PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the

WORLD HEALTH ORGANIZATION

CANADIAN SOCIETY FOR INTERNATIONAL HEALTH /
LA SOCIÉTÉ CANADIENNE DE SANTÉ INTERNATIONALE

• INDIGENOUS PEOPLES & HEALTH • WORKSHOP '93 •

• PUEBLOS INDIGENAS Y SALUD • TALLER '93 •

Villa Maria, Winnipeg, Canada
April 13-18, 1993

FOREWORD

From April 13 to 18, 1993, at the invitation of the Pan American Health Organization, representatives of the Indigenous Peoples of the Hemisphere gathered in Canada, in the city of Winnipeg, Manitoba, to discuss the health status of their own community at the beginning of the International Year of the Indigenous Peoples of the World. This was the first gathering ever held at the hemispheric level which was designed to allow Indigenous leaders and their potential development partners to consider priority Indigenous health requirements, a full 500 years after Columbus first came to America.

This Report records this historic event in Canada's two official languages and in Spanish, the language common to the majority of participants. Except for the recommendations, which are reproduced first, the Report is presented in chronological order. The text is a slightly amended version of the Summary of Proceedings which participants took home with them on Sunday, April 19. During the closing session, participants had given themselves six weeks to review the Summary Report. What you now have in hand is the outcome of this process: Rapporteur Myrna Kay Cunningham Kain, M.D., has considered all submissions for amendment and integrated them as needed.

A few of the many photographs taken during Workshop '93, along with the content of the program portfolio distributed on site, have been reproduced in an attempt to let readers share the ambience and conviviality of the event. Selected participants were interviewed (Chapter 5) on the same themes in order to underscore the need to differentiate solutions for identical problems according to regional and cultural imperatives. Participants' addresses, phone and fax numbers are included, so that interaction and networking can continue to grow among Indigenous communities. In the same spirit, the list of documents which were produced for the event or which participants brought with them to Villa Maria has been printed: Workshop '93 was meant to be the start of a development partnership in matters of health rather than an end in itself.

The Pan American Health Organization, Regional Office of the World Health Organization, and the Canadian Society for International Health, PAHO's technical representative in Canada, wish to thank the international, national and provincial agencies and organizations that co-sponsored Workshop '93; their names are listed in Chapter 2 of this report.

Very special thanks to the members of the Host Committee, the volunteers they recruited, the Indigenous Partners at regional, national and local levels who caused it all to come together and thus helped participants gain in understanding and solidarity.

Carlyle Guerra de Macedo
Director, PAHO

Sheila Robinson
President, CSIH

CHAPTER ONE: WORKSHOP RECOMMENDATIONS

As amended by
Rapporteur Myrna Kay Cunningham Kain, M.D.
on the basis of written suggestions made by
Participants to the text adopted in principle
at the closing session in Villa Maria

Preamble

The Indigenous representatives of the continent have held their first meeting with representatives of PAHO, governments, and non-government organizations, in hopes of launching a dialogue on the health status of Indigenous peoples. The workshop was an important opportunity for all the participating agencies and organizations to analyze the knowledge and experience of Indigenous peoples in health, to search together for mechanisms to improve the dire health conditions in Indigenous communities, and to define specific priorities for future action.

Workshop participants hope they have taken a first step to facilitate the systematic participation of Indigenous peoples in the future definition of health policies regarding their communities. These policies must reflect cultural elements of the Indigenous world view, thus making it possible to develop new models of health practice that allow space for Indigenous healing practices alongside western medicine and popular medicine. The ultimate purpose of this shift is to enable Indigenous populations to improve their health condition.

It was noted that the International Year for Indigenous Peoples is an opportunity for states to develop integrated policies to improve Aboriginal health.

The recommendations of this workshop recognize differences in the contexts and situations in which the struggle for Indigenous health has occurred in different countries. The different contexts include governments, institutions, Indigenous organizations, non-government organizations, and especially local communities. The recommendations acknowledge cultural differences among communities, while insisting on the importance of working together on shared problems.

It is important to note that this four-day workshop is a beginning, and does not mean that non-Indigenous participants become experts in the field of Indigenous health. The workshop was an opportunity to share information and begin to build mutual understanding and respect. Participants emphasized the need for PAHO to continue sponsoring dialogue and taking a proactive stance in encouraging member states to address the health crisis facing Indigenous peoples.

Principles

A holistic approach to health must be respected and promoted, based on the Indigenous understanding that there are four aspects to health: spiritual, physical, emotional and mental.

Self-determination, the right to participate in defining and implementing health policies; **systematic participation**, both within Native communities and organizations and towards outside institutions that have mandates concerning Indigenous people; **cultural revitalization**; and the right to retain Indigenous languages, traditions, customs and religions were all recognized as central principles. Indigenous cultures must be the basis for building alternative models of health in development.

Finally, participants agreed to a principle of **reciprocity** which recognizes that we are all dependent on one another to achieve our health and well-being. All the peoples of the Americas must work together to ensure the health of Indigenous communities.

Considerations

- Poverty is a common problem faced by all Indigenous communities, and is a primary cause of ill health. Priority issues include a lack of protection; lack of services; social diseases like alcohol, suicide, drug abuse and violence; war; environmental pollution; lack of facilities; epidemics; toxic chemicals; disappearance of entire nations; poor nutrition; lack of land; urban migration and overcrowding; and massive unemployment — all of which can be summarized in the word ***injustice***. This history of injustice was imposed on Indigenous peoples throughout a long period of invasion and colonization.
- Discrimination and the loss of Indigenous identity have had severe detrimental effects on health. Today, this manifests in the unwillingness of some governments to recognize the existence of Indigenous peoples, and their basic rights.
- Indigenous peoples have had a long history of "rationed health services", which have generally been limited for physical, social, economic, geographic or cultural reasons. Access to services ultimately depends on political will and the availability of economic resources, on access to information, and on the development of health services that reflect the unique needs of Indigenous peoples.
- Ultimately, good health will depend on Indigenous control of Indigenous health services: any other model will run into political and administrative barriers, created by officials whose prime interest is in organizing programs, spending or saving money, not in improving the health status and ensuring the well-being of Indigenous communities.
- The struggle of Indigenous communities and organizations is aimed at reclaiming a space from which First Peoples will be able to design and apply strategies to guarantee real community

participation and application of Indigenous expertise and wisdom. Indigenous communities possess their own cultural values and knowledge that should be the basis for health and development.

- Traditional medicine must not be subordinated to the western health system, but must be placed on a par with it and with popular medicine. There is a need to arrive at a balance between concepts of physical and spiritual health, and between concepts of healing and curing.

RECOMMENDATIONS

Health Policies

- In response to the alarming health situation confronting Indigenous peoples of the continent, the workshop recommends that PAHO and member governments declare a state of emergency immediately in specific communities and populations. This should lead to joint action between health agencies and the affected communities, involving strategy development and immediate action to overcome the most urgent health problems facing Indigenous populations. The health of displaced and dislocated Indigenous peoples, and of cross-border populations, should be identified as an urgent issue.
- The development of health programs and projects in Indigenous communities be based on the use of local resources, and on a process of planning, implementation and evaluation that provides for systematic community participation.
- In defining new approaches to health, PAHO and governments recognize intercultural factors as key determinants of living conditions.
- Joint working commissions between communities and government agencies precede any development of policies and programs that affect Native people.
- An ongoing effort will be required to defend Indigenous lands, improve nutrition and housing, and prevent environmental pollution. National strategies aimed at developing legislation that recognizes Indigenous needs and entitlements and provides for adequate enforcement will be implemented. It must be recognized that without political will, legislation is useless.
- Member states recognize Indigenous medicine, legalize it and provide appropriate support for Indigenous healers and their organizations, and take measures to put an end to repression of Native healers. PAHO provide assistance and encouragement for legislative initiatives described above.
- In order to prevent the loss of cultural identity, governments guarantee the recovery, protection and preservation of sacred Indigenous sites.

- National and international institutions as well as governments recognize and make use of the experience of Indigenous peoples in managing and conserving the natural environment.
- International agencies and institutes, governments, non-government organizations to mobilize economic resources for the implementation of the recommendations presented in this document. Governments to ratify and implement relevant charters adopted by the International Labour Organization and other international bodies.
- United Nations task force on Indigenous populations approve the International Declaration of Rights of Indigenous Peoples. Governments to ratify and implement Agreement 169 of the ILO, as well as Chapter 26, Agenda 21 from the World Summit on the Environment. PAHO to encourage member governments to implement resolutions regarding the health of Indigenous children approved by the UNICEF World Children's Health Summit.

Human Resources

- Strategies be designed to ensure that non-Indigenous health workers involved with the health of Indigenous communities develop favourable attitudes of understanding and respect for the culture, practices and beliefs of Indigenous peoples.
- Universities and other educational institutions assume responsibility in the promotion of cultural sensitivity and cross-cultural training within their programs. Educational institutions to provide special opportunities for Indigenous people to enter educational programs, both as teachers and as students. Communities to be consulted, both in the selection of students and in the design of cross-cultural education programs within educational institutions.
- States undertake strategies for the deployment of health workers to inaccessible and isolated areas, including the use of incentives. Incentives also to be provided to ensure that health workers of Native ancestry from isolated settings return to their home communities after they are trained.

Research

- All research related to health be discouraged unless it is planned and conducted with the full and total participation of Indigenous communities in all stages of the process.
- PAHO stimulate and actively support participatory research related to the health of Indigenous peoples. Research topics should be put forward by the communities involved. Both the process and the results of research should be shared with local communities and regional organizations. Research in Indigenous communities must provide for a mechanism that ensures local control.

- All research in Indigenous communities respect international codes of ethics.
- PAHO, governments, and other agencies support the development of local knowledge through participatory action research.
- PAHO support collaborative research projects, symposia, special publications, and networking among Indigenous people to develop and disseminate knowledge in traditional and Indigenous medicine and health.
- PAHO and member states tighten control procedures and establish new regulations to prevent the exploitation and destruction of plants and medicinal substances by pharmaceutical corporations and other interests.

Health Programs

- PAHO and ministries of health establish a surveillance system to track the health status of Indigenous peoples. Establish mechanisms that enable Indigenous peoples to participate in deciding the kind of information to be gathered, and the use it will be given by Indigenous peoples and others.
- Develop epidemiological indicators that are specific to the living conditions and health of Indigenous peoples.
- PAHO promote and support the organization of exchange opportunities for traditional healers, researchers, and other health workers with an interest in Indigenous health.
- Health programs and projects be built on respect for the culture, values and traditions of Indigenous peoples, and acknowledge geographic and social distinctions among communities.
- PAHO together with member governments develop particular strategies in designing health policy and programs for Indigenous communities that straddle national borders.
- PAHO act as a catalyst with member governments to ensure that Indigenous health programs are developed with the involvement of the communities, and that these initiatives help to develop local capacities and increasing autonomy.
- Special priority must be attached to programs devoted to the health of Indigenous women, children, elders, adolescents and dislocated Native individuals.
- PAHO to support, promote and disseminate information about ongoing efforts that attempt to articulate rapport between traditional and western medicine.
- PAHO promote dialogue and exchange on primary health care experiences and Indigenous local health systems that address the health needs of Indigenous communities, in order to define modifications appropriate to Native communities.
- PAHO develop a Native health communication and information dissemination strategy.

Follow-Up

- A commission of Indigenous delegates be formed to follow up the recommendations of this workshop and support PAHO's efforts to promote Indigenous health.
- The commission of delegates ensure that the recommendations of the workshop are presented to the next meeting of Pan-American health ministers. PAHO ensure that the subject of Indigenous health is on the agenda for the meeting.
- Workshop delegates present the workshop recommendations to the health ministers of their respective countries, as a means of supporting PAHO's work on Indigenous health.
- PAHO, on behalf of Indigenous peoples of the Americas, include Indigenous health in the next World Health Assembly.
- Establish an international task force to support and follow up on actions taken in different countries on Indigenous health.
- Establish an information network to help delegates and other interested parties maintain contact on specific issues pertaining to Indigenous health.
- Workshop participants call upon Indigenous members of Parliament to bring forward legislation in support of Indigenous health and traditional medicine.
- The aforementioned commission ensure that health of Indigenous peoples is on the agenda of all national and regional fora relevant to Native health and well-being, including the upcoming United Nations Conference on Human Rights.

Monitoring Commission

The following participants were elected by their peers to follow up on the recommendations of Workshop '93 and support PAHO's efforts to promote Indigenous health:

for Central America and the Caribbean
Dr. Myrna Cunningham, Nicaragua, Chairperson
Ms. Lucilla Barrios, Mexico
Mr. Kenneth Davis, Guyana

for South America
Senator Anatolio Quira, Colombia
Ms. Yolanda Nahuelcheo, Chile

for North America
Ms. Jean Goodwill, Canada
Mr. John Sunchild, Sr, USA

CHAPTER TWO: Program Portfolio, Workshop '93

As distributed at the registration desk
in Villa Maria

OBJECTIVES

- To collect, review and analyze information regarding the health status of the Indigenous peoples of the hemisphere as well as the organization of health care approaches that are available to them;

- To help establish links between and among individuals, organisations active in the field of indigenous health, PAHO and other stakeholders;

- To help prepare a set of hemisphere-wide recommendations to assist the Governing Bodies and the Secretariat of PAHO to define policy in this field and to consider how its own policy formulation process can establish the Indigenous peoples' full and reciprocal participation in decision on policies and programs which affect them;

- To promote the inclusion of the practice of traditional medicine in the health policies of the countries of the hemisphere.

WELCOME...

. . . to the first hemispheric gathering ever held to consider indigenous health needs. Workshop '93 is one of the first international events to be held during the International Year of the Indigenous Peoples of the World. It is unlike any other workshop on health needs and priorities: this is the first opportunity which representatives of the First Nations of the Americas and their development partners have had, since Columbus came to our shores, to jointly consider indigenous health issues.

The Workshop results from a decision of the Directing Council of the Pan American Health Organization (PAHO) to emphasize indigenous health matters in the Organization's regular programming. Because the issue is technically and politically complex, the Executive Committee's Planning and Programming Sub Committee directed that the organizers consult as widely as possible with indigenous leaders and their development partners in organizing the event.

The planning structure of Workshop '93 reflects this mandate and illustrates the deep shift in approaches to decision-making which all of our societies in this hemisphere are experiencing. The six member Planning Committee is a microcosm of the institutional, the intergovernmental and the non-governmental realities of the Americas. Two of its members give voice to the institutional and administrative streams within PAHO; one member presides over an international non-governemental body and the three others are broadly representative of the indigenous organizations and communities of South America, the Caribbean and North America. Their names appear elsewhere in this program.

It may be worth noting that the PAHO technical representative in Canada, the Canadian Society for International Health (CSIH), is a non-governmental body. This in itself is a sign of the times: never before has PAHO contracted an NGO to be its technical representative in a member country. CSIH assumed the role of Secretary to the Planning Committee when it agreed to take responsibility for the organization of the Workshop, just about a year ago this week.

At their very first informal discussion of the matter in February 1992, PAHO and CSIH agreed that the indigenous peoples of this hemisphere should determine, jointly with their development partners, what the agenda of Workshop '93 would be. It was a deliberate choice of the Planning Committee to proceed on a very open consultative basis and to recruit expert volunteers, indigenous and other, to serve as advisers to the Secretariat. The list of members of this fax-driven Sounding Board is part of the fact sheets in this document.

Efforts were made throughout the planning period to reach out to development agencies, institutions, governments and associations knowledgeable about, and interested in, indigenous health. On all these fronts, Workshop '93 organizers report some success.

Co-sponsorship by international and regional institutions has grown from three in February 1992 to six on opening day. At national level in Canada, contributions in cash and kind by agencies and departments of the Government have given Workshop '93 the support needed to just about balance budget projections.

Canada has seven National Indigenous Associations: three women's groups and four political organizations. For Workshop '93 purposes, they formed a partnership with the Secretariat. Native Partners all participated in the Sounding Board, providing advice and expertise as needed. The four Indigenous groups in Winnipeg, working with Manitoba Health, formed a Host Committee which accepted responsibility for all local arrangements. With very modest means and a lot of creativity and enthousiasm, they have established that volunteerism is alive and well in the Manitoba Aboriginal community. You will find a fact sheet on Native Partners and Host Committee members in this document.

The planning process which has led to this event reinforces the organizers' belief that open dialogue on indigenous health priorities during Workshop '93 should help frame recommendations on which PAHO and its member countries can base future policy and programs to improve indigenous health status. Workshop '93 is thus a first step in an ongoing process which can only succeed as we learn to work together. All those who are committed to the improvement of indigenous health status in this hemisphere will agree that time has come to honour the wisdom embedded in indigenous cultures in respect of health and well-being.

