contamination is a more immediate health threat than environmental contamination – especially with respect to diseases like diabetes.[99] The Cree board of health offers the following recommendations regarding contaminant research:

> [W]hen we make public health recommendations we must make a technical evaluation of the toxicology of the product. The presence of the contaminant in the environment must be characterized: the real exposure of the people must be determined not just their theoretical exposure. Direct health impacts of the recommendations must be assessed. In the case of methylmercury [in fish, which is a key concern for the Innu (Series 5 anthropology module, 2005)] this meant among other things to beware of low quality food alternatives, and of the diminished activity that would come with a ban on fishing. Scientists tend to recommend a zero level exposure without realizing the social consequences of the recommendations. Therefore a parallel evaluation must be made of the social impact both of the health problem itself and of the proposed recommendations. (Dumont and Kosatsky, 1990, p. 703)

By the time traditional foods started to be portrayed as worth eating in the mid-eighties (due to pressure from native people for more culturally sensitive educational material), the fear of contamination was strong enough to deter many native people from including significant amounts of it in their diet.[100] Samson and Pretty argue that the Innu have essentially traded one form of contamination for another – and the 'contamination'

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[98] Grondin et al. suggest that there is an extreme response to contaminant risk: "fears and concerns due to technological accidents and man-made contaminant build-ups are the most difficult to control and those that are subject to the most unrealistic assumptions or irrational behaviour". The fear gives rise to "panic, or even having some people referring to contaminants to explain any social or health problem" (Grondin et al., 1993, p. 368)

[99] Adler et al. propose that "Daily Consumption of Seal Oil or Salmon Associated with Lower Risk of Non-Insulin Dependent Diabetes Mellitus and Impaired Glucose Tolerance in Yup'ik Eskimo and Athabaskan Indians of Alaska" (Circumpolar Health, 1993, p. 8).

[100] Samson and Pretty point out that the "decline of country food consumption has coincided with the new threat from contaminants in country foods. For example, radioactive caesium (Tracey & Kramer 2000, p.48) and cadmium (Adelson, 2000, p.84) have been found in caribou in the Canadian north. Methylmercury has been discovered in fish caught by Eastern James Bay and northern Manitoba Cree (Delormier & Kuhnlein 1999, p. 182; Loney, 1995, p. 239), along with mercury, PCBs and pesticides in traditional foods consumed by Inuit populations in Greenland (Pars et al. 2000, p. 29). (2005: 13)

by high-sugar, high-carbohydrate, low protein and mineral non-native foods has resulted in the 'epidemic' of 'diseases of modernization,' diabetes being at the apex of concern (Samson & Pretty, 2005).

Recently, the newly advertised threat of hormones, pesticides and other additives in mass-produced, chemically grown, genetically modified store-food has begun to swing the pendulum of opinion among the Innu back towards a perception of wild food as healthier than store-food (Series 1 Interviews, 2005). While for many native communities situated in densely populated areas wild food is no longer accessible, "the Innu are still fortunate enough to have wild foods at their disposal in the vast Labrador-Québec interior" (Samson & Pretty, 2005, p. 11). However, there are substantial obstacles to eating a wild-food diet (see chapter 1 and chapter 5). The only other "healthy" alternative is to buy "organic"[101] food. For many Innu families (and for many Native people across North America) geographic and economic realities exclude buying organic as a real alternative.[102]

Lupton and Petersen situate the encouragement to buy organic within the shift in systemic definition of the 'public' and 'citizens'. Citizens, rather than being a collective, are understood as autonomous individuals whose freedom resides in their power as consumers:

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[101] Organic is defined here as, regarding produce, grown without herbicides, pesticides from seeds free of genetic modifications; regarding animal products, animals raised on organically grown feed and without hormone and anti-viral injections.

[102] The socio-cultural, economic and logistic issues raised by Hill and Robbins in their discussion of a federal food transportation subsidy apply to the Labrador Innu:

> Issues of food security and the affordability of a nutritious diet in Canada are not unique to the north, but they do require special consideration in remote communities where food costs are extraordinarily high even with the current transportation subsidy, where economic opportunities available to most aboriginal people are very limited, where their traditional diet are threatened by cultural change and contaminants, and where retail competition is poorly developed. (Circumpolar Health, 1993, p. 281)

> [T]he contemporary era is characterized by the replacement of the political doctrine of liberty by the notion of consumption. The 'free' individual is conceptualized as the individual who possess the maximum capacity to acquire goods, and consumption is a major source of meaning and moral values in everyday life. (Petersen & Lupton, 1996, p. 67)

The definition of the individual *qua* consumer is highly evident with respect to environmental concerns such as contamination in wild food:

> the new public health adopts a largely neo-liberal approach, focusing on the citizen as a rational consumer, one who engages as an autonomous individual in activities to prevent or reduce environmental damage and to protect herself or himself from health risks believed to be generated by the environment. (Petersen & Lupton, 1996, p. 90)

In the placement of responsibility for avoiding contaminants with the 'free' individual, there is "little or no recognition of social differences such as gender, ethnicity, age, or of physical or economic capacity to engage in the suggested activities" (Petersen & Lupton, 1996, p. 101). In other words, there is no acknowledgement of social disadvantage – of the fact that "it is the working class whose health is most threatened by environmental hazards" (Lupton and Petesen 1996, p. 102). This is highly problematic because "social disadvantage, while it is directly associated with level of exposure to environmental hazards, is also associated with fewer opportunities to escape these hazards or attempt to do something about them" (Petersen & Lupton, 1996, p. 103). At the same time, the focus on individuals allows large-scale agricultural industry and food-distributors to avoid taking responsibility for health issues. The placement of responsibility with individuals rather than industry reveals the tendency to ignore collective, systemic sources of health problems and to focus instead on superficial, short-term, individualistic solutions.

> In its focus on the individual choices and behaviours of citizens and its representation of the 'environmental citizen' as consumer rather than activist, the

> new public health draws attention away from the structural features of industrialized societies that shape work and production patterns and thereby contribute to large-scale pollution and the massive consumption of resources. As this individual focus on environmentalism routinely emerges from state agencies, it does little to challenge the role played by the state in regulating industrial production. (Petersen & Lupton, 1996, p. 101)

The MSB approach to nutrition education is characterized by this same lack of consideration of systemic factors; the following is an excerpt from the 1982 report:

> MSB continued to provide dietary and nutritional expertise to Indian and Inuit communities. The enhancement of existing Indian and Inuit diets is accomplished through the provision of advice by regional nutritionists and community health representatives. (1982, p. 13)

Nutritionists provide only "advice", not subsidization for food purchase. Nor is there any mention of whether the suggested foods are available in remote locations. The disregard for issues of accessibility and affordability leads to a situation where patients are considered as individuals in a sort of vacuum. They are blamed on cultural and educational grounds alone – without consideration of their economic, familial, and community circumstances – for making poor food choices. If a patient does not comply with the diet recommended by a health care provider, the only explanations are that they have not been properly educated, are incapable of understanding the import of educational materials, or do not wish to follow the recommendations because of food preferences. Kelm and Benyshek et al. point out, from the vantage of disparate disciplines, that it is governmental practices that have created poor nutrition in native communities, not the poor choices of native individuals influenced by ignorant cultural preferences (Benyshek et al., 2001; Kelm, 1998).

The MSB's increasing emphasis on nutrition education beginning in the seventies is part of the broader shift toward patient education in general, which is a key aspect of

the new public health. One of the incentives for this shift towards education was the changing profile of illness in native communities away from acute infectious disease and towards noncommunicable, chronic diseases and conditions such as diabetes (Joe and Young, 1994; Young T.K, 1994; Kelm, 1998).[103] In the educational approach to preventing and treating chronic diseases we see the beginning of the 'lifestyle' approach as articulated by MSB. The term 'lifestyle' was first used by the MSB in 1973. The report stated that: "a general shift in emphasis is taking place in the area of preventive health and greater attention is being paid to morbidity and mortality attributable to lifestyle, health attitudes and behaviours and environmental factors" (MSB, p. 15).[104] The centrality of chronic disease (as well as the continued importance of nutrition) is clear: "the focal points of the community health program were: immunization and chronic disease control, alcohol abuse, accidents and violence, personal hygiene and sanitation, maternal and child care, and nutrition" (MSB 1973, p. 15).

Preventing and treating chronic diseases through the lifestyle approach requires a different set of skills for health care providers, such as patient motivation, support, and

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[103] According to Joe, the role of technology and medical advances have been key to this shift in epidemiological focus: "because modern technology and medical advances have dramatically lowered the number of deaths world-wide due to communicable diseases, the attention of many international health leaders has in recent years turned to the alarming mortality and morbidity statistics associated with noncommunicable diseases such as diabetes." (Joe, 1994, p. 1) In other words, had the TB epidemic, for example, not been brought under control, perhaps noncommunicable diseases would not have become such a prominent feature of epidemiological "reality" – this thought-experiment reinforces Lupton's point about the constructed nature of epidemiological and statistical "fact".

[104] The patient education program, out of which the lifestyle approach was developed, was highly paternalistic and shaped by the view that Native culture and psychology are damaged and need to be fixed:

> Indians must be taught the three R's, and will also need vocational training, but it would be naïve to think that this will automatically solve all the problems overnight. As with the Indians elsewhere there are deeply rooted psychological problems to be overcome before the process of integration is complete. (Rockwood in Wadden, 1991, p. 47)

Considering this attitude, it is not surprising that the current lifestyle approach continues to assume a negative view of Native culture and psychology.

most importantly, education. The exponentially rising rates of chronic diseases over the next decade demonstrated the ineffectiveness of these educational efforts.[105] As a result, a policy position began to develop around the concept of "cultural relevance" – the inclusion of 'traditional' foods in the eighties is one facet of this culturally relevant approach. It was proposed that in order for education to be effective it had to

> understand cultural attitudes about health...and the client's frame of reference...[which] includes cultural beliefs and attitudes that impact directly on the health and behaviour of the client.[106] The cultures and the belief systems of the native peoples of Canada and the United States differ in varying degrees from that of mainstream culture as well as from one another, and these differences have historically been the source of problems in the dissemination of health care. (Joe & Young, p. 11)

The focus on cultural relevance was, and is, especially prioritized with respect to diabetes: "the importance of understanding cultural attitudes about health and diet, particularly with diabetes, cannot be overstated" (Joe & Young, 1994, p. 11).

As well as being associated with a shift in disease profiles towards chronic disease, the concern with cultural relevance developed in the political context of an international movement towards recognition of human rights, with special emphasis on colonized peoples (Coates, 2000; Tuhiwai Smith, 1999; Backhouse & McRae, 2002). Native people began to demand that health care be not only culturally relevant, but largely defined by native people. These demands for increased native ownership over

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[105] Coates writes:

> For over thirty years, federal and provincial governments have repeatedly attempted to reverse the social pathology [of many native communities]. Counselors have been hired, special services launched, educational initiatives undertaken, youth programs sought. But over the same period of time, by most statistical measures, conditions appear to have stayed as bad or gotten worse, defying all efforts to bring about improvement. (Coates, 2000, p. 61)

[106] The use of the term 'client' instead of patient is an example of Lupton and Petersen's point about the creation of citizens as consumers; although the term 'client' is used in a paper written in the United States where patients do have to pay and are therefore 'clients', the disconnect between a discourse of 'public' health and constructing patients as consumers is apparent.

services, and for a general celebration of difference as opposed to assimilation, gained strength among Canadian native people as a result of the release of the 1969 White Paper on Indian Affairs. The White Paper sparked a unified native response against the liberal politics of assimilation (Harris, 2002, pp. 298), and was instrumental in the creation of "strong, coherent national aboriginal organizations" (Coates 2000, pp.76) that began to fight for land-ownership and self-determination.

The greater question of self-determination is still in negotiation for most native groups (Barsh, 2004), including the Innu (Backhouse & McRae, 2002). In the field of health the move towards "transfer" sparked by the White Paper evolved over the next decades and in 1986 culminated in the release of the Indian Health Transfer Policy (a document which officially stated the Canadian government's support of native communities taking responsibility for their own health programs (MSB 1986)). The related evolution of "native involvement", "cultural relevance", and "transfer" was apparent in the MSB reports. With respect to transfer: in the release of the "Indian Health Discussion Paper" (MSB, 1979), the discussion of "policy, planning and evaluation" (MSB, 1982), the creation of "program transfer directorates" (MSB, 1989), and the signing of "transfer agreements" (MSB, 1989). With respect to native involvement and cultural relevance: in the employment of "native health workers" (MSB, 1971), the discussion of "native involvement" (MSB, 1977), the creation of "cross-cultural orientation programs" (MSB, 1979), the convention of the National Indian and Inuit Health Conference (MSB, 1984), and the development of "culturally appropriate education materials" (MSB, 1985).

Although federal withdrawal was articulated as a transfer of control to native people and an empowerment of native culture, it also threatened the special relationship between Native people and Ottawa.[107] Many native people were made suspicious and angry by the likelihood that the government was simply trying to break out of its obligation to native people. Other native people were eager to be free of the colonizing control of governmental institutions in the midst of their communities:

> When the Canadian government announced its Indian Health Transfer Policy in 1986, few discussed its decolonising potential. While the Canadian government argued that transferring control over medical services was a necessary step towards aboriginal self-government, critics wondered if this logic simply masked a desire to deny treaty obligations to First Nations by downloading expensive services onto ill-prepared communities. (Kelm, 2004, p. 335)

While administrative negotiations about transfer went on at the provincial and federal level, in communities 'native involvement' meant the training and hiring of native community health representatives and the inclusion, to a limited degree, of native approaches to healing. The evolution of the national native alcohol and drug abuse programs (NNADAP)[108] is significant to the project of Native involvement and, ultimately, to transfer. The structure of the NNADAP is the working model for self-determination in health care (it was through participation in the delivery of the NNADAP that the *concept* of native involvement became more of a reality). Despite being the most native and community-driven program, the NNADAP was only a small step towards

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[107] Of which, as discussed in chapter 1, the native people of Newfoundland had no part until after Newfoundland joined Canada, at which point some federal money was spent in Newfoundland and Labrador.

[108] The "National Native Alcohol Abuse Program" (NNAAP) was officially established in 1975 (it was later modified into the "National Native Alcohol and Drug Abuse Program – NNADAP). The alcohol abuse control studies conducted in 1971 in Nova Scotia and New Brunswick were likely the pilot program for the NNAAP (MSB, 1971).

cultural validation and self-determination.[109] Although there was some native input, the overall structure and standards were defined by the medical community. Diabetes prevention programs often take a similar form to the NNADAP, and hence its limitations also emerge in current diabetes prevention programs.

In 1985 the heading for the NNADAP was modified to read "NNADAP – a community-based approach to prevention and treatment" and it was stated that the

> NNADAP philosophy advocates a culturally-relevant, community-based approach to program development...The incorporation of appropriate Indian and Inuit cultural values, beliefs and customs into generic advocative, educational and counseling practices is the identifying characteristic of the program. (MSB 1985, p. 20)

The emphasis on *native* involvement throughout the eighties was accompanied by an increasing focus on *community* involvement – both were, and are, key to the project of transfer and self-determination. Again, despite the opportunity for community and cultural empowerment, the rise of "community-based"[110] health initiatives is yet another facet of the tendency to transfer responsibility away from the collective institutions and onto individuals and smaller groups such as native communities. Like the NNADAP,

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[109] For example, in 1978, the MSB report stated that the NNAAP "demonstrated conclusively that skilled Native workers trained in alcohol abuse prevention and counseling can effectively reduce Native alcoholism and its attendant mortality and morbidity" (MSB, 1978, p. 10). In 1979, the MSB re-introduced the NNAAP and the new mandate demonstrates an increased reliance on "native approaches": "the primary thrusts of the program are to involve native people in combating alcohol abuse and to encourage the development by Native people of a variety of approaches to the problem" (MSB, p. 11). And yet, when in 1982 a new program was designed as a joint project between DNHW and DIAND – the responsibilities were divided up as follows:

> The DNHW has overall program responsibility, including the development of NNADAP policies, and the administration and management of the program. For its part the DIAND will provide collaboration and support through other socio-economic programs. (MSB, 1982, p.11)

The fact that the DNHW is responsible for the development of NNADAP policies reveals the superficial quality of native involvement and the limited degree of creative room available to native communities. Despite the use of contribution agreements, and the description of the program objective as "to support Indian and Inuit people and their communities in establishing and operating programs", on the policy level control still lay with the DNHW and DIAND.

[110] The term "community-based" first appears in the 1981 MSB report (p.11)

Diabetes programs are characterized by the "community-based" approach. The Sandy Lake Diabetes Prevention Program, Gila River Diabetes Prevention Model, and the Kahnawake Schools Diabetes Prevention Program (KSDPP) are examples. Researchers (Macaulay et al., 1999) and successful programs such as the KSDPP demonstrate the positive elements of participatory community-based initiatives in terms of individual and community empowerment.[111] But Petersen and Lupton argue that the burden of responsibility and the obstacles to overcome are often too great for communities and must be addressed at a higher level.[112]

The 1985 articulation of the NNADAP mandate was the first time that the terms "culturally relevant" and "community-based" were so closely related in the MSB reports; together they delineate the emerging approach to native health care – particularly with respect to chronic 'lifestlye' diseases like diabetes. The fact that 1985 was the first year diabetes was mentioned as a concern, and that the CDA conference on Native diabetes was also held in this year, reinforce this connection. The rise of diabetes in Canada in the eighties, then, coincided with an overall epidemiological shift away from acute infectious disease and towards noncommunicable chronic diseases; with a policy trend towards individualistic public health care; with the political/administrative movement to increase native involvement and control over services; and with the socio-cultural trend towards cultural validation and empowerment (National Round Table on Aboriginal Health and Social Issues 1993). It is in light of these trends that both the lifestyle approach to diabetes, and the culturally relevant approach in Canada, can best be understood.

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[111] See discussion of the KSDPP in chapter 4.

[112] According to Petersen and Lupton, various studies of environmental risk perception demonstrate that environmental risks are often considered too overwhelming to be engaged; "these studies suggest acute awareness of environmental dangers and ambivalence about science and technology are not necessarily translated into political action or into change" (1996, p. 103).

The fact that in 1989, just four years after the CDA conference, diabetes had become more prevalent in native communities than in the general population in Canada (MSB: 1989), and ten years after that Health Canada initiated a five-year, 115 million-dollar effort to address the issue of diabetes for *all* Canadians (58 million was allocated to the Aboriginal Diabetes Initiative),[113] demonstrates that attempting to bridge cultural differences between health care providers and native patients has not been sufficient to stem the rising tide of diabetes. To see any real improvement in diabetes prevention and care the fundamental assumptions of both the lifestyle approach and the concept of cultural relevance need to be challenged.

Critiquing the Culturally Relevant Approach to Native Diabetes Care

As discussed in the previous section, while the clinical treatment of diabetes among native people is dealt with on a purely cultural level, in the field of medical research underlying causes are assumed to be racial and biological rather than political, social, economic, or locational. Both research on the disease and the clinical programs that develop out of this research ignore the role that individuals', families', and communities' socio-political history and current standing, economic status, and geographic location play in the development of diabetes (Thompson & Gifford, 2000). The implication is that if there is a solution to diabetes it lies within changes to native bodies and native cultures.

This research aims to explore diabetes among the Innu of Sheshatshiu without beginning from the assumption that the fundamental problem lies within the Innu body and Innu culture. Instead, it begins from the assumption that since diabetes is a disease of

[113] Through the ADI, Sheshatshiu was provided with one nutritionist and one nurse.

poverty and a politically determined disease (Benyshek et al., 2001; Samson, 2003; Samson & Pretty, 2005), the degree to which the Innu in Sheshatshiu suffer more from diabetes than their non-Innu neighbours in North West River is an indication of the greater degree of political and economic marginalization. Extending this hypothesis to the Canadian population, rather than being the result of genetics or behaviour, the discrepancy between Native and non-native rates of diabetes is probably directly correlated with discrepancies in economic, political, and social marginalization.

As discussed in chapter 1, the low economic, political and social status of Canadian Native people is a direct result of colonization. The destruction of both economic and political/cultural autonomy is key to the success of colonization. Diabetes among native people is a disease of colonialism because it is caused by the colonizers' assault on cultural cohesion and resilience. It is the loss of cultural cohesion and validity that are the key factors in the development of diabetes. When we understand this, it is apparent that encouraging cultural resilience and rebuilding cultural cohesion and validity is essential to preventing and managing diabetes. Although the culturally relevant approach to native diabetes care emphasizes the role of culture in diabetes care it does so for the wrong reasons.

The following excerpt from a diabetes prevention program report outlines the culturally relevant approach to native diabetes care:

> The clinical care of a diabetic patient is complex. It requires a blend of nutritional knowledge of dietary requirements, medical knowledge of medications used and complications of the disease, and emotional support for the patient who has an on-going chronic illness. It also requires education so that the patient can understand and therefore better take care of himself or herself. Ideally there should be a team available to the diabetic, consisting of a nutritionist, and educator who may also be a nurse, and a physician.

> It is particularly important that non-native health care professionals, when taking care of Native patients, understand that culture strongly influences how illness is perceived and presented, and how a patient interprets his/her illness and treatment. (Macaulay and Hanusaik 1987, p. 133)

John O'Neil articulates the limitations of the culturally relevant, or 'culturological', approach:

> Proposed solutions often focus on developing 'culturally-relevant' educational material that is more likely to be understood and acted upon by Indian clients. While accepting the basic value of this 'culturological' [or culturally relevant] approach to cross-cultural health education, we suggest that the model described above overlooks two important dimensions. One is the environmental context which limits preventive behavioral options available to Indian people...The other is the structure of the educational process where the status and role of the educator influence the 'meaning' of the educational message to the client. In a nutshell, the success of diabetes education for Canadian Indians is affected as much by economic, political and social factors which structure both their home environmental and the educational process, as it is by differences in beliefs and values between educators and clients. (O'Neil et. al 1987, p. 161)

Both statements are responses to the perceived need for greater respect and integration of various native approaches to sickness, health and healing. The differences between these two approaches are revealed, first in how 'culture' is conceptualized – what boundaries are set around the cultural domain – and second in the role culture is expected to play – whether it is considered to be the key to improving native health, or only a superficial element to effective treatment.

As part of the background literature review, the practices and results of culturally relevant diabetes prevention programs (DPPs) throughout North America were examined. Out of this review two main conclusions emerged: first, that the culturally relevant approach does not challenge the assumptions of the lifestyle approach to diabetes; and second, the DPPs largely define and approach culture as a negative force – an

impediment to the lifestyle treatment of diabetes that, with cultural awareness, can be overcome.