It is therefore imperative for Workshop '93 to consider the establishment of appropriate reciprocal means to respectfully listen and learn in order to turn this wisdom into practice for all inhabitants of this hemisphere, indigenous and other. The follow-up to this Workshop should create opportunities over the next several years for indigenous leaders to come together with their development partners, in different locations in the Americas, to implement the corrective action which we recognize is needed.

Our sincere thanks to all those who helped get Workshop '93 together and without whose contributions in cash and kind we would not be here today. We wish you a busy and productive week discussing appropriate ways of improving indigenous health status in this hemisphere, triggering a common understanding of the issues and setting priorities for action, during and following the International Year of the Indigenous Peoples of the World.

Secretariat, Workshop '93

INTERNATIONAL PLANNING COMMITTEE

PAHO member country representation through

- **Dr. Alfredo Vargas**, Ministry of Health, Mexico, member of the PAHO Sub Committee on Planning and Programming

PAHO operational representation through

- **Dr. Jose Maria Paganini,** Health Services Development with alternate
- **Dr. Sandra Land**, HSD

Non-governmental indigenous representation through the World Council of Indigenous Peoples (WCIP)

- **Mr. Donald Rojas,** President with alternate
- **Mr. Rodrigo Contreras**

Indigenous regional and community interlocutors:

For Latin America

- **Mr. Nilo Cayuqueo,** Director, South and Meso American Indian Information Centre (SAIIC)

For the Caribbean

- **Dr. Joseph Palacio**, National Garifuma Council, Belize

For North America

- **Mr. Alvin Windy Boy Sr.**, Chairman, Chippewa Cree Tribal Council and Health Board; with alternate
- **Mr. John Sunchild Sr.,** Rocky Boy Reservation, Montana

Consultants

- **Ms. Madeleine Dion Stout for North America**
- **Dr. Carlos Coloma for Latin America**

Secretary

- **Norbert Préfontaine, CSIH**

The Planning Committee met at PAHO headquarters in late July 1992 and then communicated by phone and fax. It discussed and set Workshop objectives, content and timing, determined criteria concerning the number and categories of participants, and approved the nomination process for selection of participants to be recommended to the Director of PAHO for final selection.

During the Workshop, members of the Planning Committee will work with the Steering group for Workshop '93, which is composed of three officers - President, Vice-President, Rapporteur, one representative from each of five working groups and a member of the Host Committee.

THE WORKSHOP '93 SOUNDING BOARD

Ottawa, Canada
Easter Sunday 1993

The Workshop '93 Secretariat wishes to extend very special thanks to the members of the Sounding Board who have been available as volunteers throughout the organizational effort required to pull this hemispheric 'first' together. Most members responded quickly and effectively by fax and phone - occasionally in writing - to the Secretariat's cries for help. A few were expert at pulling Augustin (the computer I have on loan) and myself out of the swamp. Without the advice and support provided by the Sounding Board, Workshop '93 would have been a very different product. I am listing names only (and apologize to those I am forgetting); for lack of time, I could not seek authorization to release fax numbers - nor to bring this list up to date.

Norbert Préfontaine
Secretary Planning Committee

INDIGENOUS MEMBERS

*Richard Jock, with
Virginia Toulouse and colleagues
*Jérôme Berthelette
and Kim Scott
*Vince Tookenay MD
*J. Wortman MD
*Madeleine Dion Stout

*Jean Goodwill
and Gary Pekeles MD
*Mike Monture, MD
*Diana Greyeyes

*Conrad Saulis
*Hélène Sioui-Trudel

*Mary Ann Demmer
*Roda Grey
*Virginia Meness

Assembly of First Nations

Royal Commission on Aboriginal Peoples
Native Physicians Association in Canada
Medical Services/HWC, British Columbia
Centre for Aboriginal Education,
Research and Culture, Carleton University
Canadian Society for Circumpolar Health
at Mc Gill University
Medical Services/HWC, Ontario
National Association of
Treatment Centre Directors
Native Council of Canada
National Indian and Inuit Community Health
Representatives Organization
Inuit Tapirisat of Canada
Pauktutiit
Native Women's Association of Canada

*Napoleon Gardiner	Mayor, La Ronde, Saskatchewan
*Ron Rivard	Métis National Council
and Mark Gryba	Saskatoon/Ottawa
*Richard Musto MD	Medical Services/HWC, Alberta
*Bill Curry	Ile à la Crosse, Saskatchewan
*Max Morin	Gabriel Dumont Institute
*Lionel Bird	Prince Albert Tribal Council
*Josette Couillonneur	Meadow Lake Tribal Council
*Henry Three Suns	Siksika Nation, Alberta
* José Matos Mar	Instituto Indigenista Interamericano Mexico
*Diane Reid with	Grand Conseil des Cris, Québec
Elizabeth Robinson, MD	at McGill University
*Alejandro Amaru Argumedo	Cultural Survival, Ottawa

* plus the four members and two alternates of the International Planning Committee who are indigenous. Their names are listed elsewhere in this program.

NON INDIGENOUS MEMBERS

*Maureen Law, MD	International Development Research Centre
*Duncan Pedersen	Federal University of Bahia, Brazil
*Stephen Simon,MD	Health and Population, CIDA
*Elizabeth Racicot	Americas Branch, CIDA
*Norman Cook	Coordination/Indigenous projects, CIDA
*Ed Aiston Nora Ritchie	
and colleagues at	International Health Affairs, PPI/HWC
*Neil Faulkner,	
*Gillian Lynch, MD	
and colleages at	Medical Services Branch, HWC
*Fran Perkins	Canadian Public Health Association
*Freda Paltiel	Status of Women, PPI/HWC
*Jeremy Wright	Consultant, Itchen House International
*Gaston Harnois, MD	WHO Montreal Collaborating Centre in Mental Health
*Terry Hunsley	Consultant, Terry Hunsley Associates
*Raymond Pong	Laurentian University
*Carlos Alberto Coloma	Consultant to PAHO/CSIH
*Marlyn Kefauver	US Department of Health and Human Services
*Hon. Branford Taitt	Minister of Health, Barbados
*Helmut Wintersberger	European Centre forSocial Policy Research, Vienna
*Allan Pence	University of Victoria
*Sharon Keller	University of Buffalo
*Francis Rolleston, MD	Medical Research Council

*Robert Knouss, MD	**Pan American Health Organisation/DD**
and colleagues	
Roberto Rivero	**PAHO/DD**
Enrique Fefer MD	**PAHO/HSD**
Francisco Vallejo MD	**PAHO/HSD**
Jorge Osuna MD	**PAHO/HSI**
Richard Leclair	**PAHO/DPI**
Pamela Hartigan	**PAHO/DEC**

plus the two members and one alternate on the Planning Committee who are non indigenous - listed elsewhere as PAHO institutional and operational representatives - and the fifteen members of the CSIH Board of Directors: Dr. Sheila Robinson, U. of Calgary; Peter Tugwell MD, U. of Ottawa; Yves Bergevin MD, McGill University; Caroline Hernandez, Halifax; Susan Smith, Calgary; Lynn McIntyre MD, Dalhousie U.; Nancy Edwards, Ottawa; Stan Houston MD, U. of Edmonton; Ed Ellis MD, Ottawa-Carlton; Richard Nuttall MD, NWT Government; Barbara Russell, Edmonton, student representative; Renée Pelletietr MD, (CECI) Montréal; Franklin White MD, CAREC; Dick McLean MD, McGill University, (as CUCHID representative) and Karen Mills, Edmonton (as CPHA rep.)

NATIVE PARTNERS OF THE SECRETARIAT

ASSEMBLY OF FIRST NATIONS/
NATIONAL INDIAN BROTHERHOOD

Native Council of Canada

INUIT THPIRIIKSAT KANATHMI
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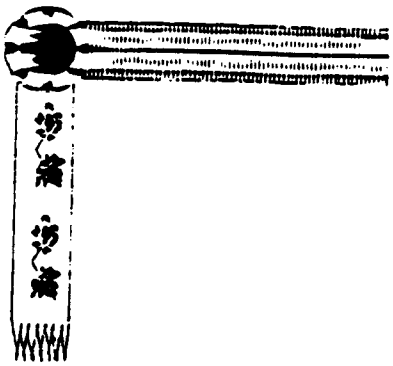
INUIT THPIRISAT OF CANADA

METIS NATIONAL COUNCIL

LOUIS RIEL

GABRIEL DUMONT



Native Women's
Association of Canada

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PAUKTUUTIT
Inuit Womens Association

MANITOBA HOST COMMITTEE

Mary Staniscia
INDIGENOUS WOMEN'S COLLECTIVE (IWC)
OF MANITOBA INC.

Darrel Phillips
ASSEMBLY OF MANITOBA CHIEFS

Cheryl Anne Carr
MANITOBA MÉTIS FEDERATION INC.

Josie Silvernagle
ABORIGINAL COUNCIL OF WINNIPEG

Réal Cloutier
MANITOBA HEALTH — SANTÉ MANITOBA

Louise Newans, Consultant,
On-site Coordinator

Workshop '93 would not have been possible without the support of a large number of individuals and organizations at the international, regional and national levels. They provided human and technical assistance as well as resources in cash and kind to complement PAHO's generous start-up financial contribution.

INTERNATIONAL CO-SPONSORS

World Council of Indigenous Peoples (WCIP)
Ottawa

•

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Mexico

•

Coordinadora de Organizaciones y Naciones Indigenas del Continente (CONIC)
Panama

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Organization of American States (OAS)
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MANITOBA HEALTH • SANTÉ MANITOBA
Healthy Public Policy Division - Division des programmes de santé

CONTENT, METHODOLOGY, PROCESS

Selection of topics for discussion as well as the choice of methodology and process flow from the following reference criteria:

a) the theme of the workshop: indigenous health status

b) the objectives of the Workshop and

c) the intercultural character of the meeting

Participants should note that the term 'intercultural' is used here to denote the richness of the ethnic backgrounds represented but also to describe the different ways of understanding health and well-being, since these understandings - common or different - will be elements of the collective solution required.

Content

Three fields have been identified for presentation in plenaries and discussion in working groups, in the form of documented case histories:

- the health situation of indigenous peoples in the Americas
- health policies and
- health systems, including their relation with traditional medicine

The topics noted above are program suggestions rather than firm recommendations. This reflects the mandate which the Planning Committee was given, namely that the workshop program and content should be set by participants themselves. The Chairperson will therefore consult Workshop participants and the members of her Steering Group on amendments they may wish to bring to the program for the week.

Methodology and Process

Given the intercultural nature of Workshop '93 - 22 countries are represented - it was considered fundamental that the methodology used be adapted to the event and consistently support open communications and encourage 'straight talk' that is close to the reality of the problems discussed.

The format suggested comprises plenary sessions alternating with concurrent sessions of five working groups. The intent is to give all participants the opportunity to share their experience and thinking with others throughout the week.

Workshop '93 has a Steering Group composed of three officers: President, Vice-President and Rapporteur. These three officers have been recruited by the Planning Committee ahead of time and will be responsible throughout the week for plenary sessions and the general conduct of the workshop.

The Steering Group will meet at the end of each working day with Planning Committee members and a representative from each working group. Together they will review progress and plan the following day.

At their first session, Working groups will be requested to choose two indigenous officers, a Coordinator and a Rapporteur, to link up with the Steering Group and help elaborate conclusions and recommendations.

Each day will start with a prayer conducted by one of the Host Indigenous Committee members.

Following the official opening on Tuesday morning, the two consultants who helped the organizers plan the workshop, will introduce 'Indigenous Peoples and Health', the background document which they authored and which was sent to all participants in advance of Workshop '93. Indigenous leaders from South, Central, and North America will then comment on it and discuss it with the two authors and the members of the audience.
On each successive day, after the opening prayer and general announcements on the program of the day, a synthesis of the debates of the previous day will be presented.

The plenary sessions will all have question-and-answer periods. Presentation of selected experiences currently in place in different countries of the hemisphere will follow. This will serve as input to the concurrent working group sessions which should focus on the action to be taken by indigenous communities to resolve the problems discussed.

Working group conclusions will be reported to the Steering Group session at the end of the working day so that, throughout the week, Workshop '93 will gradually develop its recommendations for action to be adopted at the closing plenary on Friday.

Thus it is hoped that the themes and case studies selected will provide incentive for reflection and discussion within the working groups, allow participants to share their particular knowledge and experience, and provide Workshop '93 with pertinent conclusions and recommendations for priority programming with partners.

The detailed themes, speakers, schedule for each day of the workshop will be found in table form elsewhere in this Program folder.

PROGRAM CONTENT

DAY ONE	TYPE OF SESSION / SUBJECT	THEMES / SPEAKERS	TIME
Tuesday 13		Breakfast	8:00
	Prayer and Formal Opening	Representatives of the Canadian Aboriginal Community, the Government of Canada and the Pan American Health Organization	9:00
		Break	9:45
	Health situation of Indigenous Peoples (plenary session)	**Presentation:** Background document Indigenous Peoples and Health: North America, **Madeleine Dion Stout**, Consultant Latin America, **Carlos Coloma**, Consultant **Comments** for North America: Chief **Sydney Garrioch**, Chiefs' Committee on Health, Assembly of Manitoba Chiefs, Canada for Central America: **Rosa Ascencio Ascencio**, Organización de Médicos Indígenas de Pátzcuaro - Mexico for South America: **Juan Lligalo**, Consejo de Nacionalidades Indígenas del Ecuador - Ecuador	10:00
		Lunch	12:30
	First session Working groups	**Discussion, conclusions and recommendations**	14:00
		Break	15:30
	(plenary session)	**Questions / Comments**	16:00
		Steering group (members only)	17:30
		Official welcome and banquet	19:30

DAY FOUR	TYPE OF SESSION / SUBJECT	THEMES / SPEAKERS	TIME
Friday 16		Breakfast	8:00
	Inuit Opening	**Recap** **Questions / Comments**	9:00
	Plenary Session	**1. Discussion as required and** **2. Adoption of recommendations for action**	9:30
		Lunch	12:30
		DEPARTURE FOR FIRST NATIONS POW WOW IN CARBERRY, MANITOBA	

DAY FOUR	TYPE OF SESSION / SUBJECT	THEMES / SPEAKERS	TIME
Friday 16		Breakfast	8:00
	Inuit Opening	**Recap** **Questions / Comments**	9:00
	Plenary Session	**1. Discussion as required and** **2. Adoption of recommendations for action**	9:30
		Lunch	12:30
		DEPARTURE FOR FIRST NATIONS POW WOW IN CARBERRY, MANITOBA	

CHAPTER THREE: Participants

Grants from the Pan American Health Organization, the International Development Research Center in Ottawa and several other departments and agencies of the Government of Canada allowed Workshop '93 to cover travel and living expenses for most participants. A few were self-sustaining and some others could arrange for their costs to be covered in full or in part by their organization or employer.

Initial plans called for a ceiling of 50 guests, 30 Indigenous to 20 potential partner representatives. In fact, as the reader will note from this list, 86 persons attended the Workshop.

These participants - 49 Indigenous and 37 others - represented 20 different countries. 10 of the guests who accepted the Director's invitation could not attend (*), thus reducing to 19 the number of countries represented: Argentina, Belize, Bolivia, Brazil, Canada, Chili, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Mexico, Nicaragua, Panama, Paraguay, Peru, United States of America and Venezuela.

50 were invited by the Director of PAHO □

28 attended as members of the Planning Committee, Co-sponsor representatives, Consultants or Support staff ◇

3 represented the Native Partners of the Secretariat, and ○

6 (of whom one PAHO guest) were Host Committee members ☺

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CHAPTER FOUR: Workshop Report

Day 1 - Prayer and Formal Opening

The opening session of the *Indigenous Peoples and Health Workshop* was co-chaired by Mary Staniscia, President of the Indigenous Women's Collective of Manitoba, and Darrell Phillips, of the Assembly of Manitoba Chiefs. It got under way with a prayer by Rev. Dominique Kerbrat, of Kateri Tekakwitha Parish, statements from representatives of Canadian Aboriginal communities, the Pan American Health Organization (PAHO), and the Government of Canada.

Ernie Blais, Metis National Council

Ernie Blais, representative of the Metis National Council and President of the Manitoba Metis Federation, welcomed participants to an area that he described as the "backyard" of Louis Riel, a 19th century Metis hero and martyr. He said he was also honoured that participants had gathered "to discuss some of the issues surrounding the health problems that face the Metis people".

Blais raised a number of concerns pertaining to the health of Metis people, including the absence of health facilities in some communities and a lack of adequate health statistics. He identified youth and Elders as two specific groups for which health information is needed. The Metis "are in essence Canada's forgotten people," Blais said, noting that "First Nations communities have very little and we have a lot less." He said he looked forward to sharing information with other Aboriginal groups and learning from their experience.

Phil Fontaine, Assembly of First Nations

Phil Fontaine, representative of the Assembly of First Nations and Grand Chief of the Assembly of Manitoba Chiefs, stressed the importance of addressing Aboriginal health during the International Year of Indigenous Peoples. "Indigenous peoples throughout the world have a story to tell the world, and we have to tell it," he said. "I see this particular gathering as an opportunity to add to the story, because for too long the world has not understood or known the Indigenous peoples....If we are to have justice and fairness for all, then we have to make sure that we correct many of the misunderstandings that exist, that cause our people such great difficulty." Fontaine described the workshop as an "excellent opportunity" to move ahead on Aboriginal entitlements.

Louise Bouvier, Native Women's Association of Canada

Louise Bouvier, representing the Native Women's Association of Canada, noted that her organization had decided to attend the workshop, even though it was not chosen as a funded guest. "The NWAC does realize the importance of health and Indigenous peoples, and made a decision to be present at this historic event." She said NWAC had been formed in 1974 to foster the well-

being of First Nations and Metis women within First Nations and Canadian societies. The organization currently has a mandate to address a wide range of issues and concerns, including the *Indian Act*, the Canadian constitution, family violence, HIV/AIDS, justice, Aboriginal health, child welfare, and Aboriginal rights.

NWAC recognizes that issues of alcoholism, substance abuse, child abuse and mental and physical abuse are continuing realities. Bouvier said the poor health status of Aboriginal communities in Canada is largely a result of "substandard social and economic development," combined with a "stymied political relationship" between First Nations and the Canadian government.

The Association assumes that solutions to these problems will only come from the reserves, Metis settlements, and urban and rural communities where Aboriginal people live. Although some groups deal with health strictly as a treaty right, "it is a universal concern for all our people, notwithstanding any artificial governmental distinctions between us".

Bouvier noted that health concerns become women's concerns, since women are usually the caregivers and are overwhelmingly involved as health practitioners in Aboriginal communities. She identified a number of health concerns that are common to all Aboriginal peoples in Canada, including life expectancy, infant mortality, suicide rates, diabetes, injury-related death, alcohol and drug addiction, HIV/AIDS, nutrition, prenatal and post-natal care for children and mothers, midwifery and birth planning, child care, parenting skills, and a variety of specific child health issues.

Martha Flaherty, Pauktuutit

Martha Flaherty, President of Pauktuutit, the Inuit Women's Association of Canada, noted that Indigenous peoples in Canada have had to find unique solutions to similar problems because of differences in lifestyle, culture and environment. She urged participants to "learn from each other and be proud of our differences," in order to "work things out for the people we represent".

Jean Goodwill, Canadian Society for Circumpolar Health

Jean Goodwill, President of the Canadian Society for Circumpolar Health and Founding President of the Aboriginal Nurses' Association of Canada, extended a warm welcome to brothers and sisters from different parts of the world. She noted that Aboriginal peoples from South America had experienced challenges that were far more difficult than those faced by their counterparts in Canada, and called for a broader effort to address Indigenous concerns at the international level.

Sheila Robinson, Canadian Society for International Health

Sheila Robinson, Chairperson of the Canadian Society for International Health, traced the origins of the workshop, noting that a number of organizations in the Americas had recognized the dire situation of health, nutritional status, and disempowerment faced by Indigenous populations throughout the region. PAHO had found itself in a "politically complex position", as a body that belonged to and had to work through member governments, some of which had been hesitant to recognize Aboriginal rights.

In early 1992, as a result of a proposal from Canada supported by Mexico and several other countries, PAHO resolved to emphasize Indigenous health issues in its regular programming. This new direction was to be based on wide consultation with Indigenous peoples themselves, to ensure that any new programming reflected their views on health, illness and healing. As PAHO's technical representative in Canada, CSIH agreed to organize the workshop as one step in the consultative process. Robinson urged participants to "all perceive ourselves as global citizens", and invited all present to create real opportunities for dialogue, participation and change.

Carlyle Guerra de Macedo, Pan American Health Organization

As you have heard, in addition to being the Director of the Pan American Health Organization, I am a Brazilian and carry in my veins the mixed blood of African, European and Aboriginal Brazilian forebears.

I have been extremely gratified by the presentations made by each and every one of you, illustrating the brilliant mosaic of experiences and cultures represented here. It is really a pity that the other colleagues who were unable to come are not here to contribute their own enriching experiences.

While you were making your presentations I thought of the bright promise of the present juncture in our Region, while elsewhere in the world the forces of ethnic groups and religious faiths, so long pent up, explode in conflict that deplorably interrupts productive activity, disrupts order and escalates into civil war. We, forgathered in this hall in this city, will ponder the consequences of centuries of neglect and subjection, centuries of domination, marginalization and isolation, centuries that have produced premeditated acts of real destruction of autochthonous cultures in our hemisphere, with the purpose and resolve of building a better future.

We will discuss here how to right some of the wrongs committed, and how to heal some of the deep wounds that the great clash of European and American cultures has widely inflicted in the course of our history. And it is important to note that what brought that situation about, consciously or unconsciously, was a denial of health. As a result, disease has been a weapon of

destruction much more powerful than violence, and has had a much greater impact on our native cultures than any deliberate attempt to exterminate them.

It is not surprising that we face today a situation about which, to a large extent, we know nothing at all. One of the most effective devices that the dominant cultures still use to maintain their supremacy is ignorance, for when there is no information on what is actually happening, and no attempt is made to acquire it, the fiction can then be built up that all is well. Nor may it surprise us that this ever-present dual discrimination, grounded in belittling or rejection of the values of autochthonous cultures and nurtured by the historical process that made their economic inferiority permanent, has reduced the indigenous nations to the poorest of the poor, with a health status far below the average of the general population.

This workshop faces a challenge and commitment to find ways to rise above the *status quo* by endeavouring to promote ways in which we may learn more and retain what we learn to promote permanently and even aggressively the awakening of a social consciousness that will make the situation of the Indian peoples a priority problem for our political systems. We must recognize that the different cultures, or rather culture itself, is the basic factor for that work of recovery, cooperation and accomplishment. It is through culture that we will be able, as we are doing here today, to help establish new relationships and promote intercultural encounters on which to base a solution of the problem.

This process must be founded on respect for the values of each culture, with the specific and deliberate purpose of reinforcing the recognition by each side of the identity of the other as a basis for necessary change. Let us throw off the habit of inaction, and instead lay the foundations of our own cultural identity so that we may define the changes we want. This is an essential condition for the affirmation of unnegotiable principles, such as self-determination, and also for genuine participation by our indigenous communities in the decisions of government and of the societies in which they live. There can be self-determination only if the members of those communities are able to exercise their full right as citizens to participate in the shaping of their own destinies.

We know that in this strengthening of our cultural identity we can recover and put to use the many deep and important lessons of the native lore of our America, or use it as a complement to that other "lore" that is modern science and technology. As has already been said in this hall, we must work together at the international and national levels, always mindful of the imperative need to reach the individual communities themselves.

In this spirit, the Pan American Health Organization, Regional Office for the Americas of the World Health Organization, as part of the celebration of its 90 years of existence, has accepted the challenge presented to us by the delegates of Canada to our Directing Council in asking us to

address the problem of the health of indigenous peoples, as part of the Organization's policies and programs of action. They have asked us to carry this message to all the Member Governments, to their institutions and societies, as a real beginning in discharging a debt that the dominant few in our societies have built up. We have not wanted to define how the Organization is to deal with these matters among the "health experts" alone, or even among experts in indigenous affairs, because we want to learn from the indigenous peoples themselves. And this Workshop, the first of its kind, has as its primary purpose the creation of an opportunity to learn and understand, as a starting point for action.

I want to acknowledge and give thanks for the efforts of the delegates of Canada to make this meeting possible. I hope it will serve to focus permanent attention on the health problems of the aboriginal peoples of the Americas. We acknowledge with gratitude the work done by the Canadian Society for International Health, and are thankful for the cosponsorship of the International Development Research Center, the World Council of Indigenous Peoples, and the Inter-American Indian Institute. One again I affirm to you our expectation that you will really help us understand the problems of the indigenous peoples of the Americas, so that on the basis of this understanding, we in the Secretariat of the Organization and in the Governments may chart policies and plans of action in and outside the Organization that will truly contribute to the solution of their health problems.

It is a special pleasure to be in this beautiful city of Winnipeg on a spring day such as this, but a particular privilege to share with you, if only for a day, the values, ideals and purposes that must unite us all.

Dorothy Dobbie, Government of Canada

Dorothy Dobbie, a Canadian Member of Parliament representing Health Minister Benôt Bouchard, said she couldn't think of a more appropriate place to hold the workshop than St. Norbert, the birthplace of Manitoba. She said a strength of Aboriginal peoples at the time of Louis Riel was their knowledge that integration of the cultures was the way of the future and their commitment to finding ways to live together.

"We have a long way to go to learn how to live together," Dobbie continued. People should live together in an atmosphere of mutual respect. Problems of poor health in Aboriginal communities will not correct themselves as long as Aboriginal peoples believe that they are not a part of society. There is only one planet Earth, she said, and people must learn to share it.

Every human being has something to contribute to society, Dobbie continued, adding her hope that participants would return home after the workshop stronger in their commitment and

energy to improve the health of Aboriginal peoples. She concluded by reading the words of Chief Seattle in 1854, which she said were fitting words to start the workshop:

> "You must teach your children that the ground beneath their feet is the ashes of our grandfathers. So they will respect the land, tell your children that the earth is rich with the lives of our kin. Teach your children what we have taught our children, that the earth is our mother. Whatever befalls the earth, befalls the sons of the earth. If men spit upon the ground, they spit upon themselves.
>
> "This we know: the earth does not belong to man; man belongs to the earth. This we know. All things are connected like the blood which unites one family. All things are connected.
>
> "Whatever befalls the earth, befalls the sons of the earth. Man did not weave the web of life; he is merely a strand in it. Whatever he does to the web, he does to himself."

Mary Staniscia thanked the speakers, noting that Aboriginal people believe they have not lost their philosophies of life. "We need to move away from being controlled," she said. If partnerships are to be forged between Indigenous and non-Indigenous peoples, the partnerships must be equal. "We have to have control over our lives."

Myrna Cunningham briefly listed the objectives of the discussion groups: to analyze information on the status of Indigenous health in this hemisphere; to look at ways that the information can be used; to establish communication mechanisms between people active in the area of Indigenous health and PAHO and other organizations; to bring back information to PAHO to allow development of policies in the area of Indigenous health; and to include the practice of traditional medicine in government health policies.

Background Document: Indigenous Peoples and Health

Madeleine Dion Stout

Consultant Madeleine Dion Stout from Canada presented the background document circulated to participants before the workshop. She made the following two arguments:

- Indigenous peoples were once considered to be on the margins of maldevelopment, but they are increasingly thought to be the centre of an alternative project.
- Indigenous peoples in North America have been willing agents in their own health development but their ability to be and become agents has been frustrated by external forces.

She quoted Noel Dyck's definition of Indigenous peoples as "distinct communities having long-established relations with governments." In Canada, she noted, Indigenous people include status, non-status, Inuit, and Metis people.

Dion Stout said it was important to remember that although the concept of primary health care has been adopted for Indigenous peoples by governments in North America, "it is really not at work in Canada and the U.S." One of the values of primary health care is traditional medicine and healing practices, but barriers include the effects of colonization, modernization and over-bureaucratization.

Healing is a strong North American phenomenon, and Indigenous peoples are the leaders in the movement, she continued. Healing means coping with everyday living conditions, and seeing health as wellness instead of simply the absence of disease. The medicine wheel is an important symbol of healing.

Poverty should be defined in its broadest sense, she continued, to include any basic unmet human need. In this context, poverty includes lack of sustenance, affection, understanding, participation, and identity.

Dion Stout briefly presented highlights of the report, including health indicators of mortality rates, infant mortality rates, life expectancy rates and morbidity rates, noting that in many cases, the rates are higher for Indigenous populations.

Canadian interviewees in the study made a number of recommendations for policy alternatives for PAHO and member countries, including: monitoring the health status of Indigenous peoples; educating WHO and the UN on their behalf; proposing relevant interventions; reflecting options for Native people, not models for action; remaining as apolitical as possible; and allowing Indigenous peoples to determine the threshold of PAHO's involvement.

Culture is both the underpinning and pinnacle for health development and self-determination for Indigenous people, she said. Native people are operating under a holistic paradigm, and "there should be a paradigm shift to the wellness end of the spectrum." The vision of health is changing, and PAHO has to position itself within the new vision.

Carlos Coloma

Consultant Carlos Coloma from Latin America began by asking permission from the chiefs, Elders and traditional healers to "talk about you, Native people." He questioned the current interest in Native issues, asking why it is important to examine Indigenous health problems at this late date, when governments and institutions are only beginning to talk about the issue after 500 years of colonization. Our belief that we can look at other cultures in this way forces us to "look at

ourselves as well," he said. "And for us, the process of examining Indigenous health problems brings us to examine the politics of health, of service delivery, and of the very basis for public health." The ultimate conclusion is that the challenge of Indigenous health is a challenge for us all, one which calls into question the models of health that have been implemented in Latin America.

In Canada and the U.S., the health care systems are under enormous strain, and neither system can be held up as a model for Indigenous peoples. Native peoples, although they are considered backward and underdeveloped, have reached their own understanding of health that is reflected in their own unique health systems.

Coloma wondered if Native medical systems have survived by chance, because of resistance and struggle, or because western medicine has to a large extent ignored Native systems. There are many paths to health, and one does not exclude another. Facing the problem of cultural marginalization versus integration means accepting the challenge to "reconcile certain positions, to lose the cultural baggage we carry along by inertia," to eradicate the gaps in health delivery as practiced by an institutional culture.

He suggested that primary health care has always lagged far behind other social change initiatives such as popular education and participatory research. PAHO has made a major contribution in undertaking this new initiative, which not only represents a new way of looking at reality, but is also an important starting point for the development of new understandings that will enrich the practice of public health. In Latin America, there has been lots of activity in the area of primary health care, and a network of people involved in these projects has been created. Recognition of a primary health model means critical review of the western reductionist model which reduces everything to parts, and the holistic model traditional to Indigenous cultures which sees all parts of a whole.

It is essential to realize that health involves how cultures and individuals see and identify themselves, Coloma continued. Barriers to positive self-identification include racism and structural oppression that keep Indigenous peoples in marginal positions. These barriers overcome the goodwill and inertia behind many primary health programs.

He noted that government reports about the health status of Indigenous peoples often do not match the reports of Indigenous peoples themselves. This discrepancy points to the need to have direct contact with Indigenous peoples when designing health care programs. "We don't need intermediaries to distort the thought of Indigenous peoples," he said.

"Our challenge is to build something," Coloma continued, noting that "we are used to thinking things out completely before putting them into action." Native people work with reality, discovering answers as they go along in the process of doing something. Solutions for improving the health of Indigenous peoples will be found through practice, he said.

Comments on the Background Document: Chief Sydney Garrioch

Chief Sydney Garrioch, Chair of the Chiefs' Committee on Health, Assembly of Manitoba Chiefs (AMC), Canada, said it was natural to express concerns about the document but important to make sure that the concerns helped further the discussion on improving the health of Indigenous peoples. His first concern was the methodology used in the report, how the data was selected and utilized. The data presented may mislead readers, and "prejudice the knowledge" about health in Aboriginal communities, he said.

He was also "deeply concerned" that the number of interviews undertaken for the study was too small to extract useful data about the health concerns of Aboriginal peoples. Some of the information emerging from the interviews was valuable, but many concerns were isolated and not reflective of typical situations. In particular, quoting from interview subjects gave authority to statements which were only opinions, he said, adding that the statement that Aboriginal leaders are not committed to health issues negates the hard work of leaders committed to improving the living conditions of their people.

The report should have used more specific terms and definitions, he said. For example, the statement that only two of eight provinces have specific health programs for off-reserve people tells nothing about the provinces involved, the specific programs, the control of programs or the jurisdictional issues. In addition, the statistics should have been more specific about the Aboriginal people included: treaty, status, non-status, Inuit or Metis.