The negative view of Native cultures stems from a limited definition of 'culture.' The following statement about diabetes care among native people is an example:

> The difficulties with controlling [diabetes] are further increased when the customs, beliefs, and thinking processes of two distinctly different cultures interact. It is not only the cultural patterns of the patients which create barriers to successful therapy, but also the cultural patterns of the Anglo physicians with their Western medical training that cause impediments to effective patient participation in care. If effective diabetes care is to be delivered and accepted we believe that it is necessary to understand the cultural barriers of both the patients and the providers. (Hickey & Carter, 1994, p. 472)

This quote reveals that 'culture' is constrained to its most superficial aspects – the immediately observable culture differences – and these are taken to be the totality of the cultural gap that exists between patients and providers. The power of culture as both the dynamic force and the stabilizing structure that lends a group cohesion and purpose is not recognized. Nor, therefore, is the profoundly destructive impact of colonization's assault on these aspects of cultural functionality, which is a substantial factor in the prevalence of various diseases and social ills, including diabetes. When the loss of Native culture *is* implicated in the disease process, 'acculturation' is introduced as a concept devoid of any agency and therefore it remains without political significance.[114] The faces of cultural

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[114] Rather than being aggressively 'colonized by militant nations', Native people neutrally 'intersect[ed] with modern Western societies':

> The advent of obesity and decreased activity are part of a common pattern which occurs when traditional cultures intersect with modern Western societies. Another unfortunate by-product of this acculturation process is often unemployment and poverty. The miseries that these bring often lead to an overindulgence of available self-satisfying activities such as eating and alcohol use. (Hickey & Carter, 1994, p. 458).

expression that are recognized, and seen to be problematic, are: food beliefs,[115] body-language, [116] language-differences[117] and related differences in logic,[118] body-image beliefs,[119] and disease etiologies.[120]

The most obvious evidence of the limited and negative view of Native cultures is the problematization of the centrality of food, and the small role set out in the DPP reports for Native medicines, religions, and Elders. Rather than addressing the economic and logistic barriers to accessing 'healthy' non-native food[121] and traditional foods (which are inherently healthy), cultural studies seem to suggest trying to discourage

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[115] For example, the centrality of food at cultural functions, and the value placed on food due to periods of scarcity and lack of storage facilities are seen to contribute to obesity (Hickey & Carter, 1994, p.457). Another example is that the Canadian Diabetes Association recommends eating three substantial meals a day (Canadian Diabetes Association, 2003, p. S131). The health workers in Sheshatshiu accordingly advise their Innu patients to eat three substantial meals a day. However, the Innu habitually eat smaller portions throughout the day, and they continue to do this. The result is that many people *gain* weight from following health workers' advice (Bowers ?; Series 1 Interviews, 2005).

[116] For non-native patients direct eye contact and a firm handshake, for example, are meant to convey honesty and trustworthiness. Many Native cultures highly esteem age and reserved behaviour direct eye-contact is a sign of disrespect and a firm hand-shake is overly familiar and oversteps the bounds of professional conduct (Hickey & Carter, 1994).

[117] The need for medical interpreters is widely recognized (National Round Table on Aboriginal Health and Social Issues 1993). However, O'Neil points out that interpreters are faced with a conundrum as they must simultaneously align themselves with the non-native health care provider *and* advocate for the Native patient (O'Neil, 1989).

[118] Unfamiliarity with the written tradition is one example of a 'logical' cultural difference. Native patients: "often find it difficult to understand explanations given by Anglo providers, which depend on written logic and scientific precepts. Thus Indian people often have difficulty comprehending concepts such as chronic disease, pathophysiology and 'blood sugar'" (Hickey & Carter, 1994, p. 458).

[119] Many Native cultures prefer plumpness as a sign of comfort and prosperity, rather than eschewing it as unhealthy and unattractive (Hickey & Carter, 1994). The prevalence of this preference in cultures throughout the world is noted by Marvin Harris, who also points out its sound logic (1985).

[120] Hickey and Carter conclude that chronic diseases like diabetes are difficult for Native groups to conceptualize and take seriously because they are only familiar with diseases that are "suffered as an acute physical event with obvious symptoms, with a definite outcome, and of limited duration" (1993, p. 455).

[121] The foods that are recommended on so many of the "hypo-caloric" diets suggested by DPPs are too expensive for many native families to afford, but rather than addressing this issue, the main problem is seen to be Native people's dislike of vegetables:

> People often indicated that they didn't like the foods that had been suggested for their diabetic diet. For example, one woman with a large family objected in particular to certain vegetables: "Some foods in these diets are ones many of us don't like: asparagus, broccoli, lettuce and so much salad, green vegetables. These are expensive too, and people don't buy them when they go to the store." (Garro & Lang, 1994, p. 315)

Broccoli is also specifically noted as distasteful by the Innu (see chapter 5).

functional, healthy, rich, and powerful cultural traditions centering around food. Native medicine is recognized as improving "attitudes towards oneself that can be a significant asset in the overall therapy of NIDDM" (Hickey & Carter, 1994, p. 456), but the medical validity of traditional medicine continues to be undermined and no reference is made to changing legislation or clinical structure in order to more meaningfully incorporate Native healers. Diabetic patients should be introduced to Elders and Native healers only "where appropriate" to reduce the chance that patients will "abandon recommended behavioural changes and/or medications in favour of the exclusive use of traditional interventions" (Hickey & Carter, 1994, p. 456). Finally, despite paying lip-service to concepts of integration, the ideal 'team' of consultants available to the diabetic "should consist of nutritionists, nurses, physical therapists, pharmacists, health educators, optometrists, and physicians" (Hickey & Carter, 1994, p. 467), which does not include Native Elders, healers, or food experts.

The goal of many DPPs, then, is to teach cultural awareness so that the health care provider (any member of the "team available to the diabetic, consisting of a nutritionist, and educator who may also be a nurse, and a physician") does not misinterpret 'cultural signals,' or stumble into 'cultural taboos.' The implication of this goal is that whatever the problems that currently impede the effectiveness of the lifestyle approach to diabetes are, they can be solved by adjusting the relationship between the non-native health care provider and the Native patient *without* undertaking any change in broader community and societal circumstances. In other words, the culturally relevant approach, like the lifestyle approach, avoids discussing the determining role of

economics and politics and instead circumscribes a discussion of disease within the bounds of the culture and behaviour of individuals.

This position leads us to understand the second crucial aspect of the culturally relevant approach. Most DPPs, even if they propose to address "systemic" issues of health care provision, do not intend to challenge fundamental assumptions of biomedicine or clinical practice but rather seek simply to adjust them so that they work better within the particular context of a Native community. The blatant acceptance, by even the most progressive DPPs, of genetic explanations for the high prevalence of diabetes among Native people, demonstrates the continued allegiance of cultural relevance to biomedical approaches to diabetes.[122] That the biomedical approach begins by looking for racial rather than political, historical or economic causes for diabetes indicates why biomedical solutions will not address the root problems of diabetes in Native communities. The assurance made by most DPPs that culturally relevant measures are "in no way meant to replace accepted clinical standards of care" (Garcia-Smith, 1994, p. 470), demonstrates the continued allegiance to clinical approaches to diabetes. That the clinical approach to diabetes encourages individuals to make lifestyle changes, without consideration of the immovable barriers to their doing so, indicates why the clinical approach is ineffective for many Native people who have to contend with these barriers. Hence, the culturally relevant approach, because of its concern to remain within the established bounds of health care standards and assumptions, cannot profoundly improve the prevention and care of diabetes in Native communities in the long term.

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[122] For example Macaulay et al. introduce Type II diabetes as follows: "NIDDM is a disease of multifactorial etiology where genetic and lifestyle factors contribute to the current epidemic" (1997, p. 780).

The culturally relevant approach is limited from a cultural perspective on the one hand because the definition of culture is too narrow, cultural differences are seen as barriers, and cultural norms are seen to encourage unhealthy lifestyles. It is limited from a health perspective on the other hand because the fundamental assumptions and techniques of biomedicine remain unchallenged, there is too much pressure on individual clients and providers, and too much stress placed on the relationship between an individual provider and client in achieving significant health improvements. Essentially, while the power of individuals to effect major changes without supporting contextual change is overestimated, the power of culture is underestimated. In a truly culturally relevant approach, a central goal should be the empowerment of culture. In order for culture to be powerful, it must be understood in its broadest, most dynamic sense to be simultaneously the creator of individuals, families and communities, and created by individuals, families and communities, and as what carries individuals, families, and communities from the past into the future within a larger physical, social, economic and political environment.

Andrew and Sarsfield suggest that a deeper look needs to be taken at, on the one hand, what Western biomedicine can and cannot offer, and on the other, what native cultures and approaches to health do have to offer:

> We feel that those who are sincere in wanting to promote Innu health, rather than merely developing a larger self-serving medical system, must be prepared to address problems to which the traditional medical disciplines do not have the answers.
>
> For the Innu the real health system will be one which will allow Innu society to function properly again...above all it would permit the Innu the freedom to live unmolested in the Innu country of *Ntesinan*. In recent years more Innu than at any time since the beginning of the settlement policies in the 1950's and 1960's are abandoning the government villages and reserves to live in mobile family

> camps in the interior of *Ntesinan* for a period of about seven months each year. The change in the health of Innu families when living away from the environment of the government villages is remarkable...It is initiatives such as this which represent the health-care system on which Innu energies and attentions are focused today. (Andrew and Sarsfield, 1984, p. 429)

The continued prevalence of diabetes in native communities, and the increase in diabetes among Canadians (and North Americans) generally, suggests that diabetes is not an issue of cultural barriers or individual people's poor choices. Insofar as culture is at the root of diabetes among native people it is the *destruction* of native cultures and the cultural idiosyncrasies and systemic inequalities of *non-native* culture that are to blame.

This is not a difficult argument to make. First, a diet of processed foods high in carbohydrates and sugars, lack of exercise, and high stress – the main determinants of diabetes – are characteristic of *non*-native culture. In most native cultures, high activity levels and diabetic-friendly food – the focus of all diabetes prevention strategies – were integral parts of daily life before settlement. In other words it is the non-native lifestyle, not native lifestyles, that leads to the conceptualization of diabetes as a 'lifestyle' disease. Second, the most obvious proof of the relationship between *non*-native culture and diabetes is that the sudden onset and subsequent explosion of diabetes in native communities is evident only after colonization and settlement. It was only after native cultures were virtually destroyed, their access to resources was restricted, and their political autonomy was undermined by the "civilizing" programs of governments that diabetes emerged as a problem in native communities.

The perspectives, experiences and concerns of the Innu people interviewed illuminate the reasons why the lifestyle and culturally relevant approach fail to produce a treatment and prevention program that is effective for the Innu of Sheshatshiu; articulate

the Innu view of the determining factors of diabetes; and demonstrate the need to broaden the definition of culture so that it is recognized as the key, not only to preventing and treating diabetes, but also to healing the individuals and the community of Sheshatshiu.

Diabetes Management and Prevention in Sheshatshiu

The diabetes prevention effort in Sheshatshiu began with Health Canada's Aboriginal Diabetes Initiative (ADI).[123] Through the ADI, Sheshatshiu and Natuashish were provided with one nutritionist and one nurse. In 2001 Renée Bowers was hired and worked with Edwina Jack, an Innu community member, to start up the "Innu Integrated Diabetes Project" (Bowers, 2004).

The creative and concentrated effort that these two women put into the task of improving care for diabetics in Sheshatshiu is noted by both health care workers and Innu diabetics (Series 1 Interviews, 2005). However, the effectiveness of their work was limited by the fact that a diabetes consultant and a nutritionist cannot address the most intractable obstacles that keep Innu diabetics from engaging in self-care. The impossibility of the task of teaching the mechanisms of diabetes across the language barrier (Edwina Jack pointed out that there are no Innu words for many of the technical terms used in clinical explanations of diabetes), motivating patients to come to the clinic, come to walking and exercise groups, attend cooking sessions, and stick to diets (Bowers and Jack used to go door to door to try to make contact with patients – neither would go alone as the task was intimidating and demanding) is apparent in the fact that Renée Bowers left the position in 2003, and in that Edwina Jack does not feel there is

[123] In 1999, Health Canada initiated a five-year, 115 million-dollar effort to address the issue of diabetes for *all* Canadians. 58 million was allocated to the Aboriginal Diabetes Initiative (ADI).

appropriate support for her to take on the lead position herself (Series 1 Interviews, 2005). The position of diabetes consultant was vacant for two years while the Innu arm of the clinic searched for a candidate. The position was filled but only briefly; the individual was not able to work with the situation at the clinic and in the community and left soon after arriving (Series 1 Interviews, 2005). A new candidate has recently been hired in 2006 (M. Snow, personal communication, 2006), but the same intractable problems will remain for this new individual and Edwina Jack to struggle with.

While Sheshatshiu is well-connected by road to Goose Bay and other locations across Labrador, affordability and accessibility of supportive services and amenities are nonetheless problematic issues. Diet and weight-loss are two key components of the lifestyle approach to diabetes, but the affordability and availability of 'healthy' (diabetic-friendly) foods to Sheshatshiu residents are limited. While community-based stores (there are now three) are accessible, the great majority of the items available are the very ones targeted as contributing to both the development and intensification of diabetes. Meanwhile, the nearest grocery store carrying foods recommended to diabetics and to individuals trying to prevent diabetes among their family members is located forty-five minutes away, in Goose Bay. Many people living in Sheshatshiu do not have regular access to a vehicle and so a trip to Goose Bay requires approximately eighty dollars in taxi fare round-trip (Series 1 Interviews, 2005). As a result, shopping trips occur at most once a week and often once every two weeks (Series 1 Interviews, 2005). With respect to affordability, the 'fresh', 'low fat', and 'whole' foods recommended to prevent and manage diabetes are generally more expensive than processed food. The financial status

of most Sheshatshiu families prohibits the purchase of expensive food items (Series 1 Interviews, 2005; Samson 2003; Innu Nation and Mushuau Innu Band Council, 1995).

Taken together, availability and affordability significantly limit the amount of, and consistency with which, fresh food can be consumed. And to these a third factor must be added – facility. The foods recommended to manage and prevent diabetes generally require more preparation time and culinary devotion than processed foods. Liz,[124] a non-Innu Mani Ashini clinic employee who grew up in Labrador and is herself a diabetic, explained that for her taking the time to prepare these foods is not an option on most days. For people who are working multiple jobs or long hours just to make enough money to pay for the basics of rent, medication, and food, time-pressure is a significant factor in their ability to engage in self-care practices (personal communication 2006). Buying pre-cooked foods is not an option for low-income families because prepared foods that would be advisable for diabetics are expensive. Liz put it simply when she said: "it is more expensive to eat healthy" (personal communication 2006). Although the Innu do not have to pay for medication, rent, and most do not have to pay for housing,[125] the interviews demonstrated that time-pressure significantly affects Innu families' food consumption:[126]

> There's a difference between telling people what's healthy right and people listening. It's like they'll probably go home and...none of the houses you'll go into you'll see any manuals on the wall or manuals they'll go by or where everybody gets up and have breakfast together. We gets up and we eat when we want to. If everybody's working and going to school then we eat at dinner time, or we don't eat at all if both parents are working, then they don't have time to

[124] In accordance with the Guidelines for Ethical Research names have been changed to protect the identity of individuals wishing to remain anonymous.
[125] Some people, fed up with waiting for the Band Council to provide them with housing, invest in building their own homes. For these individuals, paying loan installments is equivalent to paying rent or mortgage (Series 1 Interviews, 2005).
[126] See also the discussion of David Penashue's experience in chapter 5.

> cook, then you have to look forward to having a good supper. So there's a lot of difference from whichever way you look at it from the Innu perspective or from the English world's perspective. Series 1, Louis Rich Interview, 2005)

The final question this study set out to explore was, how does the clinical conception of cultural relevance compare with Innu perceptions of the role of culture in diabetes prevention and management? Like other native groups, the Innu have concepts of health and illness, cultural norms, cognitive structures of logic, language and experience that are particular to them. A study of these cultural particularities would likely reveal a variety of ways in which the comportment of health care providers and the design of diabetes programs could be altered so that there was a better fit with Innu modes of presentation and communication.

However, this research has shown that the fundamental reasons why the lifestyle approach to diabetes is ineffective for the Innu are outside the bounds of the relationship between the provider and patient, and outside the domain of the health care system. Because the kinds of alteration in program design that would develop as a result of an emic study focus on the provider-patient relationship and on the health care system, they leave the fundamental problems unaddressed and can therefore only effect a small improvement in diabetes care. Hence, this study leaves aside an in-depth exploration of Innu concepts of health and illness, cultural norms, and cognitive structures of logic, language and experience, and focuses instead on what role the Innu see for culture in improving individual and community health.

Cultural Validation: An Alternative to Cultural Relevance

The interviews conducted in 2005 demonstrated that, far from accepting that the idiosyncrasies of Innu culture are barriers to health, the Innu see rebuilding the strength of their culture as the key to improving both individual and community health in the broadest sense of the term. The importance of cultural validation is also emphasized in *The Path to Healing*, which refers to the vital role of "the affirmation and conservation of Aboriginal cultures and identities" (National Round Table on Aboriginal Health and Social Issues in Backhouse & McRae, 2002). The various facets of cultural validation outlined by the Innu participants, and the ways in which cultural validation will contribute to diabetes prevention and treatment, will be explored in chapter 5.

The role of Innu culture in achieving individual and community health in Sheshatshiu reaches far beyond superficial culturally relevant gestures such as: encouraging Innu to eat more wild meat; including Innu foods in diabetic recipe books; teaching health care providers the meaning of various Innu verbal and non-verbal messages and preferences – such as a dislike of the word 'diet' (Bowers, 2004); taking into account that Innu families rarely sit down to meals together and tend to eat small meals throughout the day (Bowers, 2004; interviews 2005); and that most people are uncomfortable with preparing and eating 'vegetables' aside from potatoes, carrots, cabbage and various prepared 'salads', such as macaroni and potato salad, which have little to do with 'greens'.

However, for Innu culture to begin to exercise its immense potential to heal the Innu physically, socially, and spiritually requires self-determination. This fact is recognized by the Innu (Andrew 1984; interviews 2005) and reinforced by the National

Round Table on Aboriginal Health and Social Issues.[127] But, as expressed by Benyshek et al.,[128] to empower the Innu definition of culture is also far more difficult than making superficial changes to the diabetes program to take into account the kinds of concerns just listed. What, then, is to be done in the interim? What are some preliminary steps that at root address the same need as self-determination? The focus on community involvement, despite its shortcomings,[129] is the best place to begin.

One of the main components of cultural validation is the reinstatement of the autonomy of the family group and of the Innu as a group. The success of programs like the Kahnawake Schools Diabetes Prevention Program is largely due to the involvement of the community (the KSDPP convened a 40-member community advisory board before even beginning to design a program), and the acknowledgement that diabetes is not only an individual's issue, but a wider social, community, and familial issue (parents and

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[127] See chapter 1:

> At the most fundamental level the Royal Commission saw a key role for Aboriginal self-government as providing "the affirmation and conservation of Aboriginal cultures and identities as fundamental characteristics for Canadian society".... [I]t should be understood that self-government does not mean bringing Aboriginal nations into line with predetermined Canadian norms of how people should govern themselves. It is the reinstatement of a nation-to-nation relationship. It is the entrenchment of the Aboriginal right of doing things differently, within the boundaries of a flexible *Canadian Charter of Rights and Freedoms* and international human rights standards. (Backhouse & McRae, The Implications of the Recommendations of the National Round Table on Aboriginal Health and Social Issues, para. 10)

[128] See chapter 1:

> Intervention programs that would seek to reduce diabetes prevalence rates in Native American communities by reforming the economic and political arrangements that underwrite the poverty, poor nutrition, lack of educational and employment opportunities and resources, and despair – all of which contribute to the disease process – would require unprecedented political support and commitment of resources. Simply stated, the political and economic support required to begin to ameliorate these problems is not likely to emerge out of the existing organization of institutional interests. (Benyshek et al., 2001, p. 47)

[129] The fact that it is only one step better than individualistic focus – rather than individuals, community activist groups are required to bear the burden of effecting change, the larger forces such as government, industry, and the whole overarching structure of the capitalist economy continue to be let off the hook (Petersen & Lupton, 1996).

family members were as much of a concern in the design of the program as diabetics and children at risk). The infrastructural changes that community councils pushed through, such as the removal of "junk-foods" from school property, demonstrate an acknowledgement of the wider social and institutional barriers to sustaining diet and exercise lifestyle changes and at the same time give people the skills to demand changes on this institutional, societal level (Macaulay et al. 1997).

In summary, the lifestyle approach to diabetes is ineffective because it does not address the economic and socio-political factors that interfere with diabetic people's self-care practices. The culturally relevant approach to diabetes among Native people is limited by a superficial definition of culture and an underestimation of the power of culture to engender health. The Innu argue that the reinstatement of their culture is the key to regaining health in its broadest sense, as well as with respect to diabetes specifically. They have many thoughts on how to best support their culture and existing community resiliencies. But many of the most profound changes require self-government. While the process of attaining self-government continues, it is imperative that community research and programs involve the community members and work to address the problems that are most pressing to them. The interviews conducted in Sheshatshiu in the winter of 2005 provide a nuanced perspective of the health of Sheshatshiu. They reveal that diabetes should not be considered primarily in medical terms and that 'health' cannot be isolated from the logistical, familial, political realities of every-day life in Sheshatshiu.

Chapter 5

Analysis of Interviews Conducted in 2005: The Innu Conceptualization of Diabetes

The interviews conducted in 2005 (Series 1 Interviews) present a clear picture of the Innu conception and experience of diabetes, which strongly contrasts with the clinical conception outlined in the previous chapter. The discussion of the Innu conception of diabetes is organized into the following sections: food beliefs across generations; the centrality of land to Innu culture, Innu medicine, and Innu food; cultural validation and diabetes; Innu medicine and diabetes; and responses to the lifestyle approach. The organization of these sections aims to do justice to the interconnected nature of the Innu experience of diabetes, and of the contextual, integrated understanding of health that prevails in the community.

The Innu interviewed see diabetes as a disease of settlement or of community life. This simple phrase implies a web of interconnected factors all of which play a part in the disease process and the experience of diabetes in Sheshatshiu. As discussed in chapter 4, the clinical conception of diabetes as a lifestyle disease operates on assumptions of free choice, places blame and responsibility on the individual, and requires individual behaviour modification – lifestyle changes such as dieting and exercise. The significance of understanding diabetes as a disease of settlement rather than as a lifestyle disease is that while the latter leads to individual responsibility for the disease, the former comprehends the fundamental role of broader historical, social, political, economic and cultural realities as well as biological processes. In what follows, the statements of participants will reveal the interconnected, often cyclic, relationships among various aspects of community life and diabetes.

The second question this study set out to answer was: what is the Innu conceptualization of diabetes? In her succinct responses to my questions, Maggie articulates the view of diabetes shared by all of the participants:

> **Z**: How is your health:
> **L**: No. She's a diabetic.
> **M**: And high blood pressure.
> **Z**: What do you think is the reason for that?
> **L**: She believes that being in a settlement as this. (Series 1, Maggie Interview, 2005)

To begin at the beginning, the conceptualization of diabetes as a disease of settlement is based on its emergence following settlement. The majority of participants who raised a discussion of diabetes noted this chronological relationship in one way or another. Lionel Rich put it this way:

> This is how I find strange, how come the people never getting diabetes back in the sixties? And now like I said generations going too fast and things are coming up – you know coming slowly. Like now few years a lot of people are diabetes. Diabetes comes fast. (Series 1, Lionel Rich Interview, 2005)

From this straightforward chronological correlation springs a nuanced conception of the determining factors of diabetes in Sheshatshiu. Settlement, or community life, was seen to be the conditional ground – the watershed – of diabetes. Specific factors were seen to be: eating store food as opposed to wild food; the lack of activity characteristic of community life; loss of *Innu Tukuna*; lack of validation for going into *nutshimit* and learning *Innu Eitun*; and alcoholism. These factors are in turn the product of a range of other circumstances. Although the Innu see diet-change, decreasing activity levels, loss of Innu medicine, and substance abuse as the factors most directly linked to diabetes, they are not the root causes of diabetes but only the most proximal – the final stage in a longer chain of factors leading to diabetes; the ugly fruit of a largely subterranean plant. For

example, in clinical literature the shift in diet from eating wild food to eating store food is often articulated as "diet-change," which implies that it is a tidy, single risk factor for diabetes. However, this articulation is deceptively simple.