Garrioch objected to the report's statement that traditional culture is alive and well in the U.S. and Canada. "It is not," he said; after hundreds of years of colonization and oppression, "my people gradually faded away from their own traditional ways." There needs to be a balance of traditional and western medicine, he added.

He concluded with a description of the efforts of the work done by the AMC to further the treaty right to health. "Governments and politicians are trying to define health for us," he said. The AMC's vision of health is that all life comes from the Creator, is sacred, and must be protected and preserved. "Good health must be restored and maintained."

Comments on the Background Document: Rosa Ascencio Garda

Rosa Ascencio García of the Organización de Médicos Indígenas de Pátzcuaro, Mexico said she had not had the opportunity to review the background document; instead she described her work. Her organization represents 52 medical organizations in Mexico that work with people who are poor, hungry and lack many things. "Who can cure this?" she asked. "We need justice and action from our government...We have to remind the government that we're here. We need their support."

All the small towns in the region she comes from have cases of cholera, intestinal diseases and other ailments caused by poverty. "We are poor peasants. We work to eat the following day," Ascencio said, adding that the government continues to take land to build factories that do not hire poor people, because "we don't know how to read or write." Mothers and fathers in the towns suffer "the disease" of knowing they have no way to educate their children.

Many people die in these towns because there are no health facilities, no doctors, and no way to bring sick people to places where they can receive treatment. Ascencio and others use traditional medicine on these people, but "we treat them and leave them in God's hands."

When the Spaniards came to Mexico, they found "good medicine" there, but little by little, they stole the traditional knowledge of healing with plants and restricted the use of these plants. After time, much of the knowledge was lost. However, although the Spaniards took the plants away, "the roots are still there," she said. The mission of traditional healers has always been to pass on traditional knowledge to the youth. "We don't know how to read, we don't know how to write, but we know our plants and know how to use them," she said.

She and other traditional healers expect some help from Native and non-Native people in North America, she concluded. "We need your help to carry on our work."

Comments on the Background Document: Juan Lligalo

Juan Lligalo, Consejo de Nacionalidades Indígenas del Ecuador, said that his own impression of health care for Indigenous peoples is that "certain methodologies have been imposed from the top down." Technocrats have always dominated the Indigenous peoples on this continent, he said, and after the Spanish, Portuguese, English and French invasions, "they applied their own methodologies on our people." In the process, the people in power "have given us different labels: Aboriginal people, Native people, Indigenous people."

Lligalo said the foremost wish of Indigenous peoples is unity and understanding among themselves. If this unity does not develop, "we will continue to be dominated and exploited," he said.

His government has created an Indigenous health branch but "no space for this to occur." Many health and development models have "failed miserably" because Native people were never consulted and were expected to receive the models passively. Indigenous peoples have an alternative model of health care, one in which power flows from the bottom-up, not from the top down. "We would like to work together as a people, and this is quite difficult," he said.

He questioned how pressure could be brought to bear on a government that "has never been interested in an Indian world view." The world view of Indigenous people is different from that of non-Indigenous people, he said. For example, "we don't see death as God's punishment. Our view of death is that humans grow tired and old, like trees do, and then they die." But in order to

grow, "we need nutrients, like the tree," he added.

The Spanish invaders "have taken our land away from us, and that is why we are poor," he continued. People no longer live to old age because they lack proper nutrition to make them strong and productive. "If we want to have good health, we need to let our food be our medicine and our medicine be our food." Sick people cannot work because of lack of nutrition, all because "we have no land." Indigenous peoples the world over have the same demand: land. "Mother Earth should never be sold or negotiated."

Lligalo explained that his organization had not been able to analyze Madeleine Dion Stout's section of report in detail but suggested that before the next PAHO meeting, there should be more of an emphasis on "practical, hands-on work." Carlos Coloma's section of the report "is at least 80% right," he said.

He noted that discussions about "creating an identity" for Indigenous peoples should instead be about "re-creating an identity," because "our identity was created many years ago but was destroyed." The European invasions created borders and separation between Indigenous cultures that had not existed previously, imposed capitalism, and concentrated the natural wealth and resources under the control of a few people. "In pre-conquest time, there was no time when Indians went around sick and dirty," he said. "We were sent, like deer, to the bad lands; Indian people had only the poor lands to cultivate."

Lligalo concluded with several suggestions to PAHO and WHO: the workshop should lead to recommendations by PAHO and WHO that all member states support the participation of Indian people in the development of programs for Indian people; and that the United Nations should move beyond the level of statements and declarations about Indigenous peoples to advocating funding for Indigenous peoples. "We need funds," he stressed. "Indigenous people are often indigent people," and declarations such as calling 1993 the International Year of Indigenous Peoples "will be empty words without funds."

Opening Banquet

Participants were hosted for dinner at Fort Garry Place in downtown Winnipeg, on Tuesday April 12. The banquet was co-sponsored by Manitoba Health. In turn, Provincial Leaders extended greetings to participants, as National Leaders had done in the morning. These greetings are summarized hereafter:

Mary Staniscia, President, Indigenous Women's Collective and President, Host Committee

Mary spoke from the heart about the issues and concerns of Indigenous women. Taking a global perspective, she emphasized how her organization was dedicated to working for solutions to the many problems faced by Indigenous Women, calling upon the many strengths they have in common. She warmly welcomed all her sisters and brothers form the Western Hemisphere.

Grand Chief Phil Fontaine

Grand Chief Phil Fontaine spoke about the commonalities faced by the Indigenous peoples of the Americas. The problems and struggles which our Indigenous brothers and sisters from other parts of the Americas experience are very much the same as our experiences here in Manitoba, particularly with respect to governments.

Governments throughout the Americas have generally failed to recognize the rights of Indigenous Peoples and to live up to any obligations they have towards us. In Canada, the Federal Government has not fulfilled its treaty and fiduciary obligations to the First Nations of our country. Our people are weary of the constant betrayal and inequality. We are tired of empty promises and we continue to be very cautious in our dealings with the government.

But we have not lost hope. In fact, we are rising up again; healing is taking place to a greater degree and we are becoming stronger, more self-confident, and more educated.
It is therefore a great privilege for us to come together and it is encouraging to share with one another, as Indigenous people, about our experiences, our triumphs, our pain, and our common vision for wholeness. We are doing this is a spirit of solidarity and trust and we must continue to stand together.

Meegwetch!

Ernie Blais, President, Manitoba Metis Federation, Inc.

The Metis of Manitoba live in the same conditions that the Treaty Indians but without the same services. While there is little research done on reserve populations, there is no research done on the Metis. However, we know what problems we face and we feel we also know the solutions.

The network that is set up by this conference will help us in our struggle for adequate health, taken in its broadest terms. Together we can find solutions because we have the same problems. This North-South connection will begin to address our issues. We can help each other

Ms. Sandy Funk for
Jim Bear, President, Aboriginal Council of Winnipeg:

Welcome brothers and sisters who have journeyed from the four directions of Mother Earth to attend this historic health gathering.

Indigenous Peoples have made tremendous contributions the world over and we now have the opportunity to share with others, our philosophy of health.

Our health is linked directly to the land, the forest, water and plants and cannot be viewed in isolation of other such things as employment, culture and housing.

She challenged governments to make fundamental changes to laws and policies to reflect our healing practices.

Ms. Funk finished with a saying of which the moral is: "Put the person together, the world will be alright".

Meegwetch!

Ms. Sandra Delaronde, President, Metis Women of Manitoba

I would extend a warm welcome to you on your visit to the birthplace of the Metis Nation. We are honoured that you have chosen our homeland to hold this historic and significant conference. Health issues have had to make their way in thorough the back door when the political agenda has been dominated by economic and self-government issues. It is important to remember the lessons of our grandmothers and grandfathers when working to eliminate the problems that have oppressed us for generations. That is that health does not just involve the special healing but the mental and emotional and spiritual healing for all our people. In our quest to be self-governing people, we often forget or refuse to recognize the healing that must take place in particular from a spiritual centre. This is the first aspect of our being that has been attacked by those who colonized us.

We must also remember in our quest to be self-governing that we do not put the cloak of the colonizer. We must remember to treat all peoples with dignity and respect. We must remember not to take away the power and the voice of others, whether they be voices from women in our own country.

And finally, I would like to extend our thanks and gratitude to the Planning Committee for a job well done. In particular we wish to acknowledge the work of Cheryl-Anne Carr who represented the collective Metis Nation. It is not always an easy task, but we are certainly proud of her input to this conference. We wish you a successful conference.

Réal Cloutier, for the
Honorable Donald Orchard, Minister of Health, Province of Manitoba

Our views regarding health are changing dramatically. We recognize that health must be viewed in its broadest context, not only as a function of human biology. Health is affected by many other socioeconomic factors in society that can have a positive or negative impact on health.

In accepting this broader definition of health, we must move away from our traditional view that the health of a population is directly related to the amount of health care services available to the population.

Improvements in health will require a broader range of strategies that go beyond the provision of health services. It requires participation by communities who must take on some of the ownership and responsibility for addressing issues that affect health. This must be done in partnership with government.

We recognize that Aboriginal People use health services at a much higher rate than other Canadians. However, the solutions that are required to improve the health of the aboriginal populations will require a broad range of strategies if we expect to be successful.

Day 2: First Nations Opening and Recap

The second day of the workshop began with a traditional pipe ceremony led by David Blacksmith, a Cree from Cross Lake, Manitoba. Blacksmith explained the significance of the ceremony, noting that the human body is a lodge and we each have a responsibility to make sure that lodge is clean. "We're looking for answers in a place where the problems came from," he said. "Bill Clinton is not going to come in and save us. Brian Mulroney is not going to come and save us. But we have the answers to the problems that we have as Indigenous people."

Rapporteur Myrna Cunningham drew the following observations and recommendations out of the plenary and workshop discussions of April 13:

- Solutions to the problems faced by Indigenous peoples can only come from the people themselves. Action priorities developed at this workshop should reflect an understanding of cultural differences, and set the stage for real Indigenous participation in defining holistic health policies.
- Workshop participants share a commitment to overcoming the health problems of Indigenous peoples by strengthening the knowledge base at the community level, promoting social awareness of Indigenous history, and making Indigenous health a priority in national health systems.
- New relationships must be built on recognition of cultural differences, respect for the strength of each culture, and a commitment to strengthening Indigenous peoples.
- Health practitioners must build links at the global and national levels, based on the work carried out in our communities.
- PAHO must attempt to bring Indigenous health issues to the attention of member governments in a way that will help resolve current problems based on consultation with Indigenous communities.
- There is a need to monitor the health status of Indigenous peoples, and to provide training, education and appropriate technology in support of community-based interventions. PAHO can play an important role in ensuring that adequate statistical information is assembled.
- The process of defining health policies must allow for mediation between material living conditions and spiritual needs.
- Community conditions must be borne in mind throughout the process of collecting data and defining research methodologies.
- The transfer of responsibility for health service administration to Indigenous communities must be organized in a way that ensures true decentralization.
- Traditional Indigenous medical systems should be recognized by legislation in different countries.

- There is a need to decide whether governments are being asked to provide more resources, broader participation, or a combination of both in response to Indigenous health issues. Either way, Indigenous people must be consulted directly.
- Indigenous medicine must not be used to perpetuate Aboriginal peoples' poverty, or to "tranquillize" communities after centuries of humiliation. People must be able to feel and express their anger.
- Indigenous peoples should build on their own collective identification, and must work to advance a definition of entitlements like land tenure, a clean, healthy environment, and self-determination.
- A concerted effort is required to change the mentality of health workers, institutions and policies. Indigenous peoples must be empowered to take control and responsibility for their own health.
- One of the concurrent sessions proposed the designation of emergency health zones, to reflect the health crisis in Indigenous communities. There was not a complete consensus on this point, but Cunningham suggested that the groups might want to pursue the idea later in the day.

The Provision of Health Services to Indigenous Citizens: United States

John Sunchild, Chief of the Chippewa Cree Tribe in Montana, U.S.A., said he was a person who believed that in order to create change, "you've got to jump right in, thick or thin."

He was once a happy man, he said, but after many years working with the tribal government, he has become an angry person. "My whole being is becoming legislated. Everything I do is covered by rules and regulations." He doesn't like the rules and he doesn't like bureaucrats who use the rules like Bibles.

Sunchild said he comes from the richest country in the world but the health needs of his people are not being met. He asked PAHO/WHO and the workshop delegates to be his allies — "I need the voice of all of you to justify my plea to change my government's rules and regulations regarding health care." Indigenous peoples have common issues, and they need international bodies like WHO to help open doors, confirm the reality of Indigenous peoples, and to help begin to remove the barriers to proper health care.

Sunchild related a brief history of the Indian Health Service in his country. The U.S. government maintains the legal and moral responsibility to provide health care to American Indians; Indian people and their tribal governments, however, maintain they have the sovereignty to determine what is best for them. The first agency responsible for Indian health care was the U.S. Army, and Sunchild said the army took on the responsibility partly to be able to distribute

smallpox-infected blankets to Indian peoples. The practice wiped out whole communities, and even today, some children bear the physical scars of that tragedy.

The Bureau of Indian Affairs assumed responsibility for health care until 1955, when the authority was transferred to the Indian Health Service (IHS). At the same time, legislation was passed to provide sewers and water to all Indian homes but it was another five years before many Indian communities received these services. In 1976, health care delivery was expanded, allowing his own tribe to build a hospital that is leased back to federal authorities, and in 1980, new health legislation allowed the establishment of local tribal control and management of health facilities. Laws mean little without adequate funding, however, and Sunchild and the Tribal Council continue to fight for funds to allow them more control over health care.

One battle is against a practice that allows the government to refuse to pay for health care costs if the patient was not referred to treatment by a doctor. In many Indian communities, doctors will rarely refer patients because of government cost-saving directives, and sick people are forced to seek out medical attention on their own. In one community of 120 people, residents had accumulated health care bills of $300,000 that the government was refusing to pay. Sunchild intervened in this case, visiting Washington and bringing back officials to meet with the community. The officials promised to do something to alleviate the situation but never did.

He has spoken with doctors who have left their jobs in Indian health care facilities, doctors who said that most of the people they see daily need further medical attention but they do not refer them because of federal cost-saving measures. Sunchild said that sick people are helped only when they're flat on their backs, and "if they die, that's one less Indian to worry about."

Sunchild concluded that the IHS does not work, and he again asked for help from WHO and conference delegates to improve the situation. People committed to improving health care must "fight every step of the way," he said. Alvin Windy Boy, a colleague of John Sunchild, added that "the bottom line is money — no money, no health care."

The Search for an Operational Relationship in Health Between Governments and Indigenous Peoples: Central America

Leyla Garro de Valverde, Ministerio de Salud, Costa Rica, summarized a project involving seven countries in Central America. The project, a search for an "articulation" of health care for Indigenous peoples, brought together 36 people, half traditional healers and half health care professionals. (Articulation in this sense means the parallel use of traditional and western systems.)

The project grew from a training program for doctors held in 1990 in an area that had the highest infant mortality rate in the country. After the program was completed, the doctors were

pleased with their training but nothing much changed. It was decided that a pan-Central American meeting should be the next step. All seven countries involved agreed that although the health situation of the Indigenous peoples in each country was different, the situation was critical in all, and the common denominator was that Indigenous people were at a disadvantage.

The project team analyzed different barriers that made difficult the "articulation" or joining of common issues. One was the official health care system's lack of knowledge of traditional medicine. The official system refused to use, or even adjust to, traditional systems — it is a "system designed to meet the needs of civil servants," Valverde said. She added that Native and western medicine have stayed separate and there is no real articulation of the two.

She noted that health is an important factor in social development and cannot be separated from issues like poverty and illiteracy. Poor people have no real access to health care facilities — one visit to a hospital can cost one month's earnings. Another barrier is evident when health care professionals from other regions cannot speak the language of the person who is sick.

Facilitative actions include support from international organizations like PAHO, Valverde continued, adding she was pleased that PAHO has abandoned its "timid" support and has now acknowledged the importance of the role of Native medicine. Other facilitative factors include strengthening Indigenous organizations at all levels but especially the local and community levels. International meetings are useful only to the extent that their recommendations for action are implemented.

Valverde concluded by presenting some of the recommendations made by the project team for government, non-government and Indigenous organizations. Recommendations for government included: supporting the struggles of Indigenous peoples for self determination; recognizing the importance of traditional medicine in health policies; and having Indigenous peoples making decisions about health care policies.

Recommendations for non-governmental organizations included: adapting policies to reflect the demands of the Indigenous community; decreasing the participation of middlemen in the management of funds and projects; discouraging the use of foreign goods and technologies in projects; and becoming allies to Indigenous groups in their struggles with governments.

Recommendations for Indigenous organizations included: creating and coordinating a decision-making process; monitoring the creation of groups that intervene on behalf of Native peoples; actively participating in socio-anthropological studies on Indigenous health; creating and publishing an inventory of resources for traditional healing and exchanging this information; and requesting that the authorities recognize and respect traditional healers. She concluded by adding one final recommendation: that the results of the workshop be distributed as widely as possible.

Institutions, Indigenous Peoples and Health Policies: Colombia

Anatolio Quira, Organización de Nacionalidades Indígenas de Colombia, Colombia, said the first priority of Indigenous peoples around the globe is establishing a land base. "We're losing traditional medicine and culture in Colombia," as a legacy of the European invasions that began 500 years ago. The invaders took away his people's land and pushed them to the highlands. Cultural assimilation has created very serious problems for the Indigenous peoples of Colombia, and the government is "totally unaware" of these problems. When his people became aware of the power struggle for land, they began to realize that their problems were not of their own making and they began their fight for legislative changes to "win back our lands" and improve their situation.

Barriers to the struggle include many elected officials who are also large landowners. Some of these officials have actively fought the Indigenous movement. For example, the government recently authorized what we call "negative family planning," the institutional implementation of family planning within the primary health care program. Most of the times the basic health services were provided under the agreement of family planning. In some cases Indigenous women were forced to have a tubal ligation (what we call castration). Quira and others began the fight to win back land in 1972. By 1974, there had been several deaths among the activists and some imprisonments. In 1980, the group became the Organización Nacional Indígena de Colombia (ONIC). Their activities have included land squatting, taking over government offices and setting up roadblocks on highways. The government passed a law in 1983 which recognized some of their demands, but Quira noted that all too often, laws are not fully implemented.

The issue goes further than land rights; it includes having the government recognize the knowledge base of Indigenous peoples. Traditional healers know about plants, roots, and prayers. "We need to gather together that body of knowledge, present it to the government and demand to be respected." He said the government fears the Indigenous activists are trying to take something away from them, "and they're right," but that both traditional medicine and western medicine can learn from the other.

Traditional medicine is important because his ancestors have always used it, and there are no artificial ingredients to harm people. Western medicine, on the other hand, relies on drugs "developed in other lands" that do not promote longevity and that "pollute the body." Quira believed that diet and nutrition are very important health determinants and that "we're eating poisoned food."

He concluded by describing the camaraderie that he and other Indigenous senators share and by presenting the workshop organizers with a document prepared by his organization. Some of the document's recommendations included: supporting actions of various countries that are adjusting their laws to reflect the concerns of Indigenous peoples; creating a department of medical anthropology to trainworkers in the area of health; encouraging international health organizations

to develop policies advocating environmental protection; contributing to the design of epidemiological indicators by supporting research; and promoting the creation of an international support fund for health initiatives for Indigenous peoples.

Indigenous Health and Health Policies: the Caribbean

Joseph Palacio, representing the National Garifuna Council of Belize, described the health situation of Indigenous people in the Caribbean, with particular emphasis on the social context in which health services are delivered. The region is made up of micro-states, in a world where decentralized government is becoming more and more a trend. Indigenous people still face health problems in micro-states, Palacio said; the main difference is that the issues are sometimes more clear than they would be in a more complex environment. "Even if the state only consisted of Aboriginal people, there would still be problems," he said.

Beyond the size of the region, the Caribbean is unique in another very important way: after generations of mixing between Aboriginal and non-Aboriginal populations, "it becomes a little bit difficult to differentiate" between population groups. In Belize, it is more accurate to talk about a continuum, including people who are "very Native", others who are very westernized, and a lot of people in between. "The boundaries among these people are flexible," he said. "Using the word 'ethnicity' doesn't count very much, because rarely do you have pockets of people that are isolated" according to cultural origin.

The Caribbean "is the place where the systems of the two worlds first collided," Palacio said, so that Indigenous peoples in the Caribbean were the first to experience the system of genocide, slavery, and colonialism. "Thirty years after Columbus landed in Hispaniola, about 90% of the population had died," he noted, and other colonial powers were quick to follow in his wake: "Practically any European country that wanted a colony went to the Caribbean."

Overall health indicators in the Caribbean today "are some of the best in the Third World," Palacio said, "primarily because you're dealing with countries which became independent no more than 20 or 25 years ago, and which have seen the benefit of political independence as a way of improving their health infrastructure." But Aboriginal populations in the region face significant problems in the areas of maternal and child health, malnutrition, and certain diseases, and changes in economic standing may have an impact on the entire region over the next generation or two. Aboriginal health care is generally lumped in with services to the rest of the population, so there is quite a bit of activity in the area of primary health care.

Palacio put forward the following recommendations for Indigenous health programming in the Caribbean:

- Caribbean nations must be sensitized to the issues of poverty and disease that are affecting the Aboriginal people in their midst. PAHO and other organizations must continue pressing national governments to recognize that these specific problems require a coordinated response.
- The concept of emergency health zones would be extremely helpful in the case of micro-states. In addition to geographic zones, it would be helpful to be able to designate social zones, including inner-city areas and some rural communities. "There is a tremendous amount of poverty, which might not include Aboriginal people, but it might, also," Palacio said. Specific problems include drug abuse, prostitution, and a feeling of anomie and listlessness among the people.
- There is an important equity issue in countries where every citizen pays for health care, regardless of income. The result is that poor people and Aboriginal peoples are subsidizing the rich in their countries.
- Health programs must ensure that small states receive special attention, rather than being overlooked.

The Caribbean is usually lumped in with Latin America, Palacio said, "or else we're lumped in with North America, which is even worse". Either way, there are few if any resources left for Caribbean nations.

The Cuetzalan Experience: Mexico

Carlos Zolla of the Instituto Nacional Indigenista in Mexico traced the work that had been done to set up an experimental rural hospital in Cuetzalan, in the northern part of Puebla, Mexico. He noted that Indigenous people are the most vulnerable segments of the Mexican population, with least access to health providers. He mentioned that Mexico has approximately 9 million Indigenous citizens who speak 56 different languages.

A series of slides documented the poor health status and socio-economic conditions of the country's Indigenous population, based on such indicators as access to electricity, water and sewage, literacy and school dropout rates, child and preschool-age mortality, infectious disease and respiratory ailments. The Instituto is not a part of Mexico's national health system, Zolla said, "but there is a saying that 'we had to dance with the ugliest one.'" The organization was committed to working with those populations that have the greatest health needs and the most limited resources, but found it difficult to allocate its own limited staff time — effort could be put into direct intervention through small projects, or devoted to community relations and public awareness in support of broader Aboriginal health objectives.

Cuetzalan became a model for community health care in other communities, one that Zolla said could be taken up by health institutions and non-government organizations. The project was built on three basic principles:

- No decisions were to be made without full community participation;
- Conditions must be put in place to permit the transfer of authority and knowledge to the community level;
- There is a need for strong, effective coordination between institutions, to permit major steps forward in the delivery of health services.

The Cuetzalan project also relies heavily on a primary health care strategy that was adapted to the needs of Indigenous communities, recognizes the importance of traditional healers in serving the Aboriginal population, and involves a close working relationship with Mexico's National Council of Traditional Healers. "Cuetzalan is nothing more and nothing less than an attempt to rethink health services for an Indigenous region," Zolla said.

The project was launched in 1989, in a hospital that was in an advanced state of deterioration. It serves 46 communities with a total population of 28,000. The region has been gripped by economic recession brought about by falling international coffee prices in 1989, but has been able to maintain a strong cultural identity. In order to fit in, it was necessary for the project to improvise on the western medical timetable, for example: Thursday and Sunday are market days in Cuetzalan, therefore there is more activity on those days.

In 1990, the project team decided to position the hospital as one element of a decentralized health program that would offer a combination of scientific/modern medicine, and traditional healing. The reality in Mexico is that these three elements are constantly interacting, with users frequently deciding what mix of services will best meet their needs. "It's a system of complementarity on one hand and conflict on the other," Zolla said. A health system should theoretically offer a combination of institutional and decentralized care, with all the institutions in a given region taking part. However, a high degree of coordination is often required to decide roles and responsibilities.

The Cuetzalan project relies on a number of key health agents, Zolla said. Physicians, surgeons, and other western-style practitioners have had a major role, thanks in large part to a conscious effort on the part of the project team to keep all the players at the table. Traditional healers have remained involved, despite language barriers and other cultural differences. Community outreach and prevention education programs are a third important element that has received a boost from the perception of the Cuetzalan site as an "Indian hospital". Throughout, there has been a conscious effort to avoid confusing the roles of the different professionals and practitioners,

Zolla noted: "We do not believe that traditional healers should work in health promotion. We believe in health promoters doing the promotion and traditional healers being traditional healers."

Professional credibility is an important issue for traditional practitioners, and Zolla said the healers' association was established largely to achieve economic and social acceptance for Indigenous medicine. However, the organization was formed on a non-profit basis, and its finances are still not entirely secure. Some of the traditional healers at Cuetzalan have been looking into the cultivation of medicinal plants under controlled conditions, as a means of generating revenue for the association.

Based on the Cuetzalan experience, Zolla suggested a number of directions for further action. The model must be extended and adapted to serve Aboriginal communities in urban areas, and in agricultural regions. But it also demonstrates "that primary health care is not cheap," he said. "It requires a significant investment, especially in infrastructure. We also found out that prevention, unlike treatment, requires us to keep in touch with the whole community at the grassroots level." The question, four years after launching the project, is how to maintain community links, build capacity at the local level, and deliver sound preventive health care services "without having one bloody peso to spend".

Day 3: Metis Opening and Recap

Day 3 of the workshop opened with a traditional welcome by Metis grandmothers, who underscored the role of Metis women as leaders and care givers.

Rapporteur Myrna Cunningham followed with a summary of the priorities and recommendations that delegates had raised in the course of the plenary sessions and workshops on Wednesday.

Cunningham cited an important common theme that had been repeated by plenary presenters from South America, Central America, the Caribbean and North America, with numerous examples and in many different ways: a long and persistent struggle will be needed to reclaim Indigenous peoples' rights in the face of deceit, persecution, and a combination of legislative, regulatory and bureaucratic traps. Only the ultimate, non-negotiable objective of Aboriginal sovereignty will put an end to a long history of rationing health care in a way that has made appropriate services inaccessible to Indigenous peoples.

As an antidote to physical, cultural, geographic and economic isolation, delegates talked about Aboriginal autonomy, self-determination and access to resources as the basis for good health: until now, Cunningham said, governments have based their health policies and programs on bureaucratic constraints, reflecting their own need to either generate visible programs or save money. The alleviation of pressing health problems has generally received lower priority.

In the course of the discussion Wednesday, it became clear that the Indigenous Peoples of the Americas are struggling for health in a diversity of contexts and political spaces, within a variety of different states, communities and environments. A process of "articulation" will be required in order to open up viable spaces for traditional healers.

Cunningham divided the day's recommendations into the following categories:

Health Program Priorities

- The only way to guarantee appropriate health services is for Aboriginal communities to take over decision-making capacity, with no intermediaries.
- The administration of Indigenous health services must be placed in the hands of the communities themselves, to avoid perpetuating conditions of dependency.
- Cultural differences between non-Indigenous health workers and the Indigenous people they serve must be recognized as a serious obstacle to health. Strategies are required to educate health workers to understand the cultural and health needs of community members.
- Legislative strategies are required to ensure that the health needs of Indigenous people are met. Enforcement is a key issue, because laws are meaningless without political will.

- Organizational development and massive public education campaigns are required to build public acknowledgement and support for Aboriginal rights and entitlements.
- It is important to make use of the legislative spaces that Aboriginal people have taken back, in order to consult with Indigenous communities around health priorities and strategies.
- Concrete strategies are required to ensure the development and implementation of programs that meet peoples' needs and promote real community participation.
- International health organizations must play a role in promoting and disseminating Aboriginal initiatives in the field of environmental protection, and in obtaining government commitments on strong environmental defence policies.
- Health organizations must support the establishment of a health fund for Indigenous peoples, as well as a new international body to ensure follow-up and enforcement of appropriate Aboriginal health policies. The health situation of Indigenous nations that straddle geographic borders was identified as a specific, urgent priority.
- Local and regional organizations must play a role in supporting the process of "articulation" between traditional and western medicine.
- The international community should declare emergency zones wherever Indigenous people face health problems related to isolation, poverty, or other factors.
- Caribbean countries must be included in all Indigenous health initiatives.
- A coordinated effort is required to overcome limitations to the practice of primary health care in Indigenous communities.
- Health programs and projects in Indigenous communities must be based on the transfer of adequate resources, combined with empowerment and institutional back-up for Aboriginal people.
- As a basic principle, the synthesis of traditional, western, and domestic health practice must be allowed to be carried out by the end users of the service.
- The design of Indigenous health strategies must reflect the migration from rural to urban centres, resulting in changing mortality and morbidity profiles.
- Priority issues in rural communities in North and South America include alcohol and drug addiction, child abuse, wife battering, suicide, and HIV/AIDS. Working groups recognized the global causes of ill health among Indigenous peoples, but felt it was extremely important to discuss the concrete experiences brought about by the loss of land tenure and cultural identity. Indigenous communities are in great pain, and some groups felt that practical solutions are not immediately obvious.

- Delegates from Canada and the U.S. expressed concern about a lack of follow-up mechanisms, to evaluate the results of health programs or ensure that supportive services carry over into change at the community level.
- It was noted that many Indigenous communities represent a source of cheap labour that supports economic development across the Americas.
- Participants agreed on the need to develop specific recommendations in the area of Indigenous women's health.

Health Policies and Relationships

- PAHO should play a role in assembling a complete information base on Indigenous health, and should take the initiative in declaring emergency zones to address crisis problems like cholera, suicide, alcoholism, and treaties that straddle borders.
- Traditional medicine should be maintained as a parallel system. Efforts in this area should be based on a concept of articulating complementary services, and not on integrating traditional medicine within western practice.
- Organizational support is required for exchanges among traditional healers.
- Governments must take steps to protect traditional healers from violence and harassment in their travels across borders and within countries.
- Preservation of Indigenous peoples' sacred sites must be recognized as an urgent priority, in order to prevent further loss of cultural values that are integral to good health. Groups heard of many cases in which sacred sites had been desecrated to make way for mines, tourist sites, or golf courses. This is a critically important issue within the context of holistic health care.
- PAHO should play a key role before the United Nations in promoting recognition of Indigenous peoples' experience in environmental conservation and management. Indigenous people should have the opportunity to live on stewardship lands like national parks, particularly where no other land has been made available for them.
- Elected politicians of Aboriginal origin should encourage legislative initiatives in their countries to support traditional medicine.

Training and Education

- Non-Indigenous health workers in Indigenous areas should receive training in medical anthropology, traditional medicine, and language skills, to enable them to acknowledge and respect the culture in which they are working.

- Universities and institutions across the Americas should establish a database of training resources in the field of traditional medicine.
- Educational institutions in different countries should attach higher priority to Aboriginal training needs, and should support training programs in Indigenous communities.

Implementation

- All Indigenous health programs must be based on respect for cultural values and traditions, and on recognition of geographic and social differences between the areas inhabited by Indigenous peoples.
- PAHO should act as an intermediary to ensure that programs and projects are implemented in collaboration with Indigenous communities, and that health initiatives support the movement toward self-government and self-determination at the local, regional and national levels. Program implementation should be guided by joint planning committees that include *bona fide* community representatives, not "government Indians".
- A communication strategy must be developed to disseminate information on Indigenous health initiatives and promote a focus on outcomes, not just output. Participants shared numerous examples of ineffective government programs, including HIV/AIDS services and education materials that are useless at the community level.

Follow-Up to the Workshop

- A working group of Indigenous delegates should be formed to present recommendations arising from the workshop to the next meeting of Pan-American health ministers.
- Delegates should present the recommendations of the workshop to the governments and health ministers of their own countries.
- The workshop should establish a committee to monitor the adoption of specific recommendations in different countries.
- An information network should be established to bring together delegates and other interested parties from all the countries represented at the workshop. The network should be used to share updates on legislation and other initiatives arising from the workshop.
- PAHO should continue emphasizing the importance of dialogue on Indigenous health issues, and should promote information exchanges among traditional healers.
- One of the concurrent groups said it has taken PAHO 90 years to press for a definition of traditional medicine, and suggested that delegates should be in no hurry to comply with the request.