As discussed in chapters 1 and 3, wild food is a central organizing principle for all aspects of an Innu way of life (political, economic, social and cultural – or practical, civic, secular and religious). Hence, the role of food in diabetes is primary in the Innu view as it is in the clinical view, but in the clinical context diet is simply a matter of nutritional values, and food choice is determined only by individual and cultural preference. In contrast, a discussion of diet-change among the Innu contains within it myriad other discussions about legally imposed restrictions of certification and wildlife regulations, environmental effects of industrial development, economic realities of unemployment, and logistical and ideological/cultural conflicts between employment and schooling on the one hand, and acquiring *Innu Eitun* skills through spending time in *nutshimit*, on the other hand. This is because for the Innu, diet-change is synonymous with lifestyle and culture-change; since food was the central organizing principle in Innu society as it existed before settlement, a drastic alteration in food procurement and consumption is necessarily a drastic change in political organization, economy, and social and cultural norms and practices (Samson & Pretty, 2005). A discussion about eating store food rather than wild food quickly expands into a discussion about community life as opposed to *nutshimit* life. Lionel began his interview by telling me how life was in the sixties; these excerpts simultaneously demonstrate the centrality of wild food to the *nutshimit* experience, and show how community life has changed "everything".

> Ok, in 1960's people of Sheshatshiu there were no houses at all in community. I can remember using dog teams and that sort of thing right.

> And going in country and using canoes in summer and going out in country in the Fall right up through the winter. For that matter, people were very happy. They were very excited in country because a lot of people used to go in the country all year round. You know what I mean? I have seen a lot of change wasn't good. Because the Environment was pretty well good, we eat wild food, caribou, beaver, fish, anything like that – what's in the country. So therefore this is what we miss now. Through this seventies I believe, everything is very changed. We have houses now...everything's changed – the whole lifestyle changed.
>
> People were asked by officials from Newfoundland or someone like Joey Smallwood. Joey Smallwood was here once before in Labrador, and priests was here then. Father Pearson was here...translated to the Innu people, to the language of Innu. He understand our language and he said...would you agree to have the school here in the community? A lot of people say yes, we agree...I believe they started in 1964 when they started the school...So we went to the school and people were...well, didn't go to the country at all because the school was here and we had to go to school right. Because our priest was saying to our parents that the kids should go to school to learn something useful so for that matter I think people were agreed in the community. So from now, from generations to generations things changing.
>
> We've lost a lot of kids to suicide and these things right. This is how the...everything has changed a lot. I have been in the country so many times with my father before he died. We went to South, North and the country for three months. We had a good time, we had all kind of food that we want to eat, especially the wild food. Pretty well retreat for us. Series 1, Lionel Rich Interview, 2005)

Lionel's remarks show how an explanation of diabetes as a disease of settlement or community life must comprehend "everything" about community life that has so totally changed the Innu way of life. The deterioration of their physical health, and diabetes particularly, is only one aspect of the paradigm shift enforced by colonization. In order to meaningfully illuminate the experience of diabetes in Sheshastshiu surface causes such as diet, activity, and alcohol cannot be taken in isolation; it is necessary to explore their contextual significance and the relationships among them. While the nine diabetes-specific interviews provided Innu perspectives on the proximal causes of diabetes and alluded to their contextual foundations, the other eleven interviews

elucidated these foundational circumstances and demonstrated the interconnectedness of multiple factors. As a result, the following discussion integrates perspectives from informants who spoke specifically about diabetes and those who spoke about other aspects of community life.

Food Beliefs Across Generations

The relationship between diet-change and diabetes for the Innu is best explored in terms of the basic comparison between store-food and wild food. The view of store food and wild food differs across generations (Samson & Pretty, 2005). Louis Rich, who joined the project as my co-interviewer shortly after the completion of this interview, offered a down-to-earth illustration of the difference between the preferences of young people and *Tshishennaut*:

> **Z**: So what do your kids like to eat?
> **L**: Anything. Pizza, caribou. But if you held up caribou and pizza for my kids they'll take pizza!...The Elders will take the hind leg, give away the pizza to somebody else. (Series 1, Louis Rich Interview, 2005)

But as with many circumstances in Sheshatshiu, nothing can be taken at face value – the food preferences of generations are shaped by factors ranging from TV, to priest's abusive influences, to poverty. Greg Penashue, who spoke to me from a wheel-chair in a voice made rough and whispery in turns by a stroke that paralysed the muscles in one half of his body including his vocal chords, shared a perspective that takes all the lightness out of pizza and caribou legs:

> **G**: A lot of people say...old people used to say that ever since spend so much time in the community – eat pork chops, chicken – we eat in an hour, I'll feel hungry again. They not helping them. They say if they eat wild food they could go for a whole day without eating but now if they eat pork chops they want to eat again in an hour. I guess their appetite is not as much as they're hoping to eat.

> My father used to say that a lot. If I eat porkchops he said I want to eat again within an hour. He was hungry again.
> **Z**: So is that mostly the older people that feel that way?
> **G**: Yeah. The older people yeah.
> **Z**: And younger people, how do they feel about it?
> **G**: You don't see them very much. They're getting used to almost anything now eh, because most of the time they're always going hungry anyway! Yeah. That's the saddest part too yeah...There are kids here that I know that go to bed hungry at nights. Even though they go to bed anyway because they don't have anything to eat. One time we had kids here and I was a little bit upset and I told them go home! Go back where you stay. And I couldn't sleep at night knowing them they're going back to the house – people are drinking there. I know they go to bed hungry and I couldn't sleep! Kept thinking about those kids that I sent home. I was up most of the night thinking about them. Like I could say I felt guilty for sending them home and not feeding them so whenever they're here I always want to make sure they eat enough so they can go home – so they don't go to bed hungry. (Series 1, Greg Penashue Interview, 2005)

For the *Tshishennaut*, then, a preference for wild food is grounded in an immediate experience of physical dissatisfaction. The determinants of the younger generation's food preferences are harder to pin down. Greg Penashue suggests that children will eat anything out of sheer hunger due to insufficient provision by alcoholic parents.[130] Other informants, like Maggie, simply stated that children preferred store food because it was what they had grown up with and were used to:

> She thought that is what they eat, we're talking about the grandchildren right, when they're growing up every day of their lives: chicken, pork-chops, canned food items. Then you put them in a strange place – *nutshimit* – and they don't eat. But her children still does. And there is...this is what they grew up with. (Series 1, Maggie Interview, 2005)

The differences in perspective between *Tshishennaut* and middle-aged people (or more importantly, people who have grown up both in *nutshimit* and in the community eating both wild and store food) are similarly nuanced. Lionel articulated a view that is

[130] Hunger as an issue for children was a common theme throughout the interviews. It was not always related to alcoholism – sometimes to parents working, playing bingo, or simply not preparing food (Series 1 Interviews, 2005).

common among middle-aged people of store and wild food as two fundamentally different kinds of food:

> **Li**: I [give] my kids all kinds of things – English food and *nutshimit* food. But their appetite, that don't change at all. They're still like two different kinds of food, one in store and in *nutshimit*. (Series 1, Lionel Rich Interview, 2005)

In this way, store and wild food are differentiated. However, what makes wild food a different kind of food from store food – and whether one is "healthier" than the other – is not determined on nutritional grounds alone. Some informants provided specific reasons why they thought wild food was healthier than store food:

> **L**: I asked him which would be healthier food: store-bought food or *nutshimit mishum – nutshimit* foods? He picked *nutshimit* foods simply because wildlife is not domesticated, wildlife eats from the wild and the meat is pure, there is no added things in the meat whereas chicken, pig, cow, are domesticated and fed all kinds of chemicals in their feed to produce milk, in the case of chickens it's eggs. This all has chemicals in it. This is why *nutshimit mishum* is healthier. (Series 1, Thomas Rich Interview, 2005)
>
> ***
>
> L: Because traditional food is quite different from food we buy at stores and she'd prefer food from *nutshimit*. Not only that...foods that contain a lot of other things too as well. She prefer eating wild meats than she would buying store bought items. (Series 1, Vanessa Rich Interview, 2005)
>
> ***
>
> L: She said she likes and continues eating wild meats like caribou meat. To her this is healthy food, one of the healthy foods. Store-bought foods, these give her heart burn when she eats it, so she prefer wild meats. (Series 1, Katie Jack Interview, 2005)

For others, like Lionel, the healthiness of food is more difficult to determine:

> **Z**: Do you think people would eat more healthy food if there was a bigger grocery store in the community?
> **L**: See your definitions of healthy food could be different from ours...Could be wild meat that would be our healthy food in terms of your buying store-bought food.
> **Li**: I can't answer thing that stores are very healthy food. That I can't answer because I don't know. No one knows. It could...you could say yes this food is

really tastes good right? Lot of people feel the same way. But still they don't know how healthy it is.
Z: How healthy it is. So when you go to the store...
Li: I buy anything in store...
Z: You just buy what you think tastes good. (L and Li laughter)
Li: Anything I can put in my mouth is good, you know! (Series 1, Lionel Rich Interview, 2005)

The final line in the above exchange alludes to the most important characteristic of store food, which overrides whether it is healthy or unhealthy, better or worse than wild food: if a person lives in the community, acceptance of store food is a necessity. As a result, regardless of its quality, some people (excluding *Tshishennaut* who have to eat every three hours, or unfed children) have made store food workable – it is edible, good enough to satisfy hunger:

Li: Yeah, see, there's just a lot of things that are different than you people, and how people eat in the community. Like Elders saying themselves that the food is good – the wild food is good – especially the Elders right. I find the same way but I still have to – I have no choice but to buy something in store right. I don't disagree anything at all. I'd rather have anything. Wild food is the same as store food. I still can eat it you know. I find a different way than the Innu Elders are saying. (Series 1, Lionel Rich Interview, 2005)

Preference and taste cannot be completely overlooked as factors in food choice as the remarks below indicate:

L: He said if he had a choice between the two meats – ptarmigan (grouse) and chicken – he would take partridge. And if it was deep-fried he would take chicken! (laughter)[131] (Series 1, Phillip Rich Interview, 2005)

[131] It is a widely-spoken fact that "Mary Brown's Deep Fried Chicken" (the Newfoundland equivalent of "Kentucky Fried Chicken") is an Innu favourite. It is also generally understood to be a health problem – "Mary Brown's is the killer!" was one of the jokes that came out of the interviews: "We try not to eat everything, but we do accidentally of course. Like you're not supposed to eat skin of chickens because they say it's fattening and stuff. Mary Brown's is a killer! (laughter)" (Series 1, Greg Penashue Interview, November 2005).

However, it is *necessity*, not preference, that drives people to buy store food. If diet were simply a matter of preference, most Innu of older generations – especially the *Tshishennaut* – would eat more wild food than store food:

> **L**: You look at what products they sell and they typically sell more store food right. Talking about advertising healthy foods from [*akaneshau*] point of view – but for us when we talk about healthy foods we prefer that's wild food. And there are things you cannot eat, there are plants you cannot eat, and there are animals you cannot eat and these are – we can tell the difference in having that now, you'd be able to tell whoever's next to you, 'you can't eat that, that's not good for you.' This is the knowledge we're talking about when we're talking about people telling us to follow diet for instance. (Series 1, Louis Rich in Lionel Rich Interview, 2005)

In sum, food preference varies across generations, and there are a number of factors that contribute to these differences. For the *Tshishennaut*, wild food is fundamentally healthier than store-food (Joseph Pokue, David Penashue, Louis Rich). For those people who grew up living both in *nutshimit* and in the community, store food and wild food are two different kinds of food, but both types of food are nutritious and each has benefits – wild food is preferred for its taste and cultural value, store food is easier to access, quick to prepare, and preferred by children (Lionel and Louis Rich). Among the younger generations who have grown up primarily in the community, for some wild food is unfamiliar and unpalatable and store food is preferred (Maggie), others will take any kind of food out of hunger (Greg Penashue). What is most significant, especially with a view to the prevention and management of diabetes, is that preference is not a simple matter of free choice.

Diet-change and Diabetes: Store Food as a Primary Determinant of Diabetes

While food preference varies across generations the understanding that store food contributes to diabetes does not:

> **Z**: Mm hmm. So do your grandparents, or your mom and your dad, what do they think about the diabetes as a disease?
> **L**: Talking about his mother, she too is diabetic and she too doesn't have a clue about it. I guess she blames it on what we eat in the community.
> **Z**: So you think the community food has something to do with it?
> **L**: Store-bought items. (Series 1, Joseph Pokue Interview, 2005

Even individuals like Lionel who consider store food healthy and edible – just a different kind of food from wild food – feel that store food has been a main cause of diabetes:

> **Z**: Why do you think that is, why do you think people are getting diabetes? The changes are too fast?
> **Li**: I think what it is I think the way they eat. I think there's a lot of people are eating store food where they buy store food. Not enough wild food. I think that's what it is. (Series 1, Lionel Rich Interviews, 2005)

Scientific studies (Samson & Pretty, 2005), and health care workers (Series 1 Interviews, 2005) support the Innu position that store-food contributes to diabetes while wild food does not. The confluence of scientific and medical perspectives with Innu experience is noted by the Innu:

> **L**: She once questioned the doctor – why is she having this, she never used to. The doctor said probably from all the foods, junk foods. She believes this may be the cause.
> **Z**: The doctor said that.
> **L**: Mm hmm. She said the reason why blames all this *akaneshau* stuff because when she was younger living in *nutshimit* she never encountered such problems as high blood pressure and such sicknesses. Any sicknesses she encountered in the past were taken care of through Innu medicine by her mother right. This is the reason she claims this is the reason why she isn't health wise...the *akaneshau* foods. (Series 1, Maggie Interview, 2005)

It is clear that the Innu believe too much store food and not enough wild food is a primary cause of diabetes. The above comment indicates that it is not only nutritional quality but

also medicinal qualities that are lacking in store food.[132] As well as being directly relevant to the rise of diabetes, the implied understanding of food as medicine demonstrates the interconnectedness of various aspects of life for the Innu and the centrality of food to every social structure in Innu culture.

It is for this reason that simply substituting wild food in the freezer for chicken and pork-chops (these are the most mentioned store-bought meats) does not prevent diabetes in the same way as eating wild food in *nutshimit*. The following exchange demonstrates both that "good" food is primarily seen to be wild food and that people do have limited access to wild food from within the community:

> **Z**: So you're able to buy food that you think is good for you at the store?
> **Li**: Well, actually sometimes I have wild food here. People go to, like last year my nephew sent me a caribou, I just finished it here last few months ago.
> **Z**: So now he's going to send you another one?
> **Li**: Had the caribou and I had salmon, lake trout and...these things, you know. I had wild foods in my deep freezer and then I finally finish it not too long ago when I'm still waiting for the people on Churchill road they're going caribou hunting they'll probably give me a couple caribou right, I'll have enough for next year. (Series 1, Lionel Rich Interview, 2005)

Even frozen, wild food is preferred to store food. People do get wild meat in the community whenever they can, but getting wild meat from relatives only satisfies the hunger, not the desire for all of the other elements of *nutshimit* life that "we miss now" Series 1, Lionel Rich Interview, 2005). Louis Rich describes the broader, subtler differences between wild food and store food:

> **L**: For that and other stuff, supplies at the store. Always takes the fun out of the stuff you really enjoy. I'd rather kill my meat than go out and buy it. Because you feel better for it. This is how I got it and now I have it. If I work all week to get chicken at the end of the week

[132] The secondary analysis of the extant data series and the interviews conducted in 2005 demonstrated that *nutshimit mishum* is both food and medicine. For example, *Kak'u* (porcupine) can be eaten for a meal and also has medicinal properties (Series 1, Greg Penashue Interview, November 2005).

> then I have to spend more money to go to Goose Bay and get it. Then I cook it and eat it, do I feel special? No. This is not our diet, not our...but I grew up eating domesticated foods and other things that come from [the store]. (Series 1, Louis Rich Interview, 2005)

Louis' comments remind us that although it is possible to eat wild food without going into *nutshimit*, the significance of wild food for the Innu reaches far beyond the chemical/nutritional characteristics of a piece of meat or a kind of vegetable.

Diet-change is *Lifestyle change*

Although scientific studies show the validity of the Innu view that store food contributes to diabetes on a purely nutritional level (Kuhnlein 1993; Middaugh 1993; Samson & Pretty, 2005), the Innu do not consider the nutritional value of the food in isolation. It is not only the nutritional and medicinal properties of wild food that prevent diabetes, but the lifestyle in which wild food is the norm. To exchange wild food for store food is not simply a diet-change but a lifestyle-change in an extreme sense of the phrase (Samson & Pretty, 2005). To eat wild food, a person has to first trap it, fish it, hunt it, collect it, and then prepare it, all of which involve a great deal of physical activity:

> **L**: That's the thing about the difference between me and you is our diets are very different. You know where your diet's going to be, you go to the store and buy it. Our diet runs around, we gotta chase it. (Series 1, Louis Rich in Lionel Rich Interview, 2005)

Another alternative, as Lionel Rich pointed out earlier, is to be given wild food from friends or family. Although getting wild food this way does not involve strenuous physical activity, sharing food strengthens social bonds and is a central tenet of Innu social conduct (Tanner et al, n.d.). In contrast, buying food from the store provides neither physical activity nor the opportunity for socializing through sharing. The shift

away from eating wild food not only entails missing a certain taste or kind of nutrient (such as omega-3 fatty acids), it also leads to a decrease in an important form of physical activity. Hence, the two main clinically recognized determinants of diabetes – poor diet and lack of physical activity – are introduced to the Innu with the shift to eating store food. David Penashue points out that physical activity is integral to *nutshimit* life, Maggie points out that community life does not by nature encourage physical activity: [133]

> **L**: There's another exercise part. She said in *nutshimit*, Innu they would exercise constantly whether you plan it or whether you...like...you just have exercise all the time. She said the only exercise you get here is walk to work and back. (Series 1, Maggie Interview, 2005)

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> **D**: Back then the sugar was...most people were not diabetic because what they do after they eat they burn all of that, from walking, chopping wood, walking on snowshoes. Walking on snowshoes is harder then...back then there was no skidoo for travel. Wood, saw your wood, no chainsaw. (Series 1, David Penashue Interview, 2005)

As is apparent, comments about the shift to eating store food are not limited to nutritional value but quickly open out into other dimensions of community life. The following remarks reveal the economic significance of eating store food:

> **L**: In the community we have to pay to live. Like you, you have to pay for your meal but if I was living in the bush – *nutshimit* – I wouldn't have to pay. I'd only have to pay getting there, salt and stuff. The meat I would get from hunting. That's a great difference.
>
> I go to the co-op once every two weeks. Buy a couple hundred dollars worth groceries. I have to get my food in Goose Bay and I don't have a vehicle and that costs. A taxi's about forty-four fifty. I got no vehicle. In the summer time I'll hitchhike up I get a cab back. This is...for instance, we had a couple stores here

[133] Rubin Rich ruefully shared the following observations about the laziness engendered by modern technology and settled life:

> (laughter) Everybody's spoiled to eh by this new technology. That's the sad thing too, we see these people that used to be very active at one point in the community are the ones sitting in the cars today, they won't go to the store, if a person needs to ask a question they'll go out there and beep the horn and they'll ask from there. That's how they are these days, they're really spoiled by white man's technology. (laughter) (Series 1, Rubin Rich Interview, November 2005)

but they were very expensive. We had one across the river and a restaurant and a couple confectioners. Very expensive food. The cheapest place now would be the coop. Rebates once a year, once you spend such an amount you get some back at the end of the year. (Series 1, Louis Rich Interview, 2005)

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Li: People buy, they pay their food in stores. But in country people don't. If I was to go in the country I would just buy flour, sugar, tea bags, salt and butter, whatever. And go in and get wild food myself, without buying it, you know. (laughter) Nowadays now you seen a lot...expensive food in stores. And a lot of stuff we miss like culture thing and food as well right. (Series 1, Lionel Rich Interview, 2005)

The following two exchanges with Vanessa Rich and Lionel Rich demonstrate that the expense of food is a significant factor for diabetics in Sheshatshiu:

L: She does all the shopping and she goes up to Goose Bay co-op.
Z: Are you able to get the kind of food that you want there? Is the food reasonably priced for you at the co-op?
L: She usually tries to find items that are on sale. (Series 1, Vanessa Rich Interview, 2005)

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L: The majority of the community are buying from stores.
Z: Right, so then how do you choose when you go to the store – how do you choose what you're going to buy?
L: Well I choose stuff that's less expensive.
Z: Less expensive.
L: That I can afford, if I can afford to buy a whole lot then I'll buy a whole lot.
Z: Right. What about you?
Li: I do it the same way. (Series 1, Lionel Rich Interview, 2005)

Louis Rich and Maggie reveal the lack of consideration of economic factors in the clinical approach:

L: The doctor suggested that she eat three meals a day plus another lunch before you go to bed! (laughter) I said why didn't you say to the doctor – if you can afford it, I said, if you can afford all this sure. With my salary – and I'm living alone – I couldn't never afford to follow such a diet. I eat whatever I see. Just have something in my stomach that's good enough for me. (laughter) (Series 1, Maggie Interview, 2005)

What people buy when they shop for store food is determined by cost more than by preference. The significance of this fact is that while nutrition education informs people of what they *should* be eating, it does not enable them to afford it.

Analysis of the concept of free choice as applied to the Innu store food diet must in fact go a step further to encompass not just shopping decisions, but the fact that the Innu are buying store food in the first place. Just as picking store food items is determined not by preference but by economic necessity, buying store food altogether is not a matter of choice but of necessity. One of the most profound statements with respect to diet-change and store food versus wild food that came out of the interviews was: "Well I have no choice, I have to buy food at the store" (Series 1, Lionel Rich Interview, 2005). The following exchange begins to explain why buying store food is not a matter of choice:

> **Z**: Why would people choose to buy store food as opposed to eat the wild food?
> **Li**: Well I think, like I said before, people wants to buy food in stores now because we can hardly go to country now, like I said. This is what I think. Everything is changing. (Series 1, Lionel Rich Interview, 2005)

In other words, at the root of the shift away from eating wild food is the restriction of Innu access to the land. Samson, citing Rogin, stresses the power of breaking the Innu relationship to their land:

> Sedentarisation inevitably undermined the relationship of the Innu to their hunting culture, because mobility was central to its efficiency and the land provided the basis for their social, economic, and religious ideas and practices. As with other indigenous people across North America, "*breaking the Indian relation to the land had concrete as well as symbolic significance.*"(Samson & Pretty, 2005, p. 3 italics in original).

So far, then, we have seen that food beliefs vary across generations and are the product of disparate factors (energy-levels, familiarity, hunger, and economic and

logistical necessity) only one of which is taste-preference. Also, we have seen that diet-change (the switch from eating wild to store food) is viewed by the Innu to be a primary factor in diabetes, but that it is inextricably related to lifestyle changes, one of which is a significant decrease in physical activity associated with community life. Most importantly, the perception that it is not a choice but a necessity to buy and eat store food, was shown to drive the shift away from eating wild food.

Joseph Pokue articulates the sense of imprisonment in the community that is implied in many participants' statements about eating store food, being inactive, and feeling cut off from a variety of meaningful activities. Joseph said that as opposed to being in *nutshimit*, when he is in the community he is:

> lacking [the] freedom to do things he knows how to do. When you come in the community that's what you're faced with...And this is like a prison, if a person have knowledge about cultural things and then come in the community they become imprisoned because can't do anything – immobilized. (Series 1, Joseph Pokue Interview, 2005)

In the following section we will explore the sources of the Innu perception of necessity – from what circumstances their sense of being trapped in the community and denied access to their land emanates.

The centrality of land to Innu Culture, to Innu Medicine, and for Innu Food

> As the very source of Innu well-being, *Nitassinan*, the land of the interior of the Labrador- Québec peninsula has gradually become a separate sphere rather than, as it was, at the centre of their activities; they have suffered from rates of self-destruction – suicide, alcohol-related deaths and abuse, infant mortality, and epidemics of gas-sniffing – that are among the highest in the world. The Innu follow a long line of sedentarized and relocated northern peoples who have been thrown into social turmoil, cultural confusion, and mental and physical breakdown as a consequence of the state-sponsored severance of the links to particular lands. (Samson, 10)

Lionel's empathy for the *Tshishennaut* is an example of how a discussion of diet-change quickly opens out into a discussion of the many ways, ranging from regulations to religion, that settlement and the presence of a colonizing government have affected the Innu:

> L: Just mentioning the hardship that the Elders went through. They're the ones that were more or less snatched from their land and brought to the communities and made to settle. Right and forced to eat this, forced to live rules right. These aren't the rules we lived in, these aren't...and this is not the religion we were taught in the bush. We're governed and living by somebody else's rules. (Series 1, Lionel Rich Interview, 2005)

A discussion of eating store food is not simply a matter of comparing nutritional value or differences in cost, but of the many ways in which settlement has affected Innu access to the land. These are: regulations and certification, industrial development, economic requirements for going in *nutshimit*, employment, schooling, and the effect of these two on people's ability to take the time to go in *nutshimit* and their view of doing so as worthwhile.

Taking the various obstacles preventing the Innu from accessing the land (going into *nutshimit*) one by one, let us begin with government-imposed regulations. As discussed in chapter 1, wildlife regulations have had a significant impact on Innu land use and physical and social health in Sheshatshiu. The current interviews corroborate this position:

> L: The other thing too is everything you do these days you have to have a certificate for it. For instance, to own a rifle or shot-gun you have to have a certificate. Use an example now of this other story. He also got a warning from his father when he was younger what he would encounter later in life trying to return to the bush. In terms of what I was saying earlier with regard to permits to do certain things, even to carry certain things – certain animals – you have to have a permit. Firearms certificate, ammunition. These are the things his father warned him he would encounter because of the rules and regulations you have to

follow now. The rules that were implemented from governments. Series 1, Jean Claude Vachon Interview, 2005)

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L: And when it comes to wild life conservation officers...although they have a job to do he said I don't want you as a conservation officer telling me how I'm going to kill, what I'm going to kill, how am I going to live in the bush right.
Z: Do you feel...when you're out in *nutshimit*, do you feel the presence of these people around?
L: Yeah, always they're more aware about the sudden appearance of these guys... Always gotta watch and you never know when they might fly into your camp, or just walk into your camp. Also what you have to watch out for.
Z: Have you ever had to go to court to defend yourself against charges of over-hunting or...
L: Yeah there was one incident years ago where a wild life officer seized their rifles and ammunition. But some did go to court for that. He never made it to court.
Z: But the conservation officer took your rifles and your ammunition?
L: No, he hid his. But some were taken. (Series 1, Joseph Pokue Interview, 2005)

The criminalizing nature of quotas was also apparent in comments made in the secondary analysis of the extant data series. The following observation refers to the failure of hunting diaries as a method of discovering how many Innu continued to hunt:

> The feedback I got from a lot of people was that they were not filling out this booklet because "if we say how much we were shooting or hunting or harvesting then licenses and quotas will be enforced on us and we don't want that." And the other feedback was "why should I do this for people who don't even hunt when my uncles, my grandfathers, know how much we are killing and that's the only judgment we need." (Series 4, Anthropology Module, 2003)

In this quote, both the oppressive sense of surveillance and the resistance to regulation as an unjustified and unreasonable imposition are expressed. Even though the threat of fine, imprisonment or confiscation of goods is not sufficient to deter some people from going into *nutshimit* hunting, fishing, and trapping, people do get apprehended and at that point, their access to the land is forcibly denied. For others, the illegality of harvesting without license is likely sufficient to dampen the desire to engage in hunting, fishing, and

trapping. Finally, even if a hunting group does not encounter wildlife officers, the sense of being under surveillance creates discomfort and the implied wrongness of hunting, fishing, and trapping is yet another attack on the Innu way of life.

Another form of regulation imposed by the state is property law. Louis Penashue articulates the impact of being made to feel like a trespasser in one's own land:

> He's talking about the land, government. Measuring the land, this is how much you get. Louis said that's not good. People always wants to travel. They always wants to feel comfortable, wherever they want to go hunting. They don't want to feel uncomfortable, you know. (Series 2, Louis Penashue Interview, 1998)

Also, as discussed in chapter 1, industry land use has restricted Innu access to the land and affected the health of the environment and animals, thereby reducing the quality and availability of wild food. The current interviews corroborate the perspectives in the secondary analysis about the negative impact of environmental degradation:

> **L**: I don't see how we can go back to [the land]. There's stuff that's gone. There are places that are under water! A lot of stuff that's been destroyed by industry gone from Nitassinan. That's the way. They make their money and then they're gone. I use the example for the mines project. I could say from the very beginning that's going to be the way after the extraction from the ground. It's never going to be the same. Sure you can make it look pretty, soil and grass on top make it look good, but are the animals going to be back, the ones that live there? No. One of the things I did was monitor the bears, where things where being built there were a lot of dens, population around forty and sixty bears around where they were mining. Destroyed their habitat. They did relocate the bears, they flew bears ten miles outside the site and then they came back in two days' time. (Series 1, Louis Rich Interview, 2005)
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> **Li**: I think the Environment is changing a lot too. Because the caribou usually come here in the Naskapi river all the time but we can hardly see the caribou coming. I think because of so many things the migrations is changing. Like caribou migration are changing a lot and the food, like the caribou food is changing. Caribou couldn't stay where, one place, they had to go – move – one place to another. Now today I find very strange. (Series 1, Lionel Rich Interview, 2005)

However, the presence of industry in Innu territory can also be portrayed in a positive light, since jobs provide necessary funds for traveling into *nutshimit*. This tension is apparent in the following remark:

> **L**: He don't support any major projects at all where the project is involved in destroying animals' habitat, the land. He said it's a good thing that there's jobs but he do not support any major projects such as that. (Series 1, Joseph Pokue Interview, 2005)

The destructive impact of industry presence on animal habitat and the related reduction in wild food availability and affordability is only one dimension of a complex and profound process. To destroy animal habitat is to destroy the basis of Innu society as it was practiced before settlement. As discussed in chapter 3, wild food is a central organizing principle for all aspects of an Innu way of life (political, economic, social and cultural – or practical, civic, secular and religious). To cut off access to wild food and make participation in the wage economy a necessity not only undermines physical health, it also removes the source of Innu economic, socio-political, and cultural cohesion, health and resilience. The following quote touches upon the complexities of industrial presence in Innu lives:

> **L**: He said in the future he don't see much Innu ways being practiced because there's so little being practiced now. He said with more employment with more industries starting their own thing, employing the Innu – even the Innu who are here currently who don't have permanent jobs – these are probably the reasons why we're lacking the interest to go back to the bush. (Series 1, Joseph Pokue Interview, 2005).[134]

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[134] Samson provides the following Innu perspectives from "Between a Rock and a Hard Place":

> "The government claims that the land belongs to them. But look at all the evidence that our Elders left on the land, marks on the trees, burial grounds. We know the names of places in the country...They don't recognize our names on maps." For Simenon and many other Innu...mining has the potential to wreck some of the remaining contacts the Innu have with nomadic hunting, the cosmology of *nutshimit* and the places where many obtain pride and self-esteem. (Simenon in Samson, 2003, p. 244)

And a further common perspective on the negative effects of the VBNC project:

That going into *nutshimit* requires some degree of economic well-being is apparent in the comments below:

> **Li**: Because like I said people in sixties people never used government money – from the government. People used to go on their own. But now these days people used to go on the planes and go outside community to go in the country. Then again, like I said it's dying now because people can hardly go to country because there's no money left to go in the country now. Really see people go into the Churchill road on their own vehicles. Perhaps if they can get the gas from the council they go to Churchill road. That's all we see. Can hardly see now people going to the planes to the country North and South. (Series 1, Lionel Rich Interview, 2005)

When Lionel says "there's no money left to go in the country" he is referring to the decrease in funding for the Outpost Program.[135] Samson explains the situation with the Outpost Program as follows:

> The Outpost programme which funded Innu hunting encampments in the autumn and spring of each year has been discontinued. This is despite a recommendation from the Canadian Human Rights Commission in 1993 that this programme should be continued indefinitely as a crucial enabler of Innu cultural continuity. In this regard, the government has yet to honour its own obligations towards the

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> People will drink heavy. They will bring booze back into the community especially. This will end in drowning accidents. They will spend their money in a town and nothing will be brought back to their families. Diseases will destroy the community. (Patrick Andrew in Samson, 2003, p. 243)

Vanessa, an Elder interviewed as part of the present study, acknowledged both the positive and the negative aspects of the money that VBNC brings in (Louis Rich translates):

> One of the positive things in the community now is employment, although there should be more employment. With employment you can do more stuff than you normally would if you were on social assistance...you can obtain the stuff you need, household items, food, other things that are positive to enhance a better living in the community...[but] remember when there's payday she's got worries about her children abusing alcohol. (Series 1, Vanessa Rich, Interview, November 2005)

[135] The Outpost program worked well until, according to Wadden, "the Newfoundland government axed the program because it was considered too costly. When government agent, Max Budgell overspent his budget by $2000, he was told to collect the money from the Innu" (1991, p. 68). Frustrated by the government's treatment of the Innu, Budgell quit, and "fired this salvo at how the Innu were being treated: 'The Indian is not dumb, he has seen the different men responsible for his well-being come and go, his position has not improved. Can he be blamed for viewing the white man with distrust and hearing his utterances with cynical indifference?'" (Wadden 1991, p. 68).

> Innu. The follow up report concluded that "the Government has not implemented that aspect of the second recommendation in the 1993 Report that called on the Government of Canada to preserve 'the unique aspects of existing arrangements such as the outposts program'". (Samson & Pretty, 2005, p. 20)[136]

The statements made by participants highlighted insufficient funds as one concern; unfair distribution of funds by the Band Council as another; abuse of available funds by recipients as a third; and a decline in interest in going to *nutshimit* as a fourth:

> **L**: He's referring to the early days of the Outpost Program when it started in the seventies. It was very, very popular and the majority of the community went into the bush for three months in the Fall and two months in the Spring. He looked at this as a very positive thing in our community – a very positive program to help us maintain our way of life. And also he said we seen some drastic changes from when it started in the seventies to 2005. Where there is less and less interest. People is lacking interest in returning and practicing their traditional way of life. And the people that do go in are the people that are abusing the program, abusing the funds. They go in and then a couple weeks later they come back, play bingo or something, go back... (laughter) He also mentioned early on when the program was implemented in the community, he said it was a very positive thing and he said there was always enough funds for that year. Like now we start...Outpost Programs paid for in Fall and Spring, but now when we start something like that we don't have Spring money left – it's used up. (Series 1, Joseph Pokue Interview, 2005)

The lack of government funding to defray the costs of plane fare means that fewer people are going into *nutshimit.*[137]

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[136] Samson went on to clarify the importance, in terms of Innu health, of reinstating the Outpost Program:

> An immediate reinstatement of funding for this important project (or one like it) is necessary if Innu health is to be restored and cultural continuity maintained. While no research has been done on the uptake that a reintroduced Outpost programme would have, there is ample anecdotal evidence that a large numbers of the Innu population would avail themselves of the opportunities to experience healthier and more meaningful activities in the country and remove themselves from the many sources of suffering and pain in the villages. (Samson, and Pretty, 2005, p. 20)

[137] Samson's research corroborates Lionel's statements:

> Access to the country now requires money and technologies, especially for older Innu. With no settler communities and few industrial incursions except the Voisey's Bay mine, the Innu in Natuashish can access the immediate country relatively easily. However, further excursions to favoured hunting and fishing locations such as Kamestastin and Ashuapun require snowmobiles or airplanes. Because of settler and industrial activity in Central Labrador, the Innu living in

The reference in the previous quotation to going up Churchill road versus going into the country is significant. "Going up Churchill road" is synonymous with "camping", not with going in *nutshimit*.

> **L**: He went out camping around here maybe you've noticed there are some tents along the road there where people camp during the week days or weekends – mostly weekends. He tried that too. Camps on the other side of the road. He didn't like that because there were vehicles going on the side of the road, it wasn't like being in *nutshimit*. And when he was a little bit younger he used to go with grandmother in the bush. He really enjoyed times he would spend in the bush. (Series 1, Jean Claude Vachon Interview, 2005)

Camping is a brief time in a tent, little more than a short break from community. It is not invested with the same significance as going in the country, but it is not as great a financial investment. More people go up the Churchill road because the expense is less, the cost of gasoline rather than the cost of plane fare. However, even to go camping requires owning a vehicle and some extra money, two factors that are significant obstacles for many people in the community:

> **Z**: Hm. So why do you think people don't do that – go camping or…?
> **L**: People are limited to what they can do. Some people have vehicles, some people don't. Some people work some people are on social services – income support, whatever. Gotta pay for it in some way. If we're going to go up for the weekend gotta have money for gas, food, and…stuff like that. Because some things people cannot do if they're on welfare. And people who are on welfare, they usually go to other – alcohol and drugs. (Series 1, Rubin Rich Interview, 2005)

Clearly, in that it brings in the necessary cash for supplies and transportation, employment is a significant factor in people's ability to go out onto the land and participate in a *nutshimit* lifestyle (including getting wild food and practicing *Innu Eitun*

Sheshatshiu are more heavily reliant on money and technology to reach preferred locations in the country. (Samson, and Pretty, 2005, p. 20)

skills). On the other hand, however, employment is at the same time an impediment to going into *nutshimit*:

> **L**: Some problem is people that are employed are reluctant to go back in *nutshimit* because of the fear that they may lose their job or if they go they won't be paid for it. And people that are employed by Innu Nation and Band Council are the people who are staying in the community because they have a permanent job and they also have families here in the community. (Series 1, Joseph Pokue Interview, 2005)
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> **L**: She said it's been a while, since the early seventies since she's been in the bush right, she has been raising her children and she has been in the community, she's been required to be in the community and she cannot go elsewhere. She said it's like paying to live – paying to live in the community, you gotta pay for food, for clothes for your children and then for grandchildren. She's still working, her employment keeps her from practicing. But she do have a cabin outside, she goes there frequently sometimes. (Series 1, Maggie Interview, 2005)

The relationship between employment and access to the land, then, is somewhat paradoxical. A program called "Cultural Leave", wherein people employed by the Innu Nation were granted a two-month leave to travel into *nutshimit*, was introduced as a means to break this vicious cycle, but the unreliability of employment undermines people's willingness to trust in such measures (furthermore, only a fraction of the community is employed by the Innu Nation, and the program is not offered by all other employers[138]). The profoundly uncertain quality of employment in Sheshatshiu is revealed in this brutally direct conversation:

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[138] Far from having extended times of leave, some people, like Maggie who is a home care worker, risk pay-cuts or even losing their jobs if they leave work to attend community meetings:

> **L**: Another thing too since she started working whenever there was a public meeting or emergency meeting, any kind of meeting involving the community, they told her they gotta work. I mean, they can apply for a temporary worker for that day so they can attend the workshops or whatever the case may be. And because of this she has little knowledge of what's going on. What is being...only knowledge she has is what she hears. She's got no first-hand information...Her supervisor once told her, if they attend the meeting they would be fired. Now it's open to the public. Now what is public, define that part! Not only that, they won't be paid for their absence.

P: For next summer I gotta build log cabin again, a round one this time. They're saying I'm hired again for next summer but I don't know if that's true. They're saying it but...
L: They don't even know if the same program is going to be offered next year. The leaders don't even know.
P: they're SAYING, they act like they're knowing it now but they're not. One time I was trying to get my cheque from the BC somebody erased all my time sheet for no reason.
L: Take for instance political struggles. This problem in Band Council. Treatment director. His father had a year leave from the program, he was supposed to return this year.
Z: His father was the director of the program and he took a year leave?
L: Yeah. And someone higher up decided to give the job away. This is exactly what happened to me three weeks ago. This is exactly what happened to me three weeks ago. Not directly but indirectly. I was given a job, I applied and was given it. I also applied for my son too for the same position. He got hired on I got hired on. It was a mistake on his sister's part. Denise got the names wrong. She called me, I got the job so I can go up on Monday morning. Me and Louis went down. I explained about that's my son's application, not mine. He got hired verbally, I don't know how that happened. He's supposed to go to work on Monday. This is Friday right. He goes to Monday morning, band office, nine am. Then we find out that the job that he was hired to start on Monday was given away on Saturday. That person started at seven on Monday morning. So that job had been given away on Friday so can't be given away again around the same time Louis was hired! So I tried to get to the root of the problem and I was sent on a wild Goose chase. This is exactly what we're talking about – people overruling other leaders. I'll use an example, if I put someone on the air and the chairman comes in and says take that person off the air I gotta do it. And two more of the same committee could come in and overrule her right! These are the things I think should be worked out with the leaders. It's really sad and I'm pissed off too now that you brought it up. My son is going school across the river getting last five credits. I started in May there was a lot of positions opened up and I submit all their names. This is the part that really pisses me off. My son got bipolar disorder and he's doing excellent. He's also a father too to an eight-month-old kid. And he was really looking forward to starting, called everyone he knew to tell them he was starting work on Monday. Then he finds out the fucking job is fucking taken away! That's the shit we gotta fucking put up with in this damn community. I wanted to go in there to strangle but I didn't know who I am I going to strangle! This is the feeling, you get so pissed off right! I get feeling this way about the leaders I got to stop myself or I'll just get pissed off thinking about it. This is what he was saying earlier delivering programs having jobs there's a lot of favouritism. (Series 1, Thomas Rich Interview, 2005)

It's a shame, you can't go, that's it. It shouldn't be. That's the first time I heard this. (Series 1, Maggie Interview, November 2005)

This exchange demonstrates why a program like Cultural Leave is only a superficial solution, insufficient to address fundamental problems with the way jobs are offered and on what terms they are retained.

Political and family favouritism, which for the most part are one and the same, are clearly a substantial factor in employment (and unemployment). The link between political affiliation and employment is starkly evident in the correlation between family associations and being on welfare. If your clan loses the election, it is likely you will be on welfare. Maggie describes the fall-out of elections as follows:

> **M**: [The leaders] they're not directly involved or they seem like they're not trying to help the community at all just fighting among themselves and they help themselves, whatever they need and they help people they want to help and people that don't say much are the ones that are being left in the dark. So if your clan wins the election you'll be helped in some way. And if they don't win then you're in trouble! Yeah, you gotta wait, two, four years for the next chief! (Series 1, Maggie Interview, 2005)

Not only is there a direct link between politics and being on welfare, but there is also an indirect link through alcoholism. Rubin Rich explained that "people who are on welfare, they usually go together – alcohol and drugs" (Series 1, Rubin Rich Interview, 2005).[139] As discussed in chapter 2 there is also a link between alcohol use and election campaigns. A vicious cycle is established: Not only do people get shut out of jobs for being from the wrong family, but also they are encouraged by the corrupt election campaigns towards alcoholism, which in turn interferes with employment.

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[139]Greg Penashue bluntly laid out the relationship between alcohol abuse and unemployment:

> **G**: Melvin is my youngest brother. He drinks crazy when he does drinks and never works. The only two people that I know have money is my mom and dad and they give him the money and whenever he gets the money all he does is ask their friends pick him up some beer and he does drink. (Series 1, Greg Penashue Interviews, November 2005)

A basic obscurity about job requirements and the hiring process also contribute to a general feeling of uncertainty and disempowerment among people in the community. Danielle does not search for jobs but simply asks for hours at any job in order to qualify for Employment Insurance. Amy articulates the lack of clarity surrounding Band Council positions with respect to both requirements and job activities :

> **Z**: How hard is it to get a job in the community?
> **D**: It's pretty hard.
> **Z**: What are the factors? What causes people to get jobs and other people to not get jobs?
> **D**: Hours in the EI. People ask you how many hours you need for the stamps. You tell them and that's exactly how much work you'll get.
> **Z**: So you need a certain number of hours to get employment insurance and they'll hire you for however many hours that is and then...
> **D**: Yeah, then [the job] ends. (Series 1, Danielle Interview, 2005)
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> **L**: One of the things she said leaders should do is explain their positions in our community. There are people that are working that we have no knowledge of their job title or what their duties are. And because they seem to be afraid of someone obtaining knowledge of what field that person, or what department of Band Council that person's working right...
> **Z**: Do you see those people that are in those jobs as lucky or...how do you see the people who hold those positions?
> **A**: I don't know, how did they get those jobs? What did they have to do to get those jobs? That would be good to know. And what the Innu need to do to get those things. (Series 1, Amy Nuna Interview, 2005)

It is generally accepted in the community, despite the lack of clarity about what skills are required to get most jobs, that schooling contributes to a person's employability. However, while employment is both an impediment and a necessity to accessing the land, going to school and going in *nutshimit* are mutually exclusive. In other words, the Innu, like indigenous groups all over the world, accept the liberal belief that getting an education is the way out of poverty and disempowerment. And yet far

from being a solution, schooling is the most pervasive, insidious and powerful obstacle to Innu land access.

As discussed in chapter 2, despite the policy trend towards cultural empowerment, schooling as it is currently provided continues to erode the heart of Innu culture. Attempts at cultural relevance are superficial, limited to "culture days" and activities that can be carried out in the classroom or in the community; just as when school first opened in Sheshatshiu, the yearly schedule and accreditation continues to be antithetical to Innu families going into the country.