The Changing Role of Indian and Northern Health Services: Canada

Roberta Hildebrand, Director General of Indian and Northern Health Services at Health and Welfare Canada, opened her presentation by acknowledging her Aboriginal ancestry. She had been presented with a Metis sash 3 months previously in Sault Ste. Marie she said, and was honoured to wear it during her remarks. Ms. Hildebrand reviewed the history of her organization. The 1867 British North America (BNA) Act declared that "Indians and lands reserved for Indians" fell within the exclusive legislative authority of the federal government. The 1874 Indian Act (IA) empowered the federal government to make regulations for health on reserves.

A series of treaties were signed by the Crown and Indian peoples beginning in 1876 with Treaty 6, which contained a "medicine chest" clause requiring that a medicine chest be kept at the house of each Indian Agent.

The first chief medical officer for the Department of Indian Affairs was appointed in 1904 but dismissed a decade later for his efforts to discuss the tuberculosis problem. The first Indian hospital was built in 1917, an attempt to address the severe tuberculosis problem; there are currently seven Indian hospitals, and the federal government is trying to hand them over to the provinces.

In 1945, the newly-created Department of National Health and Welfare (now HWC) took over responsibility for Indian health. The 1957 Hospital Insurance and Diagnostic Services Act ensured health services for all Canadians. In 1962, the first training course for community health workers was held in Manitoba; before that time, community health workers were not trained.

A 1969 report on Indian health services recommended a community development approach and identified as inevitable the gradual withdrawal of the federal government from direct services. In the same year, the federal White Paper on Indian policy recommended the provincial takeover of federal services to Indians. The White Paper was opposed by Indian groups and was shelved.

The National Native Alcohol Program (now NNADAP) was established in 1974, and in 1978 the government released guidelines for uninsured health services to control the provision of drugs, glasses, dental care and medical transportation and to stem the escalation of costs incurred by Indians who were not indigent or who lived off-reserve under provincial jurisdiction. Indian opposition to the guidelines was strong and the guidelines were shelved. A year later, however, a new Indian Health Policy stated that professional medical and dental judgement would be used as a measure of the need for non-insured benefits.

The first transfer agreements were signed in 1989, transferring Indian health services to community control. Seventeen agreements have been signed with bands to date. About 200 more bands are in the pre-transfer stage; the government provides money to these bands to conduct a needs assessment and draft a health care plan for their community. Once approved by Ottawa, funding is guaranteed for five years. There are some problems with the transfer program, said Hildebrand, but on the whole, transfer communities are very happy with the program. Non-transfer communities continue to use the services offered by HWC's Medical Services Branch.

The community-based health initiative was launched in 1969 to try to provide every community with the resources to form a health committee, coordinate the efforts of health care services and workers in the community, and develop a needs assessment. Through a Memorandum of Understanding with the Medical Services Branch, some communities can begin to take control of the resources for health programs.

Four initiatives are common to communities that have signed a transfer agreement and those trying a community-based health approach: a focus on communicable diseases, public health, environmental health, and the ability of the community to provide treatment services.

Hildebrand noted that health care services for Indians have grown considerably since 1944. Currently, there are 580 facilities, including 477 nursing stations, 35 NNADAP treatment centres, and 61 health offices. (She quoted the most recent figures on the number of Aboriginal people in Canada as: registered Indians, 500,000; non-status Indians, 260,000; Inuit, 35,000; and Metis, 160,000.)

"It sounds like it's not a bad health care system," she said. But despite initiatives such as the Non-Insured Health Benefit Program, NNADAP, family violence initiatives and the Brighter Futures program, the health of Aboriginal peoples in Canada remains poorer that the health of non-Aboriginal Canadians.

"Why is this?" she asked, then answered: "Because the federal government and people outside the communities are trying to run the show." Until recently, Aboriginal people were not consulted about the programs and services designed for them. "We need to listen more," and find ways to respond to the expressed needs of Aboriginal peoples, she said.

Hildebrand has worked in the health care system for more than two decades, and she believes there is hope for the future. "Medical Services Branch has to sincerely put ourselves out of business," she said, concluding that self-government initiatives are the key to improved health care for Aboriginal peoples, and "until people really begin to control their own destinies, we will never see any real improvement."

Martha Flaherty, Pauktuutit

Martha Flaherty, president of Pauktuutit, the Inuit Women's Association of Canada, said her people are tired of being symbols. The Canadian government often gives Inuit carvings as official gifts to visitors but it forgets about the Inuit after the visitors leave.

Flaherty said she is proud to be an Inuk. In the 1950s, the government relocated her family from their community in northern Quebec to the High Arctic. The ship dropped them in Grise Fiord with no food or shelter. Her father died of a broken heart, her mother was "used sexually by the RCMP" to be able to feed her family, her brother became mentally retarded from malnutrition, and her sister was lost for years down south.

Flaherty prefaced her remarks about Pauktuutit by noting that she has "problems with the word 'feminist', because it creates hostility between men and women." She believes "men and women should work together to save our children."

She explained that until 1960, most Inuit lived a traditional lifestyle on the land. Today, the approximately 33,000 Inuit in Canada live primarily in 52 communities scattered throughout the North. Inuit society is still in transition, and "the many social problems which tend to cluster around societies in transition are evident in our communities."

Pauktuutit was created in 1984 to represent Inuit women. Its mandate is to foster a greater awareness of the needs of Inuit women and to encourage their participation in community, regional and national affairs. Primary concerns of Inuit women are violence against women and children, gender equality, economic development, the administration of justice, traditional midwifery, child care, HIV/AIDS education, and youth suicide. The organization also has a mandate to represent all Inuit — women, men and children — on health issues.

"At this point in our history, we are dealing with so many problems that we can be overwhelmed if we lose sight of our basic strengths," she continued. Strengths of the Inuit include: a rich, vibrant culture; the ability to survive under adverse conditions; a living, working language; and a value system that includes cherishing children and respecting Elders. "These strengths should be the foundation of any long-term strategies to improve the health of our families and communities and engender pride and self-respect in our children," Flaherty said.

She introduced the issue of traditional midwifery to illustrate the problems faced by the Inuit. For thousands of years, Inuit women gave birth on their own or with the assistance and support of husbands, mothers, sisters or midwives. Over the years, Inuit midwives developed knowledge and skills that were passed on to generations of women. When Inuit families moved from traditional camps into permanent settlements, births began to take place at the nursing stations. In the 1970s, the federal government decided that all births should take place in hospitals, and Inuit

women living in communities without hospital services were evacuated by air to a regional centre or to southern Canada. Today, almost all Inuit children are born in a hospital, often far away from home, family, and all forms of community support.

Inuit women are not advocating a simple return to the old ways but are seeking a combination of traditional Inuit midwifery and western medicine. They seek alternatives that benefit the entire family and do not expose women and newborn infants to unnecessary risk. However, Inuit women find themselves in a debate with authorities "premised on a disrespect for our history and for the knowledge and skills which many of our Elders still possess... We have not been allowed to engage in this debate as equals."

The many social, economic and health problems facing Inuit communities today require both urgent and long-term solutions, Flaherty said. Solutions must draw from the best of Inuit and non-Inuit traditions, knowledge and technologies. She concluded by stressing the strong links between political self-determination and the ability to solve community problems.

Modern and Traditional Medicine in the Amazon: Brazil

Marcos Antonio Guimaràes, Ministry of Health, Brazil, began his presentation by showing on a map the location of the Indigenous reserves in his country. When their lands were taken away after the European invasions, the Indigenous peoples lost their traditional medicines.

Guimaràes showed a series of slides illustrating wooden sculptures made by the Yuagua Indians, who live in an area on the border between Brazil and Colombia. The sculptures represented women in various stages of childbirth. The first was a woman in labour. Another represented the start of birth, with the head of an infant visible between the woman's legs. The sculpture on the next slide showed the total expulsion of the infant, the woman in pain. "Women don't need to be hospitalized (when giving birth), they just need access to their own culture, period," he said. In Indigenous communities, breech presentations at birth are very common; this is treated in western medicine by surgical intervention. He added that in Indigenous communities, it was important for the husband to be with his wife at childbirth, since he participates actively in the process.

Birthing methods are similar among the Carajà Indians, who live in the central area of the Amazon basin. Here, a woman giving birth is assisted by two people. The midwife stands in front of the woman, and the person to provide psychological support stands behind. This second woman gives orientation to the woman in childbirth, talking to her in a soothing voice about her

experiences during previous births.

Guimaràes showed a video entitled *Goldseekers Versus the Indians*, about the impact of goldseekers on an isolated Indigenous community in the Amazon basin. The first part of the video showed the Indigenous people in their home environment, and then during contact with a non-Indigenous research and medical team. The Indigenous people sang songs of welcome to the visitors. Part of the project was to vaccinate the Indigenous people against viral diseases brought by contact with newcomers. The team also intervened with emergency medical treatment in serious cases. The goldseekers were part of a process that is "waging total war against the ecosystem," Guimaràes continued. However, the goldseekers see themselves not as wreakers of environmental destruction but as people seeking their fortune. The video included several interviews with goldseekers who spoke in a patronizing way about Indigenous peoples. Many of the Indigenous people living in the area ravaged by the gold industry believe that their world is being destroyed.

Guimaràes concluded that the Indigenous people shown in the video have been able to survive in their natural environment for thousands of years, and he urged delegates to help develop international support for their cause. Rapporteur Myrna Cunningham said she always has a mixed reaction when viewing videos of this kind, because anthropologists are often in a position to "violate our secrets."

The Human Genome Development Project

Although not part of the planned agenda, the inclusion of this item resulted from a request of several participants voicing concern regarding the project and its implications for indigenous peoples in the Region.

Pat Mooney, Executive Director of the Rural Advancement Foundation International (RAFI) in Ottawa, Canada, began by saying that "what I'm going to describe to you sounds quite crazy." A number of U.S. universities and the National Institute of Health, through the inter-governmental Human Genome Project (HUGO), is planning to sample blood from Indigenous communities around the world and store the samples in the U.S.

Mooney expressed three major concerns about the HUGO project. The first was that project researchers had identified 722 communities they would like to obtain samples from. "The assumption is that Indigenous peoples are to become extinct," he said; their blood can be stored in the U.S. and used in future projects. He added that HUGO project scientists have created a new term for Indigenous peoples: Isolates of Historic Interest (IHI).

A second concern was the potential for biological warfare. The ability to easily identify Indigenous peoples by cell type and blood line makes them vulnerable to genocidal projects such

as ethnic cleansing. It is theoretically possible to develop a disease to kill a specific community, Mooney added, and this could happen in some parts of the world.

Mooney's third concern was corporate profits. "There is enormous profitability in collecting your blood," he said. Researchers have isolated a gene, found in the blood of people living in a remote community in Italy, which seems to code against cardio-vascular diseases, and other countries are trying to patent the gene. The cost of the project is $23 million. He explained that in the U.S. and Japan, it is now possible to patent parts of the human body, and that the U.S. government's National Institute of Health recently applied for patent rights for over 2,800 human genes drawn from the brain.

A workshop participant asked Mooney what could be done to stop the project. Mooney responded that blood collection projects are known to be under way in Chile, the Nile River area and parts of Southeast Asia, and these projects should be documented. The issue should be brought to international human rights forums. As well, it should be made illegal for someone to profit from the blood of Indigenous people, he said.

Another participant said the issue was of extreme relevance to the workshop. He was recently at a conference discussing traditional medicine with a well-known and respected scientist who told him that "within ten years, we won't be looking to the forests for medicines," and that scientists will be looking to human genes to provide all medicines. "This is frightening and a serious concern," he added.

A participant from Panama said she was "extremely concerned" about this issue. There has been a research project under way in her country involving 7,000 Indigenous people. The researchers had said they were looking for new ways to treat diseases suffered by the Indigenous people, but the participant did her own research and discovered that the project was trying to find drugs that would help non-Indigenous people. This is of grave concern, she said. The research team has announced it will need more blood samples to do its work. The project is scheduled to continue for another four years. "How many blood samples will they take, and how will they be used?" she asked. "I consider this to be a possible emergency situation for Native peoples."

A special concurrent session was held later in the afternoon to discuss the issue in more detail.

Metis Cultural Evening

In the evening, a Metis Cultural event was hosted by His Honour, W. Yvon Dumont, the first Metis to hold the office of Lieutenant Governor in the Province of Manitoba. This was the first

official party given by His Honour at Government House.

Cultural entertainment and dancing were presented as a display of Metis culture. Over twenty Metis volunteers participated alongside professional entertainers during the evening. On behalf of all participants, Workshop '93 would like to thank the following Metis volunteers from Winnipeg, Brandon and Woodridge, Manitoba: Diane Bartlett; Alexina-Kateri, Anna-Celestrya, Even-Aryeh, Seraph-Eden and Thane-Dominic Carr; Anne M.L. Carr, Robert M. Chartrand; Bossy Ducharme; Holly Ferguson; Jeanette Goertzen; Utami and Nancy Grant; Carol E. Lennox; Amanda and Anne Lindsay; Ray Ann Lynch; Marilee Nault; Dorothy Rokovetsky; Nelson Sanderson; Ed Swain; Destiny Taillefer; Jeanette Thiessen and Sara Turner.

Day 4, Latin American Opening and Closing Session

On the invitation of the Steering Committee, one of the Peruvian participants, Luzmila Chiricente Nahuanca, agreed to sing a ballad from her tribe's folklore in lieu of a formal prayer.

Participants then discussed a set of recommendations for global action on the urgent issues that had been raised on the course of the week. Workshop Coordinator, Norbert Préfontaine explained that it had been impossible to complete a draft synthesis document in time for distribution to all delegates. Instead it was agreed that Myrna Cunningham would provide a verbal summary as a basis for discussion, that a six-week period (end of May) would be set aside for participants to send in written comments on the recommendations, and that the final document, including selected interventions, would be distributed by the end of August, 1993.

Cunningham noted that the ideas brought forward from the concurrent sessions had varied widely, from proposals for global structural change to very specific recommendations dealing with traditional healing and community entitlements. She stressed the importance of producing a practical, understandable document that would be useful in a wide variety of settings.

Editor's note: The draft document from which Rapporteur Cunningham summarized the week's discussion led to the adoption in principle of the recommendations which appear at the very outset of this Report.

Discussion

The first participant to comment on the presentation picked up on Norbert Préfontaine's description of the six-week review period, indicating that it would be useful to have a process for amending the synthesis document without altering its spirit. He suggested that a number of elements could be added to the document, such as a reference to the world-wide initiative for Indigenous children coming out of the World Summit for Children.

A participant stressed the importance of distinguishing between traditional and Indigenous medicine, noting that the healers at the workshop preferred to be described as Indigenous. Subsequent discussion of this point centred on the relative importance of herbs and healing practices introduced by the Spaniards when they first reached the Americas; while one participant said Spanish contributions had been integral to traditional medicine, another said European herbs are rarely used by most Indigenous nations.

A delegate discussed the importance of preserving medicinal plants, noting that a traditional medicine conference in Beijing in 1981 had asked WHO to declare October 28 as International Day of Traditional Medicine. He offered to share proceedings of the 1981 conference with Workshop 1993 organizers.

Several speakers discussed the difficulties experienced by Indigenous peoples in the Andes and the Amazon region in attempting to make use of traditional medicines based on coca leaves. It was noted that coca is one of the basic ingredients of many traditional medicines, and is completely different from the cocaine products that have been harvested for drug trafficking. "These are totally different issues," a participant said. "I want to make sure that our brother and sister communities consider this and don't look at us as drug traffickers, but as Indigenous physicians who are using a basic ingredient of our pharmacopia." It may be wrong for a non-Indigenous person to use coca leaves, "but for us it is a life-giving plant," used to treat heart disease and stress. Later, another speaker expressed concern about the development of "narco-economies" and "narco-democracies" built on cocaine.

A delegate noted that the workshop had begun with an invitation to participants to define health, and stressed that the holistic model of spiritual, physical, emotional and mental health is the basic starting point for all other discussion. On this basis, she said the reference to holistic health should be the first point in the synthesis document, not the fourth. Another participant said the document should include a glossary, noting that the definition of Indigenous physicians appears to vary by region — in Canada, members of the Native physicians' association are Indigenous people who trained as western practitioners.

Dr. José Maria Paganini of the Pan American Health Organization said the discussion reflected the workshop objective of achieving broad participation in decision-making. He congratulated participants and organizers for assembling a great deal of valuable material, and emphasized that there was no need for consensus on every point. There's a diversity of world views, he said, and it would be appropriate for the synthesis document to reflect the full range of perspectives that participants had brought to the table.

A delegate said the synthesis document was a "remarkable" work that should be accepted in principle, but expressed concern that it lacked research and statistical detail. He also suggested that no health policy will achieve its objectives until marginalized, impoverished communities have the means to build their economies.