> **G**: People go out there [in *nutshimit*]and healthy...we spend a lot of time out there, just to hunt together with their families, with the young ones. They used to...kids used to stay out of school, they used to go at least four months in the country – survive in the country, used to walk in snow-shoes. How to kill birds, partridge mostly, rabbit, fish. (Series 1, Greg Penashue Interview, 2005)

In the sixties, parents had to make a decision between teaching their children the *nutshimit* way of life or sending them to school. Looking back on his choice to complete school, Jean Claude Vachon captures this struggle (Louis Rich translates):

> **L**: [Jean Claude] was still in high school then, nearing the end of his high school years...After they graduate he had to go to school outside...His father also told him, it's not good to go to school other than the school he was teaching. When you go to white school you're going to lose everything I taught you in the past. After he completed school he returned home and found himself alone again. He turned to his father and said everything you told me in the past is true, Jean said to his father. He said one of the things his father told him about the education or going to school was no good. This is how he gradually lost interest in going back to the bush and practicing his cultural and traditional ways. This is around the time where he was having less interest in going back in the bush. (Series 1, Jean Claude Vachon Interview, 2005)

The statements below demonstrate that the same situation continues today; the first is from Lionel's perspective as a parent, the rest from the perspectives of Amy, Katie Jack, and David Penashue, all of whom attended at Peenamin McKenzie, but did not graduate:

Li: Like I said, my father used to go and I used to go in country with him. But now I can't, I got to stay in the community because my kids are staying here with me. (Series 1, Lionel Rich Interview, 2005)

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Z: So have you ever done, like, Tshaukuesh's walk [a two-week-long walk on snowshoe traversing an old Innu route]?
A: No, no stuff like that. I heard about it.
Z: Does that kind of thing interest you?
A: Yeah, but I can't go because I've got college. (Anne-Marie Nuna interviews 2005)

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L: She liked going to school. She also would go in the bush – *nutshimit* – with her parents too in the Fall and in the Spring and because of that she was falling behind with the others. (Series 1, Katie Jack Interview, 2005)

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D: But it's really different now because back then, I was raised by my mother and my grandfather and they put me more in the bush than being more in the community. So I learned more stuff, I didn't finish high school, I didn't finish grade twelve I didn't go to college. For me sometimes I feel really upset and sad about that. But back many years ago, some people I spoke to they told me that what I have learned from my parents no one can ever show me in the bush. So win or lose I still got something, I learned a lot of stuff from the bush. (Series 1, David Penashue Interview, 2005)

While going into *nutshimit* interfered with Katie Jack and David Penashue's success at school, Amy's attendance at school impeded her from exploring *nutshimit*. And, despite this sacrifice, the schooling Amy received at Peenamin McKenzie is of dubious value – she is currently enrolled in upgrading at the college in North West River in order to be able to go on to school in Newfoundland. Hence, regardless of whether people attend school or are absent because of spending time in *nutshimit*, the significance of all of these remarks is that going to school and going into *nutshimit* are made mutually exclusive by the structure of the provincial school curriculum.

As discussed in chapters 1 and 2, in the early years of settlement family allowance was the primary incentive, and social norms the secondary incentive, for families to send

their children to school. Today the importance of schooling has been internalized by the Innu on an ideological level, and reinforced by the economic necessities of community life. The fact that David Penashue was "upset and sad" about not going to school is one example of the acceptance of school as a positive social norm. In fact, the internalization of a belief in the power of schooling to improve opportunities and break the cycle of poverty was one of the most prevalent themes throughout the full body of interviews. Out of all twenty interviews, not one person actively rejected school.[140] Although most people did not complete school, and most of the younger generation had a bad experience at school, there was a uniform expression of trust that school was worthwhile. The very people who explained why they had dropped out of school were invested in sending their children to school regardless:

> **Z**: What did you think of going to school at Peenamin?
> **A**: I think it was not that good. A lot of kids fighting other kids, that's all.
> **Z**: Is that why you stopped going?
> **A**: Yeah.
> **Z**: It didn't feel good being there? So why is it that you would like to leave the community, just to go to school or for other reasons?
> **A**: Just to go to school.
> **Z**: So what are the good things that you see in the community or that you do here?
> **A**: Well, I'd like my daughter to go to school here. She turns five...
> **Z**: So you're going to send her to Peenamin Mckenzie when she's old enough?
> **A**: Yeah.
> **Z**:...what do you think about her experiencing the same fighting and stuff that you did when you were there?
> A: I don't know, maybe there are a lot of new things going on in the

[140] Jean Claude Vachon mentioned that his son had decided that being in *nutshimit* was more important than going to school:

> **L**: I was asking about his son being in school. He was in school in Lab City. Not here. He has learned the traditional things too.
> **Z**: I was just wondering if he finished school in Lab City?
> **L**: He said he no longer has interest in completing high school, rather spend time in the woods, in the bush. Referring back to the things he learned: tool making, drums. (Series 1, Jean Claude Vachon Interview, November 2005)

schools today, I don't know. (Series 1, Amy Nuna Interview, 2005)

The internalization of the importance of school is grounded in economic necessity as well as in ideology. There is no longer immediate monetary remuneration for school attendance as there was with family allowance, but although more distant and abstract, the connection between school and money is still clear. Joseph Pokue deftly draws the links:

> **L**: One of the main problems you see is employment. Unable to get employment. He said it's frustrating being on social assistance all the time because you want to get things you want to get with that little bit of money. It would be much different if a person was employed.
> **Z**: Whose responsibility is it do you feel to provide more employment opportunities in the community?
> **L**: The leaders, Band Council, and the leaders.
> **Z**: How are they making their decisions about who's getting jobs and who's not?
> **L**: He said the leaders are focused on the people that are trained or that have educational background. He sees himself as a lacking any of that because he grew up in *nutshimit*. [L and J *Innu Aimun*] Because like I said he was born in the bush. There was never any sporting and the little school you got was just basics here at the community. He said for those reasons he cannot find a job in any community because he is lacking some qualifications in other fields jobs that comes out in the community. (Series 1, Joseph Pokue Interview, 2005)

That today schooling is more, rather than less of a consideration is clear:

> **J**: In the summer time he was working in the community and in the winter time he would go back in the bush with his father and his family as well. But today education is a big thing, a big problem for him – obtaining the position. He usually gets, in the past, jobs he's had it was a labour job, job where it doesn't require much education on environments. (Series 1, Joseph Pokue Interview, 2005)

However, while Joseph Pokue might feel at a disadvantage because of his age and having grown up in *nutshimit*, the situation is not much better for youth who have grown up in the community and attended school:

Z: How do you see the organizations like the RCMP, the school we talked about a little, then there's the social work – I guess it's the human resource center – and then there's the family center and the Mani Ashini clinic, the group home, how do you feel about those organizations?
D: I don't know, I really don't care eh.
Z: You don't care whether they're there or not?
D: Yeah.
Z: How come?
D: I don't know...job that way...school that way...didn't have a proper job, just off and on jobs that's it eh.
Z: That's been your experience?
D: Yeah.
Z: So you don't see those places as opportunity for employment?
D: Yeah.
Z: Would you be able to get a job at those places?
D: I don't think so, no. You gotta have good grades and you need grade twelve. (Series 1, Danielle Interview, 2005)

That Danielle's schooling did not in fact contribute to his employability demonstrates the problematic nature of the belief in schooling as the key to success and meaningful participation in society. That his experience is typical is demonstrated by the fact that not a single informant in the study completed school at Peenamin McKenzie, which in turn is contextualized by statistics of the extremely high drop-out rates and low attendance rates at the school (as discussed in chapter 2, attendance rates can be as low as 10%).

Hence we return, full circle, to the issue of unemployment and its relationship to accessing the land. In sum, the situation we have explored looks like this: to go out into *nutshimit* a person needs money; in order to have money a person needs to have a job; in order to have a job a person needs to have completed school satisfactorily; [141] if a person completed school they are unlikely to have the skills necessary to function in *nutshimit* and therefore do not have the confidence to go on their own. Furthermore, if a person

[141] As discussed in chapter 2, schooling is not sufficient to guarantee a job; employment also depends on factors unrelated to scholastic accomplishments and completely beyond an individual's control, such as family connections.

does have a job *and* the necessary skills to survive in *nutshimit*, they are then unlikely to have the time to do more than go camping. The following remarks are an articulation of this vicious circle:

> **Z**: When you say that lifestyles have changed a lot and so you don't have time to take your daughter where your grandma took you what are the changes that make it hard for you to do that?
> **D**: Well right now I'm older so I have to take care of my kids...you got to put a table and the food. Also...you got to find the way to take yourself to Goose Bay – half hour drive from here – so you gotta get a loan, bank loan, you gotta pay your bills. How do you pay your bills? Gotta work, so you gotta find something that you love to do...how do you do that? How do you survive on that to pay the bills? Back then my grandparents didn't have no bills, all they had was unemployment because back then two hundred dollars in monthly payments. They'd buy that stuff – salt, bread...two or three boxes of tea bags. Just enough [for] how many days you're going to be in the bush, one two months maybe. But now it's different, the lifestyle is different. The clothes are really expensive but you gotta buy something. Gotta buy something for the kids – clothes. Back then grandmas and grandpas they make things. Traditional clothing, moccasins. So you gotta find caribou, gotta walk real far away to find caribou. [That's what] my dad used to do. Food. Go hunting. Bring that caribou clean it out, clean the skin out. Now you gotta work – a few hours, a few minutes – go up to Goose Bay, go to store, buy a suit, come back. Back then you got to travel many miles away to get that stuff. So that's how it's different. Now for me I...I can walk half day I get tired and gotta drink water. Back then when they kill something, when you travel when you kill the caribou, you gotta drink the blood. The blood don't make you tired and don't make you really dry, thirsty. So that's how blood worked for them. So [life in the community] it's real different. (Series 1, David Penashue Interview, 2005)

David Penashue's perspective demonstrates the inextricability of diet-change and lifestyle change – for the Innu, a seemingly simple shift from eating one kind of food to eating another is in fact a shift between two fundamentally different ways of living; one in *nutshimit*, the other in the community. It is community living that has brought diabetes upon the Innu, and community living, in turn, was thrust upon them by the civilization programs of the federal and provincial governments (Andrew 1984). One of the main ways in which community life has led to diabetes is through diet-change and lifestyle

change – or, stated more historically and politically, through the Church and government-driven destruction of their way of life, in which healthy food and massive daily expenditures of energy were integral. This loss has been, and continues to be, effected primarily through the various forms of interference with the Innu ability to go out on the land. [142] In this way, although many of these issues appear at first glance to be irrelevant to diabetes, they are in fact centrally important factors – the very roots out of which diabetes grows. Moreover, not only was breaking the Innu relationship to the land a precondition for diabetes to arise, but the continued obstruction of Innu engagement in meaningful, life-affirming activities involving the land prevents the amelioration of diabetes in Sheshatshiu.

Cultural Validation and Diabetes: Schooling, Innu Eitun, Employment, and Self-esteem

One of the most important aspects of self-government is the implication that the Innu have the ability to take care of themselves and govern themselves. This is an important first step in a greater process of cultural validation that is crucial to the rebuilding of Innu health.

On one level, the link between diabetes and cultural validation is simple; the Innu way of life as it was practiced before settlement was not conducive to diabetes, settlement

[142] Various Innu participants, and non-Innu researchers like Samson, point out that there are many Innu who persevere in practicing *Innu Eitun*, *Innu Tukuna*, and continue to go out onto the land. Jean Claude Vachon asserts that "there are a lot of people who haven't abandoned their way of life, there are a lot of people who still practice in our community. We should never leave that part of our lives. Never abandon that part of our life" (Series 1, Jean Claude Vachon Interview, November 2005). Samson writes: "the project of sedentarization has only been a success insofar as the Innu are no longer *permanent* nomadic hunters...While the authorities act to incorporate the Innu into the larger Canadian whole, the people themselves continually resist, insisting on their right to be Innu" (Samson, 2003, p.14). The importance of acknowledging this form of resistance and resilience is profound. The above discussion is not meant to portray the Innu as victims, but to reveal the many obstacles that must be overcome in order for the Innu to engage in the various "cultural" activities, which by their very nature are good diabetes management strategies.

life is. One way to prevent and manage diabetes, then, is to encourage people to go more often into *nutshimit* which, as previously discussed, is synonymous with eating wild food and being active. The significance of cultural validation, however, is far greater than the physical benefits achieved by eating wild food and being active:

> **Z**: How is changing from living mostly in *nutshimit* to living mostly in the community affected your health?
> **L**: He said the difference in the bush and living in the community – he said when he was living in the bush he was free to go anywhere – nobody was governing him except for frequent teachings from his parents. Now, living in the community he's limited to do things that he would normally do in the bush. And also health-wise since he started living in the community, probably about fifteen years how he's been diagnosed with diabetes
>
> Freedom has a lot, I sense, lacking freedom – being able to do things he knows how to do. When you come in the community that's what you're faced with. All your things are useless...his knowledge right. Like my father used to say I feel useless when I'm in the community because there's nothing I'm qualified to do. But if you put him in nushimit – he knows how to hunt he can tell you a lot about animals and water. This is the knowledge he obtained from his parents for so many years and taught his children up till now.
>
> And this is like a prison, if a person have knowledge about cultural things and then come in the community they become imprisoned because can't do anything – immobilized. That's the sad thing about trying to change the Elders that have no knowledge of the English language or anything. These are the savages. That's what they used to talk about in the early twenties.
> **Z**: Do you feel like you...you got the diabetes after moving into the community?
> **L**: Yes. That's what Elders say. Moving around, doing a lot of exercise in the bush they didn't catch such sicknesses. This is what they believe like moving around in the bush – because they're doing stuff. Now back in the community, all you're doing is sitting in the house getting drunk every weekend. That's it. This is the life that the government promised us – the good life (laughter). (Series 1, Joseph Pokue Interview, 2005)

These statements provide a multi-layered picture of how settlement and life in the community has affected the Innu. Joseph Pokue articulates both the immediate physical connection between diabetes and community life (in the decrease in physical fitness), and

the broader issues of disempowerment, frustration and boredom stemming from colonization that lead to a lack of self-care, listlessness and alcoholism, all significant factors in diabetes. The uselessness of *Innu Eitun* skills within the context of community life is at the heart of the situation described by Joseph Pokue. His unemployability is both an economic problem in terms of his family's well-being, and a socio-cultural and psychological problem – it kicks off the vicious cycle just described. Joseph Pokue offers a way out of this cycle that is essentially about validating Innu culture:

> **L**: One of the main problems you see is employment. Unable to get employment. He said it's frustrating being on social assistance all the time because you want to get things you want to get with that little bit of money. It would be much different if a person was employed.
> **Z**: What could be done to improve that situation for you?
> **L**: There are other things that he can do too as well, like right now he has great knowledge in our cultural and traditional practices and anything that's involved with Innu Eitun he has been involved in at one point or another in his life – living with his parents and later on in his life where he has family of his own too. If there was a way where...if there was a way if himself and other Elders where it does not require much reading or writing but hands on skills...
> **L**: Then he gave me the example like he got a lot of skills like Innu Eitun, skills that you gotta learn over a life time – great knowledge. These he has knowledge of and can teach other people if there were such positions offered in the community where a person like him could teach a person like me to learn about our life.
> **Z**: So would you like to see a position like that offered at Peenamin McKenzie or would you like to see it offered in some other way?
> **L**: He said if anything should be available in the future it should be offered, not in the school, not in the village, should be offered outdoors which is how people learned in the past – outdoors. (Series 1, Joseph Pokue Interview, 2005)

Hence we return to schooling and its role in employment on the one hand, and loss of cultural knowledge and valuation on the other. As discussed above, schooling is viewed by the Innu as valuable – ideally, it teaches Innu people how to operate in broader society and gives them skills to be employed in a wage economy. And yet in its current form schooling undermines the ability to practice Innu culture, and the value of and belief

in Innu culture. Despite the oft-cited feeling that interest in Innu culture is declining, informants from all generations stated that Innu cultural health is key to individual and community health on all levels. Bernadine, who is in her twenties, the mother of two children and expecting a third, clearly articulates the importance of Innu culture:

> **Z**: So if you have any ideas about what, in your mind, would be useful research...?
> **B**: I think our culture.
> **Z**: Culture?
> **B**: Yeah. Culture. Culture-wise, back in the days the old people used to teach the young people I think we're losing that here. I think that's what we should realize. What's happening in the community and teach the younger ones too right. Follow the Elders. That's what I do, I follow the Elders, I have my Grandfather and Grandmother teach me a lot when I was young too. And culture is the most important. For me that's the most important because you teach your kids when you're young. I mean once we get older we teach our kids too. The culture is more important than...just do anything, it's all culture. (Series 1, Bernadine Milley Interview, 2005)

The deeply troubling aspect of the situation with respect to the loss of cultural valuation and knowledge is that due to the many obstacles, like schooling, that stand in the way of meaningful participation in *Innu Eitun*, parents like Bernadine do not have the skills or confidence to pass Innu culture on:

> **Z**: So going without them...is it harder to go without them? Or not as fun? Is it that you feel...like it's because you don't know as much as they do?
> **B**: No, I mean I love it when I was younger anyway. I think I didn't...I didn't follow the Innu way of life I followed the white man's...the white way of life instead right. But I mean like, I can get that back...I try to get some back anyway. And I'll teach my children when they get bigger. Have their own family of their own. I'll teach them what I know then. I mean if, like me, I like to go camping if I had the tent and stuff and stove and that – I'd take all my kids and go camping. Have some quiet time with them you know. Let them run around. Teach them what I know. I don't know much but I know some! I like seeing stuff going on in the community. If it changes you know. I'm hoping it do. Because it affects a lot of people too right. (Series 1, Bernadine Milley Interview, 2005)

Danielle, who is newly a father and is in his twenties, is in the same situation:

Z: What are your main concerns for your kids?
D: I don't know, I just hope they grow up to be good kids.
Z: What is being a good kid in your mind?
D: Growing up, staying in school, going to college. All that. Just get a job and have a normal life.
Z: How important are the Innu ways for you, for your kids?
D: I don't know, they're not anymore. The way people are acting around here now eh.
Z: So you mean it doesn't...looking around at the way people act around here it doesn't seem very important?
D: Yeah.
Z: So do you see your kids learning the Innu ways as helpful to them?
D: Uh huh.
Z: Will you be able to teach that to them?
D: Yeah. I don't know much though eh. (Series 1, Danielle Interview, 2005)

The contradictory assertion of young parents that they will teach their children what they know, followed by the statement that they don't know very much, reveals the impasse that the younger generation of Innu face in trying be successful at school and simultaneously trying to hold on to their Innu identity and way of life. They have been encouraged to go to school, to "follow the white way" and "have a normal life," and as a result have cut themselves off from cultural learning, making it difficult for them to pass any meaningful sense of Innu culture on to their children.

Even older generations, people whose parents never went to school but who themselves attended at least some of the year, are lacking certain skills and a degree of confidence to go into *nutshimit*:

> **L**: When I was young there was a tool I had to make. My father showed me, I was a teenager, lacking interest, so caught up in things right, I just didn't want to listen. I figured I didn't need it right! When I got to be the marrying age, have children of my own. This tool, I needed it and I sat down and cried. I didn't get that knowledge when it was available to me at the time. I mean these are the things we are missing. For instance all my children are pretty well grown up and I didn't have a chance to be in the woods with them. I did but maybe [only] three months out of the year. That three months out of the year was two or three times while they were growing up. Because you had to be in the community I had to

provide for them, get them their clothes, school was another thing. Whenever we could we got away. (Series 1, Louis Rich Interview, 2005)

It is not only the youth who need to be taught *Innu Eitun* skills, but the older generation as well:

Z: So if you had the opportunity to teach the skills that you have would you want to do that?
Le: mm hmm
Z: So if there were funding for you to get paid?
Le: I'd want to learn more if there was education about that.
Z: And do you think the Elders would want to teach that? [silent affirmation] Yeah, that's the feeling I got from them when I interviewed them last time I was here. So what keeps them from doing that now?
Le: I don't know, school.
Z: This school?
Le: Mmmhmm they should hire an Elder all school year. Then they should hire another one after school then another one for summer. Kids getting in trouble. I think that should be good because a lot of kids are getting in trouble. Smoking, drinking, drugs. (Series 1, Lea Rich Interview, 2005)

As is stated in the next four excerpts from the interviews, the only people who can fully teach *Innu Eitun* are *Tshishennaut*, or people like Joseph Pokue who have dedicated their lives to being in *nutshimit*. The majority of informants, even those in older generations, only spoke about going into *nutshimit* with their grandparents. For some, the year of a relative's death coincides with the last year they went into *nutshimit*. Others stated outright that they would not go into *nutshimit* without the guidance of an older person. It is clear that there is an important role for those who are skilled in *Innu Eitun*, and a need for programs like the one suggested by Joseph Pokue. The first two conversations are with the older generation, people who had grown up both in the community and in *nutshimit*, the second two are with the younger generation who grew up primarily in the community:

Z: So the last time you were out in the country was 1996

Le: with my father. Back. Never even went camping.
Z: So when you used to go out in the country you mostly went with your dad?
Le: Yeah.
Z: Is he alive?
Le: No, he died in 96. (Series 1, Lea Rich Interview, 2005)

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Li: I learn a lot of things in the country...– fishing and go out with the hunters and that sort of thing. There's nothing left I think for me because my father's died here a few years ago. I was frustrated because I don't have no mother and father. All I have is my wife and the family. And I got my brothers and sisters here in the community. There's so many things that we lost in the community. (Series 1, Lionel Rich Interview, 2005)

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B: The only time I go camping is when I go with my grandparents but they're kind of ill right now and they can't do much. (Series 1, Bernadine Milley Interview, 2005)

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Z: When do you get to go [into *nutshimit*]?
L: Whenever they want to I guess, whenever the Band Council gives out money for people to go to the country. Yeah. I haven't been to the country for quite a while now, but it's always fun when you go. Whenever you go there it's always fun, you never get depressed there. Everything goes away. You don't even...you don't even worry about T.V. or the computers or all this stuff, like the radio and all that. You just don't worry about that you just find something to do there I think, like every day. Like go hunting, go fishing, playing games. Stuff like that. It's always fun to go over there.
Z: Who did you go with last time you went?
L: My mother, my grandparents. Usually I go with my grandparents.
Z: On your mom's side?
L: Yeah. Because on my Dad's side you know the grandparents died. (Series 1, Louis Rich jr. Interview, 2005)

The widening rift between the young people and the *Tshishennaut* is a key motivation for a socially, financially, and institutionally supported effort towards cultural validation. The gap in understanding that exists between the younger generation and the *Tshishennaut* makes it difficult for interested youth to obtain knowledge, even if they ask to be taught:

G: One interesting thing now ever since…I was walking up to watch the program – the Dene – which they talk about Dogrib right, their own language, Dogrib. They speak to translations and they were saying a lot of their students lost so much because they spent less and less [time] in their own environment rather than in their own environment. It's true in some sense in a lot of ways in our community because the younger generation has a tendency to speak more foreign language – English than Innu. They don't understand the Innu when the *Tshishennaut* speak, some of the words that they use are much more…the land itself, the river, lakes and the ponds and where the portages to and where they camp, what lake they camp and where they spend the most time. That's something that we have a tendency to lose so fast…that's one of the difficulties that we have now.