The next speaker stressed that Indigenous medicine is also a science — the only difference is that it hasn't been studied by formal researchers, so that it doesn't appear in textbooks or libraries. The body of knowledge about traditional healing rests with Elders and ancestors who

helped keep the tradition alive.

He said traditional medicine involves resources and characteristics that are unique to each community, and involves a process in which human beings can integrate the physical and spiritual worlds.

A participant called on PAHO to continue defending and advocating for traditional medicine. Indigenous peoples are not against patent drugs, he said, but Indigenous medical practices must also be preserved. He recommended that a follow-up meeting on Indigenous health be held in 1994, possibly in Mexico City.

A representative of a government health agency expressed concern about issues of terminology in the synthesis document, noting that some language that is "intolerable to certain groups" can be deemed absolutely essential by others. He said his country had seen a great deal of suffering because of language and usage, so that a lot of people had softened their statements as a result. He also expressed concern that the statement of principle on land entitlement, while it was of "immense value", might block the development of other items in the statement. The participant stressed the importance of epidemiological monitoring, but questioned whether management of Indigenous health services or membership in the follow-up commission must rest solely with Indigenous representatives. Another speaker stressed the importance of organizing local health initiatives in a way that brings communities together, rather than reinforcing their isolation.

Later in the discussion, an Indigenous representative from Canada said a document with softer wording would still be useful to her group. "Some of us have no problem getting downright militant and angry on behalf of ourselves and our brothers and sisters around the world," she said, but a more neutral writing style would be acceptable.

A participant addressed the issue of definitions, citing WHO statistics indicating that 80% of the world's population relies on some form of traditional medicine. By calling themselves traditional healers, he said Indigenous practitioners could establish a semantic link with their counterparts in other cultures around the world. "It may be helpful to bear in mind that this is a global phenomenon," he said, suggesting that a "substantial exchange" among traditional practitioners could be extremely valuable.

A delegate called for a recommendation that PAHO establish an office of Indigenous health, to be staffed by an Indigenous person. He also suggested that Indigenous Parliamentarians could have a substantial impact on Indigenous health issues, without requiring a major commitment of new resources. The next speaker called on government representatives to carry the workshop recommendations back to their respective ministries, and stressed the need to launch a dialogue on

Indigenous health in every country.

One participant stressed that project funds should not be channelled through government bureaucracies, but should instead be directed through Indigenous institutions. Another said she was pleased to see that the decisions and recommendations reflected the discussion in participant groups. "This is the best way to do this. We have to work together," she said, thanking the organizers on behalf of the National Council of Native Physicians of Mexico and reiterating her invitation to hold the 1994 meeting in Mexico city.

A representative from the Indigenous Health Branch of the Government of Brazil apologized for his late appearance at the workshop. He explained that the Indigenous Health Branch was in the process of being reorganized and he was happy to note that both the Branch and PAHO had similar strategies for Indigenous health. He was pleased that the recommendations he had forwarded to the organizing committee before the workshop were reflected in the workshop's recommendations.

Myrna Cunningham said the organizing committee would commit itself to doing as much work as possible to reflect the concerns of participants, and she explained the procedure for delegates to provide feedback on the final document.

After some discussion among participants, it was agreed that the group would break up into regional meetings to define the role of the follow-up committee and name members to that committee. It was proposed that the committee be comprised of three delegates, one each from South America, Central America including Mexico, and North America, and that each region also name an alternate member. One participant noted that the Caribbean region should not be ignored in this process; another suggested that each country should have its own representative linked to the committee.

Final Activities

The workshop ended with a traditional spiral dance imitating the circle of life and a "visiting" circle which encouraged the delegates to express their feelings for each other.

First Nations Celebration in Carberry

The delegates were then invited to a rural campsite, Mother Earth's Children, in Carberry, Manitoba, as an introduction to First Nations practices. Men's and Women's sweat lodges and ceremonies were offered on Friday evening and Saturday, giving an intimate view of Anishinaabe religion and culture.

Aboriginal Feast and Farewell

On Sunday morning April 18, buses brought participants to Kateri Tekakwitha Aboriginal Catholic Church in Winnipeg, where the community had prepared an Aboriginal Feast in honour of the participants from different parts of the world attending Workshop '93.

The Feast started with a spiritual service conducted in Spanish and English, celebrated by Fathers Dominique Kerbrat (who also officiated at the official opening of Workshop '93), Arthur Massé and Padre Amado Aubin, a visiting pastor from Bolivia. The themes of forgiveness, understanding and love were presented throughout the celebration as elements of and requisites to change.

There was much joy and laughter as community members and Workshop participants shared Aboriginal food and a very strong feeling of kinship. Many of the hosts and guests felt they had found long lost relatives from different parts of this world - Turtle Island. Kinship and acceptance were expressed in different ways: local Elders welcomed the Elder from the group who was invited to share the seat in Church reserved exclusively for the use of Elders, an act of respect by the Kateri community. Everyone exchanged gifts and hugs before the guests were driven to the airport and parishioners went home with fond memories and warm feelings.

CHAPTER FIVE: Interviews

In order to complement the multilateral discussions held in plenary sessions and discussion groups throughout the week and to explore the notion that the same problems may require different solutions given regional/cultural/economic variations across the Americas, workshop organizers asked that several participants be interviewed.

After consulting with Steering Committee members, the Workshop Coordinator selected six themes and asked InfoLink Consultants Inc. (they did the on-site Summary of Proceedings) to interview a minimum 2 or 3 persons per region (South, Central, North America and the Caribbean) on each of these themes.

Workshop '93 wishes to thank the 20 participants who accepted the InfoLink invitation to answer yet more questions.

1. **Provision of traditional medicine to Indigenous communities: the relationship to governmental health services. Who provides? At what cost to the consumer? Do traditional medical practitioners (shamans) and biomedical people ever do things jointly or are they working totally in parallel?**

Leyla Garro de Valverde (Costa Rica)

Both traditional Indigenous medicine and modern medicine must be part of an integrated health system for our people. Even if the traditional Indigenous medicine is, in some ways, marginal to the health programs, it can treat many of the ailments that elude modern medicine. On the other hand, modern medicine treats ailments for which traditional Indigenous medicine has limitations; thus, Indigenous peoples must have access to both systems.

Indigenous health is the cosmovision of the Indigenous culture. For governments to access this culture, they have to recognize its value and its contribution; they have to support it and respect it. This does not mean that we have to incorporate traditional Indigenous medicine to the existing health system for by so doing, the community could stop recognizing it; furthermore, as we know, with integrations of that kind, the stronger system rules and absorbs the weaker. More than being integrated, both "medicines" must supplement each other. I believe both practices can coexist, since they both have benefits and limitations, thus empowering one another. These programs have to be unconditionally funded; it is impossible to pretend to develop them without sufficient resources.

Dianne Reid (Canada)

Dianne Reid, a member of the Cree Health Board in Québec, identified a definite change in approach to Indigenous health. "First of all, government health services have always determined the policies of Indigenous health, without the participation of Indigenous peoples in developing any of their services," she said. "In the past, they've just come and said, 'here, this is the model. In order to get the money, here's the way we want you to operate. This is what we impose on you.'"

Indigenous peoples have accepted this in the past, "but the time has come when the governments have to listen to us and do things on our terms, rather than theirs," Reid said. "When you're talking about traditional practices and traditional medicine, I hope the government is not presumptuous enough to think they're going to be the ones to develop the policies on how it should be implemented." Aboriginal lands and culture have been appropriated in the past, she said, "and I don't think our people, especially our traditional medicine people or our spiritual Elders, will tolerate the appropriation of our traditional medicine, traditional healing, and Native spirituality....It's the last of our broken spirit that's left, and I don't think we will allow that to happen."

For organizations like PAHO, WHO and CSIH, this change in perspective will mean a different way of approaching Indigenous health issues. "They'll have to do it on the terms of Indigenous peoples, and not their terms, and that's a warning that's coming from spiritual Elders and our traditional medicine people," she said. "I'm just the messenger."

Reid was unwilling to address the question of articulation of services, except to say that the decision must rest with front-line Aboriginal practitioners. "Don't forget that traditional medicine people are individuals, who have their own individual approach in giving that medicine," she said. "They will decide whether they're comfortable integrating into a conventional medical system and working alongside it, or whether they feel more comfortable having a parallel medicine system. I have so much respect for my Elders that I'm not going to assume that this is the way it should be done." She stressed that the decision on integrated or parallel systems must be made by the healers in each community, rather than presuming that "that excellent case study or example from Manitoba would work really well in Venezuela...It's presumptuous to think there will be one model that PAHO or WHO or CSIH will promote as THE model, because that's not the way that traditional spirituality and healing practices work." If established organizations are sincere about promoting traditional health models, rather than just appropriating them, Reid said they will ensure that traditional practitioners are involved in developing services at the local level.

Traditional medicine is very sacred, she noted, and there are dire consequences if it is misused. "In order for those practices to really work, the four elements of spiritual, emotional mental and physical have to be present. The holistic approach has to be present. Traditional medicine and traditional healing

will not work separate from traditional spirituality: they'll be doing the same thing as western medicine, where we're only healing the physical and unable to do anything for the rest."

The issue of cost is a "touchy question" that presents "quite a dilemma" for traditional healers, Reid said. At a time when governments are cutting back on health services, Indigenous people are concerned "that the government should not use integrating traditional practices to think that that's their way out of providing health services to Indigenous people." At the same time, traditional practitioners believe they cannot accept payment for their services, because it goes against the spiritual approach to healing. The healers don't want their communities to have to pay for their services, nor do they want to be taken advantage of.

Dr. Alfredo Vargas (Mexico)

Traditional Indigenous medicine has prevailed over many diseases. This type of practice is recommended in Mexico and is one of the best ways to offer health services to the cultural group requesting it. It is true, however, that some diseases require the intervention and the use of specialized technology.

Then we can say that traditional Indigenous medicine complements "scientific" medicine. In Mexico, in some Indigenous hospitals, traditional doctors coexist with "occidental" doctors. The state lets the people decide the kind of services they want without limiting medical technology.

It is evident that the cost of traditional Indigenous medicine basically covers primary health costs and is more cost-effective. We have planned a second level model in hospitals staffed by both kinds of doctors for treatment of special medical and surgical ailments. These local systems are efficient, accessible and fair, providing population with the medical attention it needs, having both quality and warmth.

Mexico recognizes cultural roots, which are more than 30 centuries old, in which numerous traditions have survived despite time and historical contradictions. There are, actually, approximately 55 communities of traditional doctors and they treat a great number of ethnic groups. The federal government has developed a program of national solidarity through the Solidarity Committees of Indigenous Communities in order to assume responsibility for the decision-making process, the decisions being the responsibility of the federal government, the state government and the local government with direct allocation of economic resources to what the community has indicated is an essential element for the solutions. In this sense, during the program's implementation process, the community, the private sector and the government are involved.

Sharing these experiences can be our "corner-stone" for the development of that type of program.

Any experience can multiply its effects, beneficial or detrimental. We are not talking about repeating these experiences, but about adapting them to the realities of our people; the knowledge is then a multiplier of the reality of our people which will energize the development projects in our Indigenous villages.

The responsibility of the Indigenous government, of the governments and of the international organizations is to ensure the end results of that union. That will be the key to its success.

Gerald Bodeker (United States)

Gerald Bodeker of the Lancaster Foundation addressed the integration of traditional and western medicine based on his work in different international settings. "The experience varies from country to country," he said. "In some countries, there's a very well-established tradition of local people providing health care to their own communities, with some special health knowledge that they have acquired through a process of apprenticeship and insight and experience. This is generally referred to in anthropological literature as the shamanistic tradition, but it can also include herbalists, bone setters, midwives, and so on." These traditional practitioners generally cultivate and prepare their own herbal medicines, or gather and prepare them using forest herbs.

Bodeker cited India, China, Vietnam and Nepal as countries that have centrally-administered departments of traditional medicine, offer training and degree programs in traditional medicine, and place graduates in clinics and hospitals in different rural and urban settings. These practitioners will often return to work in their own communities or regions, although their expertise is not based solely on local experience.

Sponsorship also varies widely, from full government support in China, to a combination of government employment and private, fee-for-service practice in India, Vietnam and Nepal. "By and large, the source of payment for Indigenous and traditional medical services is the consumer," Bodeker said.

"Normally, this is very low. In a few countries like South Korea, however, traditional practitioners charge and earn more than western-trained medical practitioners. The applicants for the traditional medical schools have higher grades than those for the western medical colleges, and have higher status in the community."

Government funding is available in countries like Vietnam, where traditional and western-based practitioners work together in dual-service hospitals and clinics. Integrated programs are also in place in South Korea, and in some parts of India and Mexico. In Africa, by contrast, there is very little government sponsorship for traditional programs. In Uganda, however, the AIDS support organization

has involved traditional healers alongside western practitioners in providing care and treatment to people living with HIV. A high level of co-operation "has largely arisen out of a recognition by the government of two major factors," Bodeker said. "One is that there is no cure, so that the alleviation of symptoms is the most humane and realistic goal, and herbal treatment and traditional modalities can be very helpful." Second, the cost of western drug treatment is so high "that economic necessity is forcing them to look to their own herbal and Indigenous traditions for treatment."

A prevention message is common to both western and traditional medicine, and Bodeker said traditional medicine has a lot to offer in the fight against AIDS, as well as the response to increased incidence of cardiovascular disease in Latin America and Asia. For example, yoga and a vegetarian diet "are documented contributors to a reduction in heart disease," he said, "so traditional medicine has direct relevance to a health education message." The message does change, however, where traditional medicine means relying on Indigenous resources: Bodeker pointed out that oral rehydration therapy can either involve purchasing salts and packages from a local pharmacy, or teaching people to mix their own solution of salt, water, and local herbs or ingredients. The common objective is to promote liquid retention and prevent the depletion of body salts; the difference is between imported techniques or culturally familiar technologies.

The organization of national health systems has a direct impact on medical practice in the field, Bodeker noted. In some countries, including Nicaragua, India, Pakistan and China, rural health workers are provided with both Indigenous and western medical supplies. The degree of emphasis on Indigenous treatments affects the instructions issued to health workers, and to consumers, too. So once again, "the health message does change, and health educators must necessarily be sensitive to those cultural variations that occur when traditional medicine is part of the health package."

Bodeker said parallel health systems are common in most countries where traditional medicine exists. "I think you will find that traditional medicine operates in parallel with western medicine in most countries, by default or by neglect," he said. "It's largely overlooked, or viewed as a placebo or of marginal value by western-trained practitioners." Too often, people who receive western medical training and then return to a setting in the south will tend to disparage their own Indigenous traditions.

"The Indigenous system is essentially marginalized as far as policy and government resources and official recognition are concerned," he said, but there is a definite difference between official recognition and popular support. "Research shows that the majority of rural people rely on traditional medicine as their traditional source of health care, and more than half of urban populations in studies in Asia will seek traditional medicine as well as western medical treatments for medical conditions." Often, consumers seek western-style treatment for acute health problems, but see traditional healers for more chronic ailments.

Olivia Palacio (Belize)

Olivia Palacio said traditional health services can only work in a parallel situation. In her country, people must go to western practitioners first, then turn to traditional herbal or massage treatment if they need an alternative approach. This sequencing is necessary because the traditional healer would face legal repercussions if a patient died without first seeking the opinion of a western practitioner.

This rigid framework is frustrating for traditional healers, Palacio said. Western practitioners may not know what to do for some patients, because they aren't trained in herbal medicine. The traditional healers among the Carib people of Belize are mostly women, and practice midwifery as well as traditional medicine.

Payment for traditional services is based on the cost of herbal ingredients plus a small donation. "They don't charge plenty," Palacio said, noting that the typical treatment costs $3 to $4.

2. Participation of Indigenous peoples in decision-making about matters that affect health and community life

Juan Lligalo (Ecuador)

Indigenous peoples' participation must be at all levels: health, education, way of life, etc. Health must then include the physical well-being which implies enjoying basic rights such as adequate food, quality of life, health and education.

Participation in these and other activities is essential so that Indigenous peoples can get information and can participate in the decision-making process on issues as basic as health. I say this based on what I now know of the work of organizations such as PAHO, more than 90 years in existence; I would like to know what PAHO accomplished during that time regarding Indigenous Peoples' health? I can say that, except for this meeting, PAHO did not, for all these years, reach out to our Indigenous Peoples and that their health has not changed much since then.