I used to notice when I was…I work at the Innu Nation and you could have a conversation with *Tshishennaut* if you knew what your talking about, if you don't know what you're talking about the interest is not there by the *Tshishennaut.* Because there's no point I guess in listening to nobody who doesn't even know about anything about *nutshimit.* That's what I'm really good at. We almost have two languages in the community. One of them is foreign and the other one has to do with the education. And the other one has to do with how I was brought up in the country. I've spent most of my life in the country. I've never had what they call education. I went as far as Grade seven. I learned English through working with so many academic people. (Series 1, Greg Penashue Interview, 2005)

The bilingualism in the community mentioned by Greg Penashue is one of the main reasons many participants cited for the continuation of regular schooling while also offering an Innu education:

Z: What sort of things do you think they could do to make Peenamin a better place to learn?
L: the teachings are fair but also she'd like…to have her children learn more about English…When her children goes home they speak Innu anyway right, so she feels they're being taught equal Innu language…She just don't feel that it's very important that she learn that from school because she speak the language anyway and that's her first language and that's what she speaks every day. But in school it's different, you learn English language. (Series 1, Katie Jack Interview, 2005)

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Li: I like to see more kids going to school and learn about our language instead of just English the second language. I'd like the kids learn our language because it's important for us. For me I can say that because I don't want to lose my language because when I was in school I start to talk English when I was five years old. I

learned from whenever I see a person talking English I learned from them, then I went to school and learned from school as well. But still I don't lost my language yet. This is what I'm saying this is important for our kids...our language is important. Then again...even though, if I was in grade eleven going in high school university whatever I would still keep my language, my own language because this is the most important of all in the community right. Series 1, Lionel Rich Interview, 2005)

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B: I know there's Innu Aimun there [taught at the school]. That's the most important too is our language, the Innu language too for the young ones not to lose their language when they get older. I know for me my children they can, there's four kids I have, they don't speak Innu they lost their language when they were young. I think it's because of me too because I never teach them and it's mostly English they know now. But trying to catch up and understand that language is more important than anything else I guess. For me it is, because I have both languages and I think we should learn Innu Aimun, but my kids only have one language. But I'm trying to get them back and trying to teach them that the *Innu Aimun* is important too and they'll need two languages when they grow up – they have Innu Aimun and English right. (Series 1, Bernadine Milley Interview, 2005)

Many participants suggested that the school curriculum be balanced by the introduction of *Innu Eitun* skills, and a greater emphasis on *Innu Aimun,* indicating that Joseph Pokue's perspective on the need for such programs is widespread in the community:

Li: This is again I have seen this year was some time they start in June a program – cultural program. Actually, I believe from sixteen and up went *nutshimit* to work, to learn how to make log cabins. And this is important for those sixteen and up to learn something like this. And also we would like to see the kids learn the culture. Like I said the in the sixties when we were in the country was pretty well good. But now we don't se that anymore. Because it's gradually dying itself, you know, slowly. I think there would be more to have and Elder or somebody else to teach culture stuff. Like how to make canoes, how to make snowshoes, how to make paddles and these things that we can use in the country. (Series 1, Lionel Rich Interview, 2005)

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Le: Could provide money for people to learn about their own cultural and traditional things [that] we were heavily involved [with] in earlier years. We're still involved but not as much. Find some Elders and some younger generation. Schools, environment, community. Money should be spent more wisely. (Series 1, Lea Rich Interview, 2005)

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L: One of the sad things is that our Elders are getting sick and we're losing our Elders because of their age. We should respect and love our Elders. These are the people who have knowledge of our traditional skills and cultural background – these are the teachers. Also when a child is young he should be introduced to the Innu way of life at a very early age. There are a lot of people who haven't abandoned their way of life, there are a lot of people who still practice in our community. We should never leave that part of our lives. Never abandon that part of our life. (Series 1, Jean Claude Vachon Interview, 2005)

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B: I know there's a lot of Elders that teach. [To] a lot of young kids too, like crafts. They used to but I don't know if they do it anymore, they used to teach crafts, sewing – teaching stories [about] them days back what the old people used to do, you know, hunting, fishing. That's more important too. Like their, people's [ways]...what they need to do, or how can they learn? That's why they need and Elder to teach them right. To make them be role models for the young ones. That's most important too right. (Series 1, Bernadine Milley Interview, 2005)

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L: One thing we should create is cultural and traditional teachings whether it's tool-making, carving, anything relating to the Innu traditional way of life, he feels this should be brought into schools and taught there. (Series 1, Thomas Rich Interview, 2005)

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L: She said there should be more Innu teachers involved with our school teaching Innu children. Also she said they teach...I think it's from preschool to grade three...this is all that's taught Innu but beyond that it's not. She said it should be taught all the way up through high-school, that way we wouldn't have as much negativity, it would balance out. We learn your way of living and their way of living because their way as well is what we're living it's what we have adapted over the years. (Series 1, Vanessa Rich Interview, 2005)

The fact that there is widespread support for keeping *Innu Aimun* vibrant, and for teaching *Innu Eitun* in order to rebuild cultural health, does not mean that people are in agreement about how *Innu Eitun* should be taught – by whom, whether in school, in the

community, or in *nutshimit*. As well, there is some skepticism about the younger generation's interest in learning these skills at all:

> **L**: [I asked] if we brought in programs, I said, where we teach traditional and cultural stuff to students. She said she doesn't know, in the past that that's been tried and then the case was just...no interest there. They just won't learn. (Series 1, Katie Jack Interview, 2005)

It is precisely because schooling has become such a potent and accepted idea that the Innu will work out these kinds of questions among themselves – *if* they are allowed to radically restructure the school curriculum. Furthermore, informants suggested that if the *Innu Eitun* programs were offered within a wider context of cultural validation the disinterest would transform into empowered curiosity. The participants have suggested that if parents and *Tshishennaut* got jobs because of their expertise in *nutshimit,* rather than being unemployed and alcoholic; if students got credit rather than punishment for going into *nutshimit* and learning *Innu Eitun* skills; and if there were a more stable, healthy environment in which youth could learn, due to the subsequent decrease in despair and self-loathing-induced substance abuse, the opinion of cultural programs and of going into *nutshimit* would become more uniformly positive.

The informants emphasized that in order to offer a true learning environment for *Innu Eitun* – a program like the ones described by Joseph Pokue and others – the school curriculum must be an Innu creation, education must be transferred to the Innu. However, as discussed above, to offer programs is only one part of a broader shift that must take place to create an encompassing context of cultural validation; the Innu believe that for this shift to occur requires self-determination. Hence, like the issues around social services (housing, sanitation, water quality), community programming, and

employment raised by Katie Jack, Lea Rich and Joseph Pokue, designing education to rebuild cultural health requires self-determination.

Innu Tukuna and Diabetes

Another kind of change that must occur in order to improve Innu physical and cultural health revolves around Innu medicine or *Innu Tukuna*. As demonstrated by the secondary analysis of extant data sets, there is a direct relationship between diabetes and *Innu Tukuna*, since according to various *Tshishennaut* wild food and plants have preventative medicinal qualities as well as nutritional ones.[143] Maggie was the only informant who linked diabetes and *Innu Tukuna*,[144] but other informants expanded on the relationship between medicine and religion, and between food and medicine:

> **G**: The traditional medicine means you're using plant to cure one another. And the other one uses...another part...people use their dreams a lot and things that they hunt – animals, different animals, and you know what they...like this time of year porcupines spend a lot of time in the marshes. There's the little roots that grow in the marshes [used] to gain weight – put fat on themselves. So porcupine spend a lot of time in the marsh right now. Even beaver, if it get colder earlier the beavers eat a lot, they put on a lot of weight. And masq'u – black bear – it's do like that too. And the saddest part about this tradition – I don't know if that's the right word, we're using tradition, we always use this – tradition right. Even academics "shamanism". It was a religion but it never been explained in religion. Some people used to worship those for health.
> **L**: *Tukuna* means medicine.
> **Z**: So does that include...?
> **G**: That includes, it's a very broad base that term I think. Beaver eats a lot of leaves and plants too eh, so people usually eat a lot of beaver, caribou. *Kak'u* [porcupine] too yeah.

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[143] The extant data series is the primary source for this statement because in the 2005 interviews only Maggie connects *Innu Tukuna* to diabetes.

[144] For Maggie diabetes is a result of "all this *akaneshau* stuff because when she was younger living in *nutshimit* she never encountered such problems as high blood pressure and such sicknesses. Any sicknesses she encountered in the past were taken care of through Innu medicine by her mother right" (Series 1, Maggie Interview, November 2005).

> **Z**: So eating the wild food is...how does that affect your health? Does it make you feel different than eating...?
> **G**: It's different yeah, because they're not force-fed, they're not given needles like cows and chickens. They feed themselves, they're in the wild, they don't have a [house] like chicken does. (Series 1, Greg Penashue Interview, 2005)

As with wild food, however, the role of *Innu Tukuna* in diabetes is greater than its physical curative work. The undermining of *Innu Tukuna*, which is both medicinal and spiritual/religious/shamanistic, is central to the assault on Innu political autonomy (Tanner et al., n.d.), social cohesion and resilience, identity and self-esteem. Francis Penashue's remarks in chapter 1 about the Innu being "evil" and "without history," Joseph Pokue's remarks about the Innu being the "savages," and the following comments from Greg Penashue demonstrate the profound psychological effect of the Church's and governments' assault on *Innu Tukuna*:

> G: The other thing too is...when you talk about this spiritual stuff a lot of kids don't believe in it...My father knew that too...that if you talk something about spiritual beliefs, yes we could talk about it, but nobody would appreciate those unless they see them right. That's what happened to the younger kids too, they don't appreciate them because they don't see them. You almost have to see what they're talking about. My dad worked with the shaman person at least twenty years. That's how he...he never used to believe in that [either]. After he works with them at least thirty, twenty years, the belief starts to come as they goes, [the] years. He said it's kind of hard to explain to anybody. They almost have to see what you're talking about. If you don't experience it it's nothing. You could think that...if you don't see what they're talking about you could think that this person is bull-shitting you right? Easy way of...most people have a tendency to do that. To believe it...one thing that I talk to the priest about one time. I ask him to come over to the house we'll talk about our own religion. I said the people that the Innu used to practice the religion, these spiritual beliefs – shaking tent and everything else – I said that was our religion. I said when you guys came here you tried to destroy that. He never come to see me but they did, the Churches did that. When the Churches came in they came in with governments, they had this... this saying – assimilation. And they move into the communities, they want to turn me like you – like white. It didn't work. It backfired on them. What happened was that...they say Jesus Christ was in this earth three thousand years ago. Some of the archeological evidence that archeologists finding say Native groups existed at least nine-thousand years in here. So I said it must have meant

> something that religion that we used to use. For us to be able to exist in the history, nine-thousand, eight-thousand years ago. That's what, three years, four [thousand] years [before] Christ. There was an old guy, he used to say a lot of stuff one time. His name was Joseph – Shimun Pasteen...one time he said – I've been here before anybody was here in this land. He said even before God! They said he must have made Earth before God. (Series 1, Greg Penashue Interview, 2005)

The need to rebuild respect for, and knowledge of, *Innu Tukuna* is articulated by a number of participants, both men and women, of all ages. The first remarks were made by Louis Rich Jr., a new father in his early twenties, the remaining remarks – which are more pointedly oriented towards developing an *Innu Tukuna* program in the community – were made by Vanessa, Lea, and Maggie, who range in age from forty to sixty:

> **Z**: Did you ever get treated that way [with *Innu Tukuna*]?
> **L**: No.
> **Z**: Would you like to see traditional medicine be offered in the community?
> **L**: I think they do use it. Some people. It's not like they have a store...Sometimes I think our heritage or our culture is going to be gone sometime in the future. It's like, respect your Elders right. Listen to them. If that doesn't happen we'll just be... we'll just be living in...how do I say...living in white culture where everybody talking in English nobody would know anything about their heritage and culture. (Series 1, Louis Rich jr. Interview, 2005)
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> **L**: I ask her if she has any knowledge of the traditional medicine. She has some knowledge she has seen it being practiced in *nutshimit*. Also she said she don't practice as much traditional medicine as she likes, not only that she is lacking knowledge where she's been in the community for so many years now things have changed. The other thing is we don't have access to traditional knowledge now. She obtained knowledge but she never had much practice. But her mother still practices the traditional medicine. (Series 1, Vanessa Rich Interview, 2005)
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> **Z**: Do you use any Innu medicine with your kids?
> **Le**: No.
> **Z**: would you like to see that available?
> **Le**: Yes. Some of the Innu medicines are good.
> **Z**: How would that work?

Le: get someone who knows about it teach the other people.
Z: would they be able to offer that out of the clinic?
Le: No. I wouldn't like to see that! (laughter) Elders doing it.
Z: would they be able to do it in the community?
Le: I think so
Z: but separately from the clinic?
Le: mm hmm. (Series 1, Lea Rich Interview, 2005)

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Z: How do you find the health care in general at the hospital?
L: She don't believe it's doing enough to help.
Z: How so, what else would you see done?
L: She said in the early days where Innu used to help other Innu, Innu used to help with the traditional medicines...instead of going to the hospital.
Z: So you would like to see more *Innu Tukuna*?
M: Mmm mm,
Z: Are there any ways you could suggest for...how that could happen more?
L: Those who practice traditional medicine are no longer with us. Because of this, because she didn't learn any of this when she was young, she lost all of this, she lost all her knowledge that my mother possessed at one time. She doesn't learn stuff, we should be learning what is left. Because it's...the elderly are slowly going and when they go the knowledge goes.
Z: So do you think it's too late, or do you think that someone can still learn these things?
L: There are some Elders for instance her husband's mother is still alive. She have knowledge of traditional medicine. They practice some from time to time. Because our Elders are deceased...but they are still practicing in the community, just not as much as it was at one time and this, what little is left of it we going to learn one little bit anyway.
Z: So is there some way that...I don't know, some changes could be made to encourage those *Tshishennaut* that are still living to teach those skills, that knowledge?
L: She is using one example where there was a woman...it's another Innu reserve...Kalauashimash, don't ask me to spell it!...And she said that while she was there she is teaching other people traditional medicine. And one of the things when she was there was...some people in the crowd were coughing so [this] person made medicine using boughs and other plants and she said this is one example of traditional medicine. And before she said all that, she said we should, or our leaders should, have some kind of program where we take as many Elders in hire and teach what's left of what knowledge they have. What knowledge we learn from them. They know...we could have that knowledge and put in books. To preserve it. One of the questions that woman presented to them was that she

asked them if there were such teachings of traditional medicines in our community and our reply was no, right. And people in Québec have started more events teaching the traditional medicine.
Z: So maybe they have some kind of program you could look at to sort of copy?
L: And this is all documented, it's curriculum, it's part of the school...I think there was...instruction on some of that and on what some of the Innu Elders did in their community for teaching their younger generation Innu medicine and other crafts.
Z: So basically we don't have to re-invent it in Sheshatshiu, we just have to get the leaders to do it?
M: Yeah. Mm hmm. That's what they do in Québec.
L: And they should do it here! (Series 1, Maggie Interview, 2005)

The importance of reinstating *Innu Tukuna* as a legitimate medical and cultural system is profound. To leave the Church's condemnation of it unchallenged is tantamount to endorsing the resulting internalization of evil and legacy of self-doubt and self-destruction that now cripples the Innu efforts at individual and community healing. While the project of teaching and believing in *Innu Tukuna* rests with the Innu, one major step towards its validation would be legalization. As demonstrated by the Nisga'a, self-government is necessary for Native medicine to be licensed (Kelm, 2004).

At every juncture that has been discussed, self-determination is the long-term solution to achieving individual and community health for the Innu – which includes but is not limited to effective diabetes prevention and management strategies. Coupled with successful land claims negotiations, self-determination will diminish the sense of government surveillance and criminality of hunting, fishing and trapping; as a result, wild food can begin to regain priority in the Innu diet – a significant form of prevention and treatment for diabetes – both for people on the land and for those in the community who are unable or unwilling to get wild food for themselves. Self-government will make room for a new school curriculum that is not mutually exclusive of going into *nutshimit*,

and which unites the Innu belief in the usefulness of schooling and *Innu Eitun*. As well as encouraging people to go more often into *nutshimit*, which is the ideal diabetes prevention and management strategy in terms of diet and physical activity, the accreditation, employment and cultural validation made possible by an Innu-designed curriculum will significantly contribute to rebuilding the economic independence, self-esteem and resilience necessary for people to be able to take care of themselves. Self-determination will allow for discussions about a new governmental structure – several informants offered realistic alternatives that would acknowledge the deeply embedded clan divisions which the current structure exacerbates. A governmental structure which is designed to minimize the inequalities stemming from political and familial favouritism (nepotism) will address the root sources of stress and uncertainty. These sources lead to substance abuse and keep the community in a state of antagonism and social dysfunction, therefore keeping individuals from taking care of themselves and each other. Finally, self-government will legalize *Innu Tukuna*, which is a necessary acknowledgement of the historic violence done to the Innu belief-system by Church and government and a key component in creating a meaningful context of cultural validation.

In summary, when the Innu say that diabetes is caused by "being in a settlement such as [Sheshatshiu]" they refer to the many aspects of community life outlined above. Food, fitness and alcohol are only the most definable three of many interconnected factors and circumstances that contribute to the development and continuation of diabetes in Sheshatshiu. Beginning from these three, the map of the diabetic experience in Sheshatshiu unfolds to reveal that politics, household security, infrastructural inadequacies, family breakdown, industrial development, schooling, the Church and

government regulations all play a part in maintaining the deep ill-health – the legacy of colonialism – of which diabetes is only one symptom.

Participant Responses to the Lifestyle Approach to Type II Diabetes

The third question this study set out to answer was, how does the Innu conception of Type II diabetes compare with the clinical conceptualization of it as characterized by insulin resistance and primarily determined by genetic and lifestyle risk factors? The interviews demonstrate that the Innu, like epidemiologists and clinicians, see lifestyle factors such as diet and activity-level as contributing significantly to the disease process. The Innu view differs from the clinical view in that settlement and the non-native lifestyle associated with settlement are seen to be the primary determinants of diabetes. Despite this difference, diabetics in Sheshatshiu have to contend with a pretty much by-the-book clinical approach to diabetes. A number of responses to the lifestyle approach emerged from the interviews ranging from outright rejection to full acceptance of clinical recommendations for management. The more common response to clinical diagnoses and explanations was a vague understanding and mild concern with aspects such as the differences between Type I and Type II diabetes, the differences between pills and insulin and the significance of changing from one to the other, and the mechanisms of blood-glucose levels. One participant, however, had a more clinically precise understanding of these aspects and referred heavily to them throughout his discussion of his experience. The more common response to diet and exercise recommendations was rejection – some individuals rejected the recommendations having first attempted to follow them, others without attempting them. Two other individuals accepted the diet and exercise recommendations to varying degrees, and the same one participant who described his

diabetes in clinical terms fully accepted the recommendations and had had variable success implementing them.

Before further exploration of these positions, it is important to distinguish between acceptance of the lifestyle *approach* to diabetes and the lifestyle *conceptualization* of diabetes. Some Innu, like David Penashue, have been able to incorporate[145] the lifestyle approach so that it works for them.[146] David Penashue, for example, has persevered in diet and exercise changes, which is a *de facto* acceptance of individual responsibility – the key mechanism of the lifestyle approach to the management of diabetes. However, although David Penashue is willing to assume his responsibility for managing diabetes, he nevertheless perceives the disease at root to be a disease of settlement.

Although David Penashue's acceptance of individual responsibility for diabetes management does not preclude the conception of diabetes as a disease of settlement, his acceptance of, and attention to, individual responsibility shapes his discussion of

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[145] In the sense of the word as defined by Kelm:

> incorporation functions paradoxically through a process, described by Sahlins, as one where strategic cultural change encourages political resistance which, in turn, ensures cultural survival. By taking on some parts of colonial culture, indigenous people evince agency and in so doing refuse the inert, subordinated self-image ascribed to them by the dominant society. (Kelm, 2004, p. 336).

[146] The contrast between David Penashue's and Lionel Rich's use even of the term "lifestyle" demonstrates the difference in their attitudes. While Lionel actively rejects the recommended "lifestyle", David clearly accepts it:

> Li: Oh yes. Worked well if people listens. But some people don't, right. I mean this is where I told doctor about this – I can't live the way you live I said, my lifestyle is different than yours. This is the first time, I mean, this is the life-time diabetic right. I mean, rest of my life. (Series 1, Lionel Rich Interview, November 2005)
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> D: I watch everything that I eat right now I gotta to bring my sugars down. I gotta watch that and change my lifestyle, learn about how much I eat – bread, the meat, wild meat. (Series 1, David Penashue Interview, November 2005)

diabetes. The tone of those who rejected the lifestyle approach, or who only partially accepted it, demonstrates that diabetes for them is only one among many concerns. In contrast, David Penashue's tone and the amount of time he spent talking about his diabetes demonstrate a keen interest in, and prioritization of, diabetes over and above other concerns. The significance of this difference in interest and prioritization is that a clinically circumscribed perception of diabetes like David Penashue's, which focuses on lifestyle management aspects, obscures the broader socio-political, economic and cultural determinants of diabetes in Sheshatshiu. In contrast, these broader issues were impossible to ignore in the accounts of people who spoke briefly about diabetes but at length about a range of circumstances in Sheshatshiu. In other words, while those who reject the lifestyle approach point to the contextual root causes of diabetes, which can only be addressed by deep-reaching socio-political changes, those who accept the lifestyle approach focus on the more superficial concerns of diabetes management, which can be addressed at an individual level.

The following exploration of participant responses to the lifestyle approach will focus on the range of responses elicited, thereby illuminating the reasons why some people reject dieting, exercising, and the whole concept of lifestyle change, and others see these kinds of changes as possible and helpful in the management of their diabetes. The subtleties of response are best revealed by an in-depth exploration of two interviews that exemplify rejection and acceptance of the lifestyle approach. Hence, the discussion will be divided into two sections, the first relating to Vanessa Rich's experience and perspective, the second, to David Penashue's experience and perspective.

Vanessa Rich

With Vanessa the topic of diabetes came up in the context of a conversation about community life as compared with *nutshimit* life. She mentioned a number of issues with community life, but only when we asked her directly about her health did she reveal that she was diabetic:

> L: Healthwise she's a diabetic and, of course, nobody likes being a diabetic and this is one of the problems she encounters too. There are a lot of diabetics in the community. (Series 1, Vanessa Rich Interview, 2005)

The fact that Vanessa Rich did not bring up diabetes until the terms "health" and "healthiness" were used in a question, signifies that, for her diabetes is associated with clinically defined health concerns. That this type of health concern is only one among many is quickly established when she categorizes diabetes as yet another "one of the problems she encounters" in the community. Vanessa Rich's tone indicated that she was not particularly interested in talking about diabetes. The content of her remarks reinforce this seeming indifference:

> **Z**: Do you have Type I or Type II diabetes?
> **L**: She don't know. All she knows is diabetes. And she takes daily medication. She used to take insulin at one point and then she could no longer take it and now she's taking pills.
> **Z**: So do you worry about the diabetes a lot or do you have other things that are more important to you than that?
> **L**: She don't dwell on it as much, there are times when she forgets she's diabetic, there are times when she forgets her medication. (Series 1, Vanessa Rich Interview, 2005)

Her vagueness about Type I versus Type II diabetes, pills versus insulin, and her tendency to forget taking her medication altogether, suggest that she does not have a clear understanding of diabetes as it is defined in the clinical sense. The following exchange sheds some light on why:

> **Z**: Do you find that your needs are taken care of in the community, do you get the health care that you need?
> **L**: She is getting the care that she needs but there may be some things in the instructions she may have trouble understanding and because of that she may be doing other things she's not supposed to be doing with her medication. Then again, might not.
> **Z**: Problem with the instructions? Because they're in English?
> **L**: Yeah. They're in English, they're all in English.
> **Z**: So is there enough translation happening?
> **L**: Yes there is a translator provided for the health nurse in the community. There is one employed to do such translations. (Series 1, Vanessa Rich Interview, 2005)

Vanessa Rich cites the language barrier as one reason why she might not be using her medication properly, and yet there are translation services provided at the Mani Ashini health clinic. One way to approach this issue is to look into the nature of the translations services: are they insufficient, unavailable, offered by an untrustworthy individual etc. This approach, however, locates the problem within the health care system and does not take into account other factors. We must consider the issue of translation within the context of the informant's qualification, "then again, might not", and her statement that "there are times when she forgets she's diabetic, there are times when she forgets her medication" (Series 1, Vanessa Rich Interview, 2005). The fact that medication instructions are explained and written in English[147] does not explain how Vanessa Rich is able to forget about her diabetes, nor would perfect translation guarantee that she would follow a perfect medication regime – as she asserts, it might not. The fact that she sometimes forgets that she's diabetic is the key to understanding her attitude to diabetes. It is clearly not the most immediate concern for her. A concern that *is* of immediate and

[147] Writing them in *Innu Aimun* would not necessarily be a solution as it has not been standardized and many people do not read it either. In fact, many people who do not read *Innu Aimun* do read some English including this informant: "I asked her if she reads the newsletter that comes out. She said yes, she reads the English version that comes out because she cannot read as good in *Innu Aimun*" (Series 1 Interviews, 2005).

looming concern for Vanessa Rich is alcohol and substance abuse in the community, a subject which she returned to repeatedly during the interview:

> L: I asked her what were the negatives she sees in the community. She answered by saying one of the negatives is the abuse of alcohol and drugs that is in the community and having a negative effect on our children. Also...the other thing she also is negative towards is when our children or loved ones are abusing drugs or alcohol – you worry constantly whether they're going to come home peacefully or whether they're going to come home at all? Or where are they at drinking or are they getting in trouble, stuff like that for a mother and father to worry about almost constantly especially on pay days. In the community for the next few days until that person sorts it out. (Series 1, Vanessa Rich Interview, 2005)

The connections between alcohol and diabetes have been discussed in the previous section. Vanessa's perspective reinforces these links.[148] With respect to understanding why diabetes is not Vanessa's primary concern, like Katie Jack, for her, alcoholism and substance abuse are only the surface expression of tensions stemming from a complex of community-wide issues. At the same time, however, alcohol and substance abuse are the starting point for a vicious cycle that gets passed on through generations. Vanessa expresses a different aspect of the cyclical process described above: youth going hungry not only has physical health consequences in terms of diabetes, it also affects their ability to be engaged. If they are not engaged they become restless and bored, and turn to alcohol and drugs. These addictions, in turn, lead to teen pregnancy, and the cycle begins anew. The need to engage youth is crucial in order to break the cycle of alcoholism;

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[148] As described previously by Greg Penashue, there is a problem with alcoholic parents not providing sufficient food for their children. Vanessa Rich also speaks to this issue:

> L: Well, I don't know about well, but she said there are children in the community that aren't eating at all when they go to school, that's what she said. And there are children that come back from school at dinner time and they don't eat and still go back to school. Sometimes people are less motivated they don't want to go back to school because they're hungry!...The other thing too she said is people that have booze in their house, especially in the mornings at many times they don't have time because they get up late and when they get up it's off to the school bus and they're gone. (Series 1, Vanessa Rich Interview, November 2005)

Vanessa sees it as the Leaders' responsibility to provide programs for the youth to keep them motivated and engaged:

> **L**: She said there should be more programs or activities – leaders should be looking at more activities for younger generation, more work for the younger generation to motivate them to stay out of trouble. Because mostly...people are free to roam anywhere they want and it's when they're bored, through boredom they do other things like getting in trouble or drinking alcohol and the other negative things that are happening in the community. If she were one of the leaders that could make changes, one of the things she would ban is alcohol in the community and also other, for instance, drugs, if there was any way they could do that. this is one of the major problems we have in the community – a lot of people are doing it.
> **Z**: Why do you think that the kids are reluctant to learn...the *Innu Eitun* and things?
> **L**: Because there's less traditional activities being taught in the community because of the lack of certain persons...then we have...around the same generation are having families of their own at a very young age. There are ways to correct that – one is banning alcohol being brought in the community. She feels this is the major problem we have in the community. (Series 1, Vanessa Rich Interview, 2005)

Here, again, we see the connection between alcoholism and problematic leadership that was revealed by Katie Jack and Lea Rich in the previous section.[149]

Understood within the context of social breakdown described by Vanessa Rich, her seeming indifference to her own diabetes makes more sense. Although she never

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[149] Vanessa Rich describes the way that politics tear apart the social fabric of the community:

> **L**: There's a lot of things that should be done in the community because there's a lot of fighting and bickering amongst the leaders and stuff that's supposed to be happening in the community that's not happening because it's the leaders that are fighting among themselves and they cannot be fighting and put programs at the same time. Instead of fighting against, should be fighting with to fight for better programs, fight and work together. She wants to see leaders fighting for the same thing for the community members, not fighting against each other. One of the things she'd like is to have people get along with each other for a change within the community, get to know each other a little bit more better and then we'll be able to work things out together, if we work together.
> **Z**: What does she think is standing in the way of that?
> **L**: There's a lot of envy and jealousy and it's because of the leaders, when they're struggling, who wants to be leader, who's going to be our leader. If that was ironed out they would work better. (Series 1, Vanessa Rich Interview, November 2005)

articulates this tension herself, it is likely that she would view focusing on her own health problems – especially a problem like diabetes, which for a long time does not have extremely debilitating or obvious symptoms – as an inappropriate and selfish priority. When seen in this light, her rejection of lifestyle change recommendations, such as dieting and exercise, are a reasonable choice, not unreasonable non-compliance.

> Z: Did you find that you had to change things about the way that you lived when you found out that you had diabetes?
> L: No not really.
> Z: Do you eat anything specific, any specific diet that you have to be on for diabetes?
> L: (laughter) She is given a diet but she don't normally follow it. Because traditional food is quite different from food we buy at stores and she'd prefer food from *nutshimit*. Not only that...foods that contain a lot of other things too as well. She prefer eating wild meats than she would buying store bought items.
> Z: Do you mostly end up eating store-food?
> L: Mostly store bought foods because she eats wild meat whenever she can, whether she can buy it in the community or whether she's given it by her relatives or obtain it from other relatives. In that sense she do, but it's more store bought foods. (Series 1, Vanessa Rich Interview, 2005)

Not only does the clinical diet recommendation not take into account her wild food preferences,[150] but also it does not take into account economic realities and time-pressure:

> L: She does all the shopping and she goes up to Goose Bay co-op.
> Z: Are you able to get the kind of food that you want there? Is the food reasonably priced for you at the co-op?
> L: She usually tries to find items that are on sale. (Series 1, Vanessa Rich Interview, 2005)

Given that her primary shopping determinant is price, it is unlikely that Vanessa Rich would be able to afford foods recommended for diabetics (fresh fruits and vegetables, whole grains, low-fat, non-processed foods).

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[150] This is obviously not the case with all health care providers – David Penashue's doctor recommended that he eat wild food whenever possible. The fact that Vanessa Rich does not see her desire for wild food as positive with respect to diabetes indicates the problematic nature of the interaction between provider and patient. While David Penashue has the familiarity and confidence to ask questions, Vanessa Rich does not have either of these nor David's facility in English. The power imbalance between non-native providers and Native patients, even when an interpreter is present, is a significant issue (O'Neil, 1989).

Furthermore, even if she were able to afford these items she would still not likely purchase them, since she does not have the time to prepare them. She does all the house-care, shopping, and cooking for the family and as well she is often obliged to baby-sit. Let alone having time to exercise or cook special diabetic meals, she hardly has time to visit her friends:

> **L**: She feels better and happier in *nutshimit* rather than in the community.
> **Z**: Why?
> **L**: This is where she practice her knowledge of traditional and cultural activities. And she have knowledge that historically she practices it each time they are in *nutshimit*. The other thing too is sharing other camps in the bush, she said it brings you closer, you are able to visit your neighbours or neighbouring camps whereas in the community you don't see much of that anymore eh where people go and visit other friends.
> **Z**: Do you know why people don't visit in the community?
> **L**: (laughter) Maybe this is like in modern housing I don't know she said. And the other thing too is people don't have time because there is so much work involved just to maintain a house. Whereas in a tent it's quite different. And the other thing too is when you're left with your grandchildren too you can't go anyway. And there's a lot of this happening. (Series 1, Vanessa Rich Interview, 2005)

In sum, Vanessa Rich rejects the lifestyle approach not because of translation issues (though these are a concern), and not out of petulant non-compliance, lack of discipline or laziness, but primarily because it does not work with the realities of her everyday life in Sheshatshiu. First, the silent, personal nature of diabetes makes it less of a priority than more immediate, glaring, family and community issues – such as worrying about the safety of addicted children. Second, there are political, economic, social and time-pressure barriers to implementing the lifestyle change recommendations. While other participants' accounts added to the complex of barriers obstructing diet and exercise

recommendations,[151] all revealed that diabetes in general was less of a priority than other concerns. The other concerns are uniformly deep-rooted political, social, economic and cultural issues that the health care system does not address. For this reason, in order for diabetes care to become relevant and effective requires broad and profound changes in the community as a whole. Most of the informants thoroughly reject the lifestyle approach to diabetes – enacting their rejection in the dismissal of clinical descriptions and recommendations. This rejection and their continued illness is an embodied outcry against historic and current colonization and a refusal of the obligations required by the new public health of the "good citizen" (Petersen & Lupton, 1996, p. 65) .

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[151] The following remarks remind us of the integrated nature of the *nutshimit* lifestyle – a diabetic-friendly diet and exercise were a necessary part of daily life – versus the nature of community life, which is inimical to the appropriate diet and to exercise:

> Li: Then I found out I was diabetic. I lost my weight pretty fast. I was maybe a hundred-and-thirty pounds. But now I know how to control my diabetes. I learn a lot of things, new stuff, diabetic things right. But I couldn't do the way the white man do, like I cannot go on diet – I mean I'm supposed to. I couldn't do that at all because I like my food the way I am, it's very hard for me to...I was working there, last, this year when I was in Voisey, my sugar went right down because I was moving a lot when I was working, goes right up to two point four. My blood sugar was two point four. That's pretty low, I either had to take some sweet stuff, like a candies and drinks whatever right. To control it. So I was pretty well good when I was in country. (Series 1, Lionel Rich Interview, November 2005)

On top of the fact that Lionel does not accept dieting as a reasonable process, that he worked at Voisey's Bay and his blood-sugars fluctuated wildly while he was there is significant. To embark upon, and sustain, a diet and exercise regime requires relatively stable circumstances. The psychological and logistical disruption caused by travel back and forth between Sheshatshiu and Voisey's Bay is considerable. As well, the fluctuating physical demands on Lionel's body as he oscillated between concentrated bursts of heavy work followed by a significant time off in the community, would have been considerable. Maggie also referred to the lack of meaningful integration of diet and exercise in community life. For her, however, the strain dieting placed on her family life was a primary obstacle to dieting:

> L: That's another thing too see. She was following her diet like doctor has...[suggested]. When she was on this diet and she tried this on her grandchildren and children, they didn't like it! This is why she gave up...Everything she had to eat had to be boiled right, couldn't be no fat. And with the potatoes weren't allowed to eat, only half a potato... [I] ask if the doctor has suggested any exercise plans. [She said] 'Oh yeah, he did give her exercise.' But she planned to follow? She said 'No...she get plenty of exercise walking back and forth to work'...There's another exercise part. She said in nutshimit Innu they would exercise constantly whether you plan it or whether you...like...you just have exercise all the time. She said the only exercise you get here is walk to work and back. (Series 1, Maggie Interview, November 2005)

David Penashue

The contrast between David Penashue's response to clinical explanations and Vanessa's is striking. While Vanessa is unsure whether she has Type I or Type II diabetes, David Penashue goes into detail about various organs and bodily systems involved with diabetes:

> D: At first it was difficult to understand what was going on with my body and how my body works because back then I wasn't paying attention to my body the way it works inside. Before it was if I drink water this is how it goes if I eat this is how it goes, this is how I clean myself. But I was not more conscious the way my body goes inside. But after that how I was a diabetic person with my body – where your sugar goes through the system in your blood and your liver is the pump and if you have no insulin at all in your body the sugar stays there and increase your heart pressure and does a lot of damage without not realize it. (Series 1, David Penashue Interview, 2005)

His facility with this kind of information is enabled by various factors. First, he is fluent in English (I conducted the interview with David Penashue without the aid of a translator); second, he has the confidence to ask questions:

> **Z**: So when they told you that [all of the information above] did you have an interpreter or did the doctor tell it to you all in English.
> **D**: The doctor told me in English and I just asked more questions. (Series 1, David Penashue Interview, 2005)

David Penashue's confidence and familiarity with questioning is a product both of his ability in English and his training and experience as an AA sponsor, group director, and drug and alcohol counselor.

The degree to which David Penashue has accepted the lifestyle recommendations is apparent even in the manner in which he raised the topic of diabetes:

> **Z**: So what about fruit and vegetables is that something you get at or...
> **D**: Yeah I eat that because I'm diabetic person. I was diabetic for two

> years and a half so I watch everything that I eat right now I gotta to bring my sugars down. I gotta watch that and change my lifestyle, learn about how much I eat – bread, the meat, wild meat. What my doctor said to me was eat as much as you can of wild stuff. (Series 1, David Penashue Interview, 2005)

Rather than rejecting the idea of dieting, the mention of fruits and vegetables triggered David Penashue to begin talking about his experiences with diabetes. The fact that he refers to fruits and vegetables *and* wild meat is significant. First, it is significant that it was his doctor who suggested eating wild meat. This occurrence demonstrates, on the one hand, that there is some recognition at the clinical level in Sheshatshiu of the positive benefits of the *nutshimit* diet, but on the other hand, it raises questions about why more Innu diabetics did not talk about their doctors recommending a wild-meat diet.

Second, the reference to both fruit and vegetables and wild meat is significant because it demonstrates the possibility for adaptation. In other words, diet and exercise changes are one way to manage diabetes. These recommendations can be, and in some Native communities already have been, adapted to prioritize native foods. The broader facet of this shift is the acknowledgement that it is non-native, not Native, lifestyles that lead to diabetes. Hence, the fact that David Penashue has accepted lifestyle change recommendations does not mean that he necessarily accepts the conception of diabetes as the fault of the individual Native person who has been led astray by cultural beliefs. What is most significant about David Penashue's engagement in dieting and exercising, however, is that he is able to accomplish these changes – they work for him – and there are specific reasons for this.

One of the main reasons the lifestyle approach to diabetes works for David Penashue is that he had already been convinced, through his involvement with Alcoholics

Anonymous (AA), of the usefulness of positioning the individual as the primary site of change. David Penashue was trained as substance abuse counselor at the Charles J. Andrews treatment center, and is a firm believer – having himself been rescued by the AA approach – in the power of the individual to effect profound improvements in his or her health.[152]

> D: First of all it was more concentrating on yourself. Back then I didn't understand what it was, I thought when I stopped drinking – [things would be] absolutely perfect. But I still questioned myself. Why do I still have all this anger? Why am I still having all these problems? Why do I still feel like I want to drink? How do I do this, how do I vent?
>
> I learned a lot of things from the Charles J [the substance abuse treatment center]. The training, different people showing you how to concentrate on yourself how to vent your anger. You can just go outside and scream or you can just stay inside in one place and throw some things around or hurt yourself. So which one is more better, just go outside and scream or stay in and hurt yourself.
>
> Like fifteen years ago. People didn't understand what's alcohol. They just think that some old people don't know why their son is drinking, how come they don't stop drinking, how come every time they make money they got to drink? They don't understand the...it's not alcohol that's the problem it's the things you think about, what's bothering you inside. You got to attack those and deal with them, and deal with them in a professional way. (Series 1, David Penashue Interview, 2005)

David Penashue articulates the transference of this belief to his approach to diabetes as follows:

> **Z**: So what are your main worries about having diabetes?
> **D**: First I didn't really care, I was just trying to bring my sugars down. Then my girlfriend pushed me a lot. Told me I have to concentrate take my diabetic more seriously. First when I was diabetic I focused so much then suddenly I just lost interest. Now I gotta push myself. Like I was telling you you gotta teach somebody to stop drinking so that's what I'm doing myself. I once seen

[152] Mary, the only other informant who accepted the lifestyle approach to diabetes, is also a firm believer in AA. Like David Penashue she herself is a recovered alcoholic, trained and employed in the counseling field. Diabetes came up in conversation with Mary when she referred to her diabetes in passing to illustrate a point about the necessity of getting out of the role of victim in order to overcome addiction. She said that she had to stop seeing diabetes as controlling her and understand that she was in control of it, and that this was the kind of attitude one needs also to overcome substance addictions (Series 1, Mary Interview, November 2005).

> somebody...who's working with diabetic people. I asked questions, how do I do this? (Series 1, David Penashue Interview, 2005)

The similarity between the AA approach and the lifestyle approach is that both focus on the individual's role in achieving health. However, while the AA approach empowers individuals to heal themselves because they are the *only* ones who can, it is made very clear that the individual ought *not* to blame himself or herself for having become an alcoholic in the first place. In contrast, the lifestyle approach suggests not only that it is an individual's responsibility to change his or her lifestyle in order to manage diabetes, but also that the development of the disease in the first place was largely a result of the individual's poor lifestyle choices. Because David Penashue understands this dimension of individually-oriented approaches he can, as suggested above, simultaneously accept lifestyle recommendations and reject the conceptualization of diabetes as a lifestyle disease insofar as it suggests diabetes is the fault of individuals and cultures. In this way, though David Penashue sees his efforts to make lifestyle changes as the most effective way to manage his diabetes, this does not mean that he has internalized the belief that his poor lifestyle choices are the root cause of his diabetes.

One way that his training at Charles J., and having overcome his own addiction to alcohol, contributes to David's ability to implement lifestyle changes is that he has learned the skills to support himself through making and sustaining such changes. David Penashue's reference to will-power demonstrates this point:

> D: You got to have will power to do it. The doctor says just do it for twenty minutes one day. Twenty minutes walk. Everybody can do that. (Series 1, David Penashue Interview, 2005)

Also, his experience both as a counselor, and in receiving counseling himself, engenders a familiarity with sharing personal information, pushing for information and asking

questions. The ability to ask questions enabled David Penashue to gain an in-depth understanding of his diabetes and why he should try to control it:

> **Z**: So when you were diagnosed with it and they said ok you gotta watch what you eat and walk more, did you understand what they were saying did it make sense?
> **D**: At first it was difficult to understand what was going on with my body and how my body works because back then I wasn't paying attention to my body the way it works inside. Before it was if I drink water this is how it goes if I eat this is how it goes, this is how I clean myself. But I was not more conscious the way my body goes inside. But after that how I was a diabetic person with my body – where your sugar goes through the system in your blood and your liver is the pump and if you have no insulin at all in your body the sugar stays there and increase your heart pressure and does a lot of damage without not realize it.
> **Z**: So when they told you that did you have an interpreter or did the doctor tell it to you all in English.
> **D**: The doctor told me in English and I just asked more questions. They used to have a lot of programs for diabetic people at Mani Ashini clinic. Once a month they had meals for diabetic people. They told me that I was the only one, they were amazed my sugar was normal. Found that it just went back up again...but now I got to change it all again because I have a little girl...you gotta be strict with yourself. Doctor said to me you got to look at your grandkids, I might lose something [indicating a body part]. Like they said if you cut yourself your leg or your hands a little bruise or cut it takes so long to heal. Your body needs insulin. In your body you have insulin to work that you need to heal. If you get a cut it will heal. If you're diabetic it will take so long to heal you might lose your leg or hand or whatever the place that you cut. So you got to watch your eyes, your toes, your nail toes, fingers. Watch that you don't cut yourself. (Series 1, David Penashue Interview, 2005)

Hence, the role of AA in David Penashue's success with the lifestyle approach to diabetes is multifaceted: there is his belief in the individual's ability to enact change, the knowledge that he is capable of making and sustaining difficult behavioural changes himself, and his training in ways to initiate and support both himself and other people through the process of change. A further important facet is that his ability as a counselor

is what gives him employability.[153] The fact that he has steady and relatively well-paid employment is key for all of the reasons outlined previously.

Another key element to David Penashue's ability to make the lifestyle approach to diabetes work is, as indicated in the quotation above, his girlfriend's support. The following remarks further demonstrate the importance of a supportive family environment:[154]

> **Z**: what about the rest of you family, girlfriend and daughter?
> **D**: My daughter is not diabetic, I hope she is not going to be diabetic and my girlfriend is not diabetic.
> **Z**: So do they eat pretty much the same things that you eat? How does it work out for you having to watch what you eat and them not being diabetic?
> **D**: My girlfriend is really strict with herself what they can eat because she is really conscious of her weight. Me I just go in the cupboards, anything I can see! So like sugar for me, for her she's really strict with herself.
> **Z**: So she's almost better at it than you is that what you're saying?
> **D**: Yes!
> **Z**: So does she do more cooking or you?
> **D**: yes she does more cooking. And some wild meat that I want to eat I go to my mom's place because she cooks wild meat also. (Series 1, David Penashue Interview, 2005)

Finally, it must be noted that David Penashue has had some success implementing lifestyle changes *despite* the various challenges that the lifestyle approach does not take into account. As discussed above, for Vanessa some of these barriers were alcoholism, political strife, economics, and time pressure. For David Penashue, the main difficulty is work-related time-pressure and stress:

> **D**: Sometimes my sugars go really up and down and that's mostly stress. My sugar's going up and down.
> **Z**: Stress from...?

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[153] Mary is also employed through her experience and skills as an addictions counsellor.
[154] Mary also expressed the importance of having a supportive family, but in the opposite manner. For her, overcoming her family's resistance to her needs as a diabetic was yet another element of casting off the role of victim and assuming the role of someone deserving and in control.

> **D**: From work mostly and doing the things you gotta do. Doing them you lose yourself. You got to take care of your client first instead of yourself so you lose track. I got to speak for myself. I am diabetic person and I have to watch what I eat and I have to make that time to do those things that I need to go do it. Most of that time I got to take care of myself. I got to make a schedule for myself. A schedule to be a parent, a schedule to be with my woman – my girlfriend – gotta make time to help around with my grandparents. So where do I have the time. And also I have my work. (Series 1, David Penashue Interview, 2005)

One of the most significant characteristics of the challenges outlined by David Penashue and Vanessa – of discipline, of family circumstances, employment, and time-pressure – is that they are not specific to Native people but affect all diabetics, especially those who do not have economic freedom, or stable, flexible family or community circumstances. In other words, for many diabetics the lifestyle approach does not work for the same reasons outlined by David Penashue, Vanessa, and other participants: they do not have the money to afford appropriate food; they do not have time to prepare appropriate food, engage in exercise, and go for regular check-ups; their family is not supportive of a diabetic diet; and there are other family or community issues that seem more compelling than the personal matter of diabetes. Insofar as the lifestyle approach fails to address these barriers to an individualistic, self-care-oriented management regime it will continue to be ineffective for diabetic patients regardless of their race or ethnicity.

Conversations with health care workers at the Mani Ashini clinic reveal that non-Innu patients who come to the clinic, as well as the health care workers themselves, experience many of the same difficulties as the Innu participants in the study. The two women I spoke with are both themselves diabetic and both spoke about the difficulty of managing diabetes primarily in terms of economics, time, and family-pressure. When they spoke of their own food preferences, they did not contextualize them primarily as a cultural idiosyncrasy particular to Labradorians or Northerners, but as the habit of

economic necessity. On the topic of patients' reactions to being diagnosed with diabetes and recommended to diet, Innu and non-Innu alike were skeptical of "green stuff" – fresh fruit and vegetables. When they spoke about attendance at diabetes information sessions and presentations, attendance was equally sparse in North West River as it was in Sheshatshiu.

The best way to demonstrate this is to look at the conception that the Innu preference for "meat and potatoes" is culturally informed and an impediment to the effective work of dieting. The existence of wild meat, wild potatoes, and bannock in the pre-settlement Innu diet does make the transition to store-bought meat and starchy vegetables and foods more familiar than a switch to fruits and green vegetables, as is demonstrated in the comments below:

> L: I mean broccoli and other vegetables are also foreign to us. Only last twenty years we started eating those. We got our own vegetables. Got our own chickens (laughter).... It runs around, it comes when we need 'em! (Series 1, Maggie Interview, 2005)

However, a more important factor driving the prioritization of meat and starchy foods is that they are cheaper, more filling, and less perishable than fresh fruits and vegetables. A diet of meat and potatoes, rice and bread is a diet typical to many northern, rural and poor households. In the words of the receptionist at the Mani Ashini clinic, "those are the foods that make a family stretch" (personal communication 2006). In the light of economic realities, the consumption of cheap and filling foods like potatoes and rice is in fact a good decision, despite the long-term consequences of diabetes. Using the example of xerophthalmia, a disease of the eye which leads to blindess, Marvin Harris demonstrates that individuals and cultures often get blamed for making bad choices – having "bad thoughts" – out of a "failure to identify the rational causes of apparently

irrational foodways." Furthermore, this lack of understanding "can lead to ineffective or dangerous remedies" (Harris, 1985, 245).

With respect to patient non-compliance, that Innu and non-Innu alike do not faithfully follow treatment instructions is also apparent. The popular local artist Shirely Montague, who was born in North West River, has a song titled, "Diabolical Diabetic." The fact that she has written a song about diabetes demonstrates the prevalence of diabetes as a concern in the region, while the lyrics articulate the exact sort of "non-compliance," and indifferent attitude often attributed by clinicians to Native patients. For example, one of the verses goes as follows:

> I tamper with my dosage on a whim, I go out on a party, and I feel like being naughty, I just add some extra juice to my syringe. Oh, I'm a diabolical diabetic, I like to live a little recklessly, I've terrorized the neighbours... I've thrown caution to the winds, ignored advice from friends, seen my sugars go down low and swing back up again!... Still eat cake and custard, choose mayo over mustard, most days I seem to do just fine. (Shirley Montague)

In short, convincing people to engage in 'healthier lifestyles' that necessitate changing "newly acquired habits" associated with "automotive transportation, running water, packaged foods, and 'couch based' entertainment...is as difficult in Native...culture as it is in Anglo culture" (Hickey & Carter, 458). The similarities of experience between the Innu and the settler population, many of whom are Métis, go beyond food preferences, behavioural habits, and money-issues and into the broader experience of cultural disorientation and loss, and powerlessness as the singer/song-writer Jim Payne attests (listen, for example, to "State of the Nation").

Pointing out these similarities is not intended to suggest that there are no differences in the Innu and non-Innu/settler experience of diabetes. The socio-political situation described above in detail by informants like Katie Jack, Greg Penashue and

Joseph Pokue is a product of colonization and therefore particular to the Innu and life in Sheshatshiu. For settlers, on the other hand, there are other issues; the necessity of paying for medication for example (see footnote 98). The significance of these similarities, however, is that they reveal the problematic nature of the lifestyle approach to diabetes without the variable of ethnicity clouding the issue. When seen in this light, the limited potential of the culturally relevant approach to effect positive change for Native diabetes emerges more clearly.

The best way to achieve improvements in diabetes care in Sheshatshiu is to encourage land claims and self-determination negotiations to a speedy and successful (from the Innu perspective) conclusion. Given the centrality of the land to individual and community health, it is clear that the way must be cleared for that relationship to be rebuilt; this will require significant land ownership and self-determination. Given the central role of community politics in undermining individual and community health, it is clear that the current structures of community government must be changed to better fit the Innu conception of leadership and the longstanding tradition of family loyalty and autonomy; this too will require self-determination. The interviews placed diabetes in the context of a much broader experience of health and illness in Sheshatshiu. Diabetes was discussed as a concern, but one that was less of a priority than addressing community governance, inter-personal relationships, substance abuse, and validation of Innu culture. However, the very measures that participants suggested to deal with these primary concerns will also support the kinds of self-care practices and behaviour changes recommended by the clinical lifestyle approach.

Conclusion

On April 18th, 1989 Judge James Igloliorte acquitted the Innu of the charges laid against them by the Crown for 'trespassing' on Department of National Defense 'property':

> In my opinion, Mr. Olthius has presented a valid defence and also a successful one. We are not dealing with any land which has been the subject of divesture through treaties under the Indian Act.... Through their knowledge of ancestry and kinship [the accused] have showed that none of their people ever gave away rights to the land to Canada.... The provincial and federal statutes do not include as third parties or signatories any Innu people. I am satisfied that [the accused] believe their ancestors predate any Canadian claims to ancestry on this land.... All of the legal reasonings are based on the premise that somehow the Crown acquired magically, by its own declaration of title to the fee, a consequent fiduciary obligation to the original people.[155] It is time this premise based on seventeenth-century reasoning be questioned in the light of twenty-first century reality. Canada is a vital part of the global village and must show its maturity not only to the segment of Canadian society that wields great power and authority...but also to its most desperate people. The 40-year history of these Innu people is a glaring reminder that integration or assimilation alone will not make them a healthy community. By declaring these Innu criminals for crying "enough!" the Court will have been unable to recognize the fundamental right to all persons to be treated equally before the law. (Igloliorte in Wadden, 1991, p. 151)

The Innu occupation of the air-force base runway in 1988 and their continued protests after Judge Igloliorte's ruling are evidence of the Innu effort to decolonize themselves. Judge Igloliorte's ruling demonstrates that sometimes Native people can use colonial institutions as tools to support decolonization. However, Judge Igloliorte's ruling was subsequently overturned by Newfoundland's court of appeal (Wadden, 1991). In a series of court-cases Innu ownership of *Nitassinan*, instead of being championed by law, was portrayed as 'unrealistic' or a figment of history.

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[155] Samson also highlights the questionable nature of the provincial government's assumption of ownership over Labrador: "possession has been quietly incorporated into the mythology of Newfoundland" (Samson, 2003, p. 45).

The remarks of Bob Nutbeem, a columnist for the St. John's *Evening Telegram*, exemplify a typical response to Native efforts towards decolonization. Nutbeem felt that Judge Igloliorte ought to be 'reprimanded for his decision' and that the Innu ought to stop 'wallowing in history': "It's apparent to me...that history has passed them by, and unless they want to be captives in a massive aboriginal zoo, the will inevitably fall under the steamroller of time" (Nutbeem in Wadden, 1991, p. 153). Nutbeem's perspective is disturbingly reminiscent of government agent Walter Rockwood's.[156] The fact that in half a century neither the issues affecting the Innu, nor the prevailing perspectives on 'viable' solutions have changed, demonstrates that colonization is not a thing of the past. The Innu are not 'wallowing in history.' They are trying to extricate themselves from the real and current effects of colonial policies and institutions that continue to undermine individual and community health today.

The Innu participants' alternatives to the lifestyle approach and the culturally relevant approach are compelling examples of this effort towards decolonization. Their understanding of diabetes as a disease of settlement and community lifestyles acknowledges the unique political history stemming from provincial and federal jurisdiction over Newfoundland and Labrador, and the power imbalance between these two levels of government and the Innu. It also foregrounds issues of economic, familial, political and cultural autonomy, and points to the role of colonization in shaping the current marginalization of the Innu in these areas. The participants' certainty about the

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[156] The same sense of fatalistic, inevitable destiny characterizes Rockwood's remarks nearly half a century earlier:

> One fact seems clear, - civilization is on the Northward march, and for the Eskimo and the Indian there is no escape. The last bridges of isolation were destroyed with the coming of the airplane and the radio. The only course now open, for there can be no turning back, is to fit him as soon as may be to take his full place as a citizen in our society. (Rockwood in Samson, 2003, p. 18)

need for cultural validation demonstrates firstly, that far from being an obstacle to achieving health for diabetics, rebuilding Innu culture is the key to improving individual and community health overall. Secondly, the results of cultural validation will also achieve the aims of the lifestyle model, while avoiding the individualism of the clinical approach.

Many non-Innu feel that the passage of years has dispersed colonial responsibility for the Innu plight (even though in the Innu case colonization only occurred fifty years ago), and that the source of Innu ill-health is now only the Innu themselves – their addictions, their corruption, their lack of capacity. It is true that the current incarnation of colonialism in Sheshatshiu is multi-faceted: *akaneshau* advisors continue to shape Band Council and Innu Nation policies, *akaneshau* continue to manage Innu money, colonial institutions such as the RCMP, provincial school systems, and health care continue to dominate the physical and political landscape of Sheshatshiu. At the same time, colonial interests are now upheld by the Innu themselves – politicians, health care workers, industrial liaisons – and Innu community members state that at this point their greatest social issues stem from within and can be solved by no one but themselves. As discussed in chapter 1, substance abuse and related social breakdown, the destabilization of Innu culture, and the current political structure are the legacy of colonialism. Despite the passage of time, and taking Innu involvement into account, the Church, both levels of government, and the Innu are all responsible for the current situation in Sheshatshiu:

> I have told you what I think personally. I too blame the Whites. The blame rests firstly with the priests who went from place to place in the country gathering the people to come into one place. And then the government came and tied the rope on us. We still can't untie ourselves today. (Sylvestre in Andrew, A. 1984)

When we talk about diabetes as a disease of colonization we must understand that colonization, like culture, is a dynamic process. Deanna Nyce, chief executive officer of the Nisga'a University College, refuses to see Nisga'a history only in terms of colonization, but argues that the Nisga'a have instead engaged in incorporation,[157] a "long-standing strategy for dealing with the realities of living in colonial relations with the Canadian state" " (Kelm, 2004, p. 336). Like the Nisga'a, the Innu have not been passive victims of colonization; they too have actively engaged with colonial institutions to try to improve their situation.[158] However, the current health status of people in Sheshatshiu indicates the difficulty of incorporating the tools and systems of the dominant "EuroCanadian society [which] was intent on changing First Nations, on eradicating Native culture and replacing it with their own" (Kelm, 2004, p. 336).

The Innu interviewed in 2005 showed the major sources of ill-health in Sheshatshiu to be their own political system, political leaders, and difficulties with substance abuse. With respect to diabetes specifically, it is the politically determined unequal distribution of resources that drives many Innu to substance abuse, and keeps

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[157] As defined by Kelm:

> incorporation functions paradoxically through a process, described by Sahlins, as one where strategic cultural change encourages political resistance which, in turn, ensures cultural survival. By taking on some parts of colonial culture, indigenous people evince agency and in so doing refuse the inert, subordinated self-image ascribed to them by the dominant society. (Kelm, 2004, p. 336).

[158] The Innu engaged in many of the same practices as the Nisga'a such as adopting and renaming foreigners, engaging in religious syncretism, convincing the priests to wear Innu garb and pay respect to Innu sacred objects in the Church. This selective process is highly frustrating to many health care workers who feel that Native patients misuse, overuse, and abuse the health care system. These individuals see the waste of resources and personally suffer from 'unreasonable' patient demands' and conclude that Native people, rather than skillfully manoeuvering within the constraints of the colonial power imbalance, are simply unable and unwilling to properly care for themselves. With respect to diabetes, the selective acceptance of medical recommendations is an example of incorporation: many Innu do take medication, but do not believe in altering their lifestyles – an *akaneshau* cure for an *akaneshau* disease. David Penashue and MMO *have* incorporated lifestyle changes, but their willingness to do so is the result of their successful incorporation of yet another colonial tool – the alcoholics anonymous technique for overcoming addictions.

them from adopting 'healthier' lifestyles and engaging in self-care practices that are pivotal to diabetes management. Although diabetes is undeniably a concern for many Innu in Sheshatshiu, individuals' own addictions to substances, the communal social problems arising from substance abuse, and the daily strain of trying to navigate uncertain livelihoods in substandard conditions take precedence over a concern with diabetes. The current role that colonial institutions play in the diabetes disease process is to keep enforcing and supporting a structure of government that perverts the long-standing social structure of the Innu into corruption and nepotism, which in turn lead to community and family break-down and self-destructive behaviour inimical to self-care practices.

It is crucial to point out that the fact that the Innu loosely define leadership and have strong family ties is not inherently negative. The Nisga'a way, or the Inuit way for that matter,[159] is not better than the Innu way, it is simply a better fit with colonial forms of government. Similarly, Innu bodies and food beliefs[160], like those of other native groups, are not inherently unhealthy, but have been made so by the colonial practices of

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[159] As discussed in chapter 1, in contrast to the Inuit, the Innu are portrayed as disorganized and incapable of successfully running programs. Seen through a decolonizing lens, the Inuit are not more capable than the Innu. Rather, each group has followed a different path: while the Inuit have been willing and able to incorporate the colonial health provision paradigm, the Innu resist colonial institutions. The Mushuau Innu protest against the justice system in 1993 is a powerful example. Larry Innes, long-time advocate for the Labraodor Innu stated: "Once again the Innu have been jailed for standing up for their rights" (Innes, 1995). Katie Rich, then chief of Utshimassit, spoke from the Newfoundland Supreme Court in Goosebay:

> When we try to stand up for ourselves, we are branded as criminals and put in jail.... My people have been crying for a long time. No one has listened. We keep saying the same thing over and over. I didn't think if I wrote a letter about the conditions and conduct of the court circuit that anyone would have listened. We took this action [blockading the runway to prevent the Judge from landing in the community] because we felt we had to do something. (Rich in Innes, 1995)

[160] Such as a preference for meat and a preference for multiple small meals rather than three large meals. In fact, health care practitioners who specialize in insulin-response mechanisms do not recommend eating three substantial meals, and suggest instead eating consistently but in small amounts is the best way to balance blood-sugars and insulin responses (Dr. A. McClellan, personal communication, 2006; Dr. M. Werb, personal communication, 2004).

the Canadian government (Kelm,1998, p. xix; Samson & Pretty, 2005). It is the colonial imposition of Band Council and elected government that has warped the perfectly healthy and functional characteristic of family affiliation into the monster of 'nepotism.' When the Innu attain self-government, and if they are allowed to define for themselves what that government should look like, the corrupt and dysfunctional 'nepotism' can be transformed back into a workable form of social organization (Bellow, 2003).

Diabetes prevention programs will not be able to contribute significantly to the amelioration of diabetes in Sheshatshiu until the political sources of ill-health are addressed. Maggie offers a solution to the political problems in Sheshatshiu that demonstrates the viability of incorporation and respects the Innu desire not to be taken "back into the past": to instate a government that includes four equal representatives from each of the four clans simultaneously respects the 'strong and persistent social structure' of the Innu *and* allows the Innu to continue living in a community that can offer the amenities of modern technology.

With self-government the political sources of ill-health can be addressed and an unfettered process of cultural validation can begin. As discussed in chapters 4 and 5, cultural validation is key to diabetes prevention and management. It is through cultural validation that meaningful physical activity; an emphasis on eating *nutshimit mishum* rich in vitamins, minerals, and proteins, and low in processed sugars and carbohydrates; and an integrated view of food, health, and medicine will become the norm again for the Innu. Once this occurs, the fundamental elements of the lifestyle approach to diabetes will be taken care of. It is at this point that emic studies of cultural differences between Innu patients and non-Innu providers will become useful, for, as Kelm points out, "complete

disengagement from the dominant culture in the Canadian context where the indigenous societies have been absorbed by the state is not possible" (2004, p. 336). Self-government will not solve the health problems facing the Innu overnight. Even once the health profile of Sheshatshiu improves, the services of health care workers and the tools of biomedicine will continue to be necessary and useful to the Innu (Benyshek et al., 2001; O'Neil 1989; Sarsfield 1988). There will continue to be a relationship between Innu and non-Innu health care providers and consequently a need to understand and navigate cultural differences. However, within the broader context of cultural validation, the work of cultural relevance in the clinical setting can be understood to be only a small part, not the entire definition and limiting bounds, of Innu culture. So what, then, is the value of researching diabetes in Sheshatshiu?

> But where danger is, grows
> The saving power also.
> (Hölderlin in Heidegger 1962/1977, p. 28)

"Diabetes has emerged as one of the main public health threats to Native populations in the second half of the 20th century" (Macaulay 1997, p. 779). Studying diabetes, a non-native researcher risks promulgating narrow colonial visions of medicine and of Native bodies as inevitably, hopelessly and increasingly sick. And yet diabetes, in its very costliness, its epidemic proportions, its elusive etiology, its socio-cultural and economic dimensions, and its unceasingly difficult treatment requirements, starkly illuminates the way forward. Diabetes demands a paradigm shift in the Canadian approach to health. It demands that medical discourse not continue to carry on in a political and economic vacuum. Diabetes cannot be successfully addressed by the medical system as it is currently defined, and it makes sense that Native people reject behaviour-change

recommendations stemming from the Western culture and lifestyle out of which diabetes has sprung. In Sheshatshiu, diabetes *can* be addressed by Innu culture.

In the face of their political invisibility, and throughout their struggle to create a workable relationship with the provincial and federal governments, the Innu have consistently fought for their right to be Innu. It is this fight that will lead to the improvement of diabetes in Sheshatshiu. This thesis does not provide a novel, clever, complicated model for an improved diabetes program for the Innu of Sheshatshiu. It is yet another voice adding into the chorus of people 'crying enough' (Innes 1995; Igloliorte in Wadden 1991). Non-Innu people – priests, scholars, and community members – and the Innu themselves, have been arguing since settlement for greater Innu autonomy. 'We keep saying the same thing over and over,' 'no one has listened' (Rich in Innes, 1995). To suggest that the way to Innu health is through validation of *Innu Eitun* and *nutshimit mishum*, encouragement of *nutshimit* programs like the Outpost Program and the *Tshikapisk Foundation*, transfer of education to Innu control, land-ownership, and self-determination is not new. The best answers are often painfully obvious – our unceasing efforts to find better, smarter solutions are a frenetic cover-up of our unwillingness to admit that we may just have to undo all the work that we "always justified as being 'for the good of mankind'" (Tuhiwai Smith, 1999, p. 24). Canadian society must commit itself as wholeheartedly to dismantling the colonial systems boxing in the Innu as it was to settling and assimilating them fifty years ago.

Many Innu feel that the key to regaining health in Sheshatshiu is for Innu people to start to talk to each other and like each other again:

> I think the people who are the leaders should teach the whole community how we are going to work together instead of just fighting each other.... The way it is, no

> one is perfect in this world. I can't say I'm perfect.... Seen clergies, doctors, priests, whatever, no one is perfect. But if we can work together the things would be changed in the community. The time will change the whole system will change. If we can look towards each other every day in our lives – how did we deal with our Elders before? This is how we should go back on this again. This is how we should work together. It is very hard to do it but in slow part. I think the people in the community need to learn how to deal with the others. There's a lot of things they're saying each other in a bad way – dirty stuff and that sort of thing. That's not the answer to the community, to the people of the community. Let's work together. I got no say in if the white people comes in and says to me – .... When there's a meeting going on in community always say to myself in public why can't we work together rather than just fight each other? How can we heal our community? Let's look – we have a good community, we have a nice community, let's work together and more and work more specific in our community. Rather than just fight around. Baby stuff, baby stuff that's all. (Series 1, Lionel Rich Interview, 2005)

Many Innu do not feel that the *akaneshau* can help them in this process of re-learning how to work together and respect one another – of uncovering again the 'omnipresence of respect' in their culture. Although this is true on many levels, I believe there *is* a role for *akaneshau*.

Poverty and political strife, the sources of animosity in Sheshatshiu, grew out of and continue to be aggravated by colonial domination. Today "research within late-modern and late-colonial conditions continues relentlessly and brings with it a new wave of exploration, discovery, exploitation and appropriation" (Tuhiwai Smith, 1999, p. 24). It is a telling fact that Tuhiwai Smith dedicates a section in her book to outlining the "Ten Ways to be Researched (Colonized)" (1999, p. 99). The projects she uses as examples are current, and yet their motivations "are not new...Indigenous knowledges, cultures and language, and the remnants of indigenous territories, remain as sites of struggle" (1999, p. 99). Native bodies continue to be "made" by colonial medicine (Kelm, 1998, p. xvii), science continues to dehumanize Native people (Tuhiwai Smith, 1999, p. 26), and

colonial political and legal systems continue to "deny them further opportunities to be creators of their own culture and own nations" (Tuhiwai Smith, 1999, p. 1).

This thesis is an effort to understand my role in the historic and current colonization of Canada's Native people, and to contribute to their decolonization. Tuhiwai Smith states that from the Native perspective decolonization "demands that we have an analysis of how we were colonized, of what that has meant to our immediate past and what it means for our present and future" (1999, p. 24). Although it is essential that *Native* intellectuals, artists, academics and leaders analyze, re-interpret and re-write history, as a member of the colonizing culture I *am* involved in the process of both colonization and decolonization, and it is my desire and duty to 'do my homework' and contribute to "alter[ing] the dominant view that our relations with the First Nations were ultimately largely benevolent" (Kelm, 1998, p. xvii). Judit Moschokovich states that "it is *not* the duty of the oppressed to educate the oppressor" (in Kelm 1998, p. xviii). And, as feminist theorist Gayatri Chakravorty Spivak attests, it is my task to "learn what is going on" and to undertake "a *historical* critique of [my] position as the investigating person.... When you take the position of not doing your homework – 'I will not criticize because of my accident of birth, the historical accident' – that is a much more pernicious position" (Spivak in Kelm 1998, p. xvii italics in original). I have heard stories and listened – relying on these stories to inform my approach to working with the Innu of Sheshatshiu. But I have only begun to educate myself and to think about how I can best contribute to decolonization. I will have to continue to listen, to reflect on my own lifestyle and the ways that I too have been colonized, in order to ensure that my actions work towards decolonization, not against it. Maintaining openness and reflexivity in the

search for decolonizing methodologies, and actively working to educate and dismantle colonial systems, is the crucial role that *akaneshau* can play in supporting the Innu process of regaining their health.

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Interview Questions (developed by Louis Rich, Zoë Nudell, Lea Rich, and Bernadine Milley)

1. Do you think your children are being taught well in school?
2. What things can be done to have a better school curriculum?
3. Do you think that there's enough qualified Innu teachers at our school?
4. How important do you think the breakfast program is at school?
5. What do you think we could create for a better learning environment for school?
6. Do you read newsletters concerning the Innu?
7. Do you listen to the community radio?
8. Do you practice your cultural and traditional ways of living?
9. What do you think about the outpost program?
10. Do your parents still practice their traditional medicine?
11. Do you have any knowledge in traditional medicine?
12. Do you encounter racism among our neighbouring communities NWR and Goose Bay?
13. Do you feel there's a housing shortage?
14. Do you own a home?
15. What can be done to have adequate and sufficient housing?
16. What social problems do you encounter in the community?
17. Do you feel our leaders are doing enough to motivate the younger generation?
18. What programs should leaders produce to motivate our children?
19. How do the politics in the community affect you?
20. What do you think of the new organizations that are popping up in our community? (Eg. family resource center, new rcmp station, group home, clinic)
21. What kind of resources were available before these organizations were here?
22. Do you have any health problems?
23. Are your health needs taken care of in the community?
24. Name one thing you would change about the way you are living in the community
25. If you were one of the important leaders, what would you do to change the community?

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