We are starting the cultural rescue, the traditional Indigenous medicine rescue, our recognition as a people rescue. We hope for a concrete declaration of PAHO as well as a concentration of health resources in the direction of the most recognized organizations at the Indigenous level.

Senator Anatolio Quira (Colombia)

We believe that some of our rights are not recognized by the governments. This type of event gives us the moral strength to continue to fight for our demands. We no longer want to be discriminated against. Indigenous peoples have the right to life, to health, to environment. We have to consider them by respecting their culture.

The recognition of our cultural wealth is very important, especially in the International Year of Indigenous Peoples.

Events like this allow us to learn more about each other; it is a meeting in which we realize we have common problems. We need to implement as soon as possible the resolutions of this international event so that the beneficial proposals become more than words.

In this respect, we, as Indigenous peoples, are trying in Colombia to be part of the collegial and governmental bodies. This is not easy, but with pressures from different Indigenous organizations we have been able to obtain some space: with these initiatives, Indigenous Peoples are empowering themselves to defend their rights more efficiently.

Our participation at the legislative level is very important because many of the decisions affecting health and education of Indigenous peoples have been made at that level. Presently, we only have three Indigenous senators and two representatives, but we believe that participation at the municipal level will help us strengthen our influence in the decision-making process. We must also make clear that our participation in the government is independent of any political party as we do not believe in that kind of alliance. It is important for our people to remain autonomous.

As for traditional Indigenous medicine, we can participate in the consultative and decision-making processes at the parliamentary level; we can also contribute at a national level to the definition of policies with respect to health; there is no doubt that it is necessary to work in conjunction with modern medicine. Education also plays an essential role in the conservation and promotion of traditional Indigenous medicine.

Finally, to be in good health, Indigenous peoples have to have access to the land, as the answer to a lot of our problems depends on this; access to the land will allow us to better our living conditions.

Chief John Sunchild (United States)

For John Sunchild, Chief of the Chippewa Cree Tribe in Montana, the Winnipeg workshop was a long-awaited opportunity to muster international support for Indigenous health initiatives in the U.S. "My hope was that we were not just there to cry on each other's shoulders, that something else would be forthcoming. And certainly, as the meeting progressed, it was evident that there would be future meetings, future directions," he said. "What I got out of the workshop was that for once, instead of being frustrated with health issues and problems, it's now out in the open, to the point where people can be frank about it and not be afraid of retaliation from funding agencies."

In the past, he said, the institutions responsible for funding Indigenous health programs in the U.S. have made it difficult for communities to speak out on their health needs and problems. But now, with the involvement of PAHO and the World Health Organization, "we have an avenue to be heard beyond

the national funding agencies. That was the biggest thing I got out of the workshop, and I hope I'm right. Certainly, I didn't expect immediate action. I know it's going to take time. But my feeling is that it's on the right track." He said he was looking forward to the first follow-up meeting of workshop representatives, scheduled for Summer 1993 in Washington, as an opportunity to review the workshop results and develop plans for implementation.

"We don't all of a sudden expect millions and millions of dollars to be pumped into this thing, but surely the process has begun," Sunchild said, noting that he had already shared the results of the workshop with a number of different organizations in the U.S. One immediate result: The Indian Health Service, a branch of the U.S. Department of Health and Human Services, has agreed to structure its annual consultation conference in 1994 according to unmet health needs identified by tribal representatives. "We need to get to the grassroots clear across the United States on these unmet health needs," Sunchild said, "and we need to address these unmet needs." The ultimate outcome of the new links established at the workshop can be defined in very concrete terms, like access to indoor plumbing and emergency health services for all Indigenous peoples.

Sunchild recalled that he had left the workshop early for a brief meeting with U.S. First Lady Hillary Clinton, who had expressed some interest in the outcome of the event. He said he looked forward to the day that he could make a presentation on Indigenous health needs to a U.S. Congressional committee with representatives of PAHO or the World Health Organization by his side. "We've always had the documentation," he noted. "All we wanted was the institutional support."

He said he hoped concrete ideas on the form that support might take would come out of the proposed implementation planning meeting.

3. **How does the 'Indigenous Peoples and Health Initiative' improve the understanding of Indigenous health issues? Would the systematic exchange of experience help? Can Indigenous organizations be recruited as multipliers to disseminate the new awareness/consciousness that is growing in all parts of the world on this issue? What about documented case histories (successes and failures?)**

<u>Martha Flaherty (Canada)</u>

Martha Flaherty, President of Pauktuutit, the Inuit Women's Association of Canada, said Indigenous health initiatives do help create awareness, but warned that it takes a long time to build true understanding and respect. "It takes time to sink in," she said, and "even if they do understand but they don't want to respect, if they don't want to take what Native people are saying, it's not going to help." Systematic exchanges of experience can be useful, "especially if they have consistency in terms of the same people, or people from the same group."

Flaherty stressed that a true understanding of Indigenous health must take in a range of social service and housing issues that have an impact on wellness. She said Indigenous organizations have an important role to play in building understanding. "There should be more information from us that can be passed on to whoever needs to understand, especially to people working in the health field, people who have power, because a lot of people don't understand Indigenous issues." Much of the information that has been distributed in the past has been produced by white people, she noted, and "it's not the same. It has to come from us, not from them."

Governments and non-Indigenous populations must also recognize the differences between Indian and Inuit people. "We may have the same problems, but we have different beliefs and a different way of dealing with the issues," Flaherty said. "That has to be understood. Otherwise, it's like putting Chinese and Japanese together, or Lebanese and Italian. We're from a very different environment. We're coming from a very cold, harsh place where it's much harder to survive."

Even the logistics of providing health or other services to Northern communities are different, Flaherty noted: "It's not like driving from Ottawa to Toronto, or even from Ottawa to Mexico." The distance and isolation mean that fewer Inuit are fluent in English, and fewer have higher education because there are no colleges or universities in the Canadian North. The result is that other groups, even including Indian nations in the Southern part of the country, receive more resources, and Inuit health "becomes fundraising, rather than solutions."

<u>Carlos Zolla Luque (Mexico)</u>

When we emphasize the Indigenous peoples' situation, we discover a common denominator, regardless of the nation. Frankly, the health of Indigenous peoples compared to the rest of the population is disadvantaged. Thus, asking PAHO and the governments to prioritize the health status of Indigenous peoples is not a differentiation but an equalization of an historical condition of unfairness.

I would say that there are three basic conditions to consider:

First, we need important reversals in basic necessities such as food, hygiene, medical infrastructure, as well as specific programs combining local resources with institutional intervention.

Secondly, we have to take into account the new situations for Indigenous peoples in our countries. In Mexico, for example, we can find Indigenous peoples not only on their Indigenous lands but in the big cities, at the borders, on the farms where they work as temporary manual help, etc.

Thirdly, new health problems such as alcoholism, drugs, violence, accidents, AIDS are occurring in Indigenous populations. It is important to note, amongst the Indigenous populations, the resurgence of diseases like cholera, diseases which were considered eradicated.

Initiatives should be used at various levels, first of all, to generate projects and programs with full participation of the community. The exchange of information throughout the continent is necessary in order to share the experiences of successful models.

From these exchanges of experiences, PAHO could define specific health programs for Indigenous peoples. Also, we hope that the International Year of Indigenous Peoples will not only be one more celebration for the governments of the hemisphere, but we rather hope that it works towards solving such disparities.

Marcos A. Guimaràes (Brazil)

I believe the only way to improve health is through integral participation of Indigenous Peoples in the search for solutions and for their development. It is also of great importance for the world to know of the problem, so the international organizations like PAHO can support that type of initiative.

Without the exchange of ideas and experiences, it is very difficult to reach established goals. Their problems being basically the same, Indigenous peoples have to unite in order to demand a solution. The participation has to be essentially Indigenous.

4. South/North relationships: can twinning programs work? What is required from non-Indigenous partners to facilitate this? Is there any possibility of recruiting institutional partners to develop the notion of solidarity through action programs — i.e. doing things together in two (or perhaps more) countries with funding partners willing to work under Indigenous leadership?

Yolanda Nahuelcheo (Chile)

North-South relations are very important for they allow us to access a lot of information concerning the living conditions of other Indigenous people. This then allows us to better understand the global problem and, at the same time, motivates us to keep on participating in the search for solutions. The information and understanding is essential for the analysis and development of concrete proposals for the relevant activities. In the case of Latin-American countries, there has been a lack of interest in Indigenous Peoples' problems; we must consider the solutions from within a social-political framework which allows for a global solution.

To get back to the theme of establishing North-South relations, these must be controlled by Indigenous peoples. I believe that Indigenous organizations, not governments or states, have to be the principal players in the establishment of these alliances. Also, Indigenous organizations have to demonstrate their ability and their representativeness to other brother groups and international organizations.

It is possible to try to involve other institutions which can generate solidarity with Indigenous peoples. The Mapuche Village has been successful in establishing relations with universities, NGOs and other institutions; it is a first step towards the consolidation of relationship which will bring us to the realization of concrete initiatives for solving our problems.

Carlos Coloma (Consultant)

Historically, North-South relations have not been favourable for the people in the South. Without doubt, there are certain sectors of society that have been more affected by these relations, especially Indigenous Peoples; it has been proven, by noting similarities in the health conditions of Indigenous people throughout the continent, that judging from the public health established they have found themselves in the worst conditions. Many of the diseases occur in a certain social context, allowing us to note the differences between North and South, differences which are determined by the socio-economic model of these countries; some health problems of the northern
Indigenous people such as mental health problems, suicides, etc. are a product of an economic model of the industrial type. On the other hand, in the South the health problems are related to economic underdevelopment.

When establishing a framework of North-South relations, we have to identify the elements based on such relations. This is not easy. I believe there are more questions than answers. For example: How can we avoid the evangelist sects dividing the Indigenous community with their religious proselytizing campaigns, performing "miracles" which will cure AIDS and other diseases, trying to impose an ideology by way of a health framework? How can the ways of the pharmaceutical industry, which takes products from the South and sells them back at an exorbitant price be changed?
How can policies unsuitable for Indigenous peoples be modified? Again, this is not easy and the solution is even more difficult when we know that individuals interested in changing it are but a minority.

There exists a subordination of the governments with respect to all the different health policies of our countries, for example when it was concluded that global problems were a result of accelerating population growth, the North designed birth control campaigns for Latin America; this had serious consequences for Indigenous Peoples. In all cases, we have to discuss a global process that leads to the articulation of these relations and it is through that process that we can establish new health relationships. To develop our own models, with the least dependency possible, resources and initiatives represent an enormous challenge for the South, and I believe that it is worth reproducing the experience of Indigenous Peoples in the development of their cultural medicine; they are the only ones that have appropriately handled the environment. This is how we can proceed in the future, and it is here that we will meet and define with whom we will unite, as well as identify those who keep contributing to health deterioration.

Dr. Pamela Hartigan - NGO Liaison Officer - PAHO

Pamela Hartigan of the Pan American Health Organization reflected on the question of twinning programs and their effectiveness, calling to mind the key message from the workshop in Winnipeg. This message emphasized that Indigenous Peoples across the Americas are essentially facing the same issues.

Although cultural differences are to be expected, "the issues of autonomy, self-empowerment, and reclamation of their lands are the central themes for all these people". In this context, she said, North-South relationships can be extremely powerful and effective.

Issues of equality and reciprocity must also be addressed in the context of North-South partnerships, however. "In most NGO partnerships of this type, the northern partners are usually the people with more access to funds, but they have to work through southern organisations in order to get those funds. Their ability to channel funds puts them in a position where they can impose their agenda on the recipient partner". That is less likely to happen with indigenous North-South relationships because neither of them have access to funds... and that was very palpable at the Winnipeg conference. Partnerships between northern and southern indigenous groups can be "much more positive because I don't think either one feels they have an upper hand. They both face the same problems of marginalization and poverty".

The most important rule for a non-indigenous agency, Hartigan said, is to realize from the outset that they "are not in a position to dictate to Indigenous Peoples. Non-indigenous groups can facilitate opportunities whereby indigenous groups can come together to exchange experiences and insights and search for solutions to common problems. But it is important to keep in mind that Indigenous Peoples must be at the helm of any activities or programs that affect their communities".

A vision of PAHO's role in developing solidarity through action programs will be reflected in a discussion document that is to be presented to the Organization's Executive Committee as a result of the Winnipeg conference.

More generally, Hartigan said the conference discussion had underscored the importance of participants identifying the best work they as individuals can do in their spheres of influence. In her own area, which involves promoting linkages between grassroots organisations and among them and government entities, she said she would be looking for ways to involve Indigenous Peoples' organisations in ongoing initiatives.

As an example, she cited efforts to control a cholera epidemic in Panama, noting that preventive programs will have to reflect concepts of health and illness among the Kuna tribe, and bridge a communication gap between western practitioners and traditional healers. An important first step will be to ensure that the two health systems are respected and considered equally viable.

Hartigan ended the interview suggesting that "PAHO's ability to act as a bridge between the health sector and indigenous groups will be very important... I just hope we can do honour to the follow-up".

Joseph Palacio (Belize)

Joseph Palacio said South-North twinning programs can work in principle, provided that a mechanism is in place to define precisely how. Twinning can occur at the University level or at the grassroots, or can be focussed on technology from the South that is no longer available in the North, or vice versa. Regardless of context, the process requires "commitment, discussions, and a greater regard for either side about the other."

Non-Indigenous partners can facilitate the twinning process with funds, but their commitment to appropriate mechanisms is equally important, Palacio stressed. "I think it's ignorance, really, and general paternalism that it has to be done only on the terms of non-Indigenous peoples." Indigenous organizations in Belize can enter into institutional arrangements with non-Indigenous partners, "but over and beyond that I think the issue here is one where governments can become involved." He said the current situation calls for "specific funding arrangements which recognize the validity of Indigenous organizations, both here as well as in the South, and that's particularly difficult because governments are still not really open to Indigenous organizations in both the North and the South. So I imagine that, even as we say the government should take the lead, we're also aware that if at all possible, the Indigenous organizations themselves should take the lead, with the hope that the governments will follow soon."

Palacio said the Canadian development agency, CUSO, has been active in Belize, and has demonstrated a great deal of flexibility to working arrangements that do not involve governments. But many of the organizations that have supported community development in the South have faced funding cuts that make it difficult to deliver on the enthusiasm they feel at the organizational level. The skills available through some private sector organizations might be transferable, he said, suggesting that health professionals could form technical groups to work with University departments in the South.

"But then again, I would emphasize that there is a problem of equity here, or maybe not so much equity as equitableness and reciprocity, where there is a genuine understanding that the transfer can be mutually advantageous," he said. "That's where the mindset comes in. We in the south have not sufficiently asserted our own capabilities, and we are not sufficiently convinced that we have capabilities that we can teach, so that's also a problem for us. It's a whole problem of self-consciousness, awareness of identity, and pride in us. I think the most common type of exchange, if you want to call it that, is through casual tourism, where people visit and learn but stay within their air conditioned hotels. And they're very apt to be critical of the heat, the flies, the stench, without looking at the people, that there's a humanness operating there which transcends whatever the contingencies might be." To ensure that this broader understanding is incorporated in twinning programs, "there would inevitably have to be broker organizations which would operate on both sides to ease the entry," he said. These organizations would include past twinning partners, as well as anthropologists with training in cross-cultural sensitivity and

representatives of funding bodies. "I see a workshop like this as being very helpful in this sort of dialogue," he said. "There has to be a beginning of a frank dialogue between North and South," and "I think this workshop has been a forum for that kind of exchange."

5. Documented case studies of health in development

Dr. Eduardo de Gortari (Mexico)

Cuetzalan hospital is the first combination of both medical cultures: traditional Indigenous medicine and modern medicine. This rich experience has been the fruit of diverse factors. The most relevant is the change in Article 4 of the Constitution, established by the government of President Salinas, which recognizes the Mexican nation as a multicultural country and thereby opens new avenues for Indigenous Peoples, including the recognition of traditional Indigenous medicine.

In Cuetzalan, there was an opportunity to open a second level hospital, offering traditional Indigenous medicine such as midwives, massage, herbal medicine and others, along with modern medicine. In Cuetzalan, we are developing a process of integration in both directions. This is not always easy as some rejection exists on the part of some young doctors; but it is being integrated.

What is important is that they have been accepted by the community, the individual has access to both kinds of medical treatment, which complement each other.

Following the success of Cuetzalan, the Mexican government has continued to promote that type of program, which must be based on the respect of both traditional Indigenous and modern medicine.

Carlos Zolla Luque (Mexico)

The Cuetzalan experience is nothing more than trying to develop a model adaptable to the local conditions of an Indigenous region. We emphasize the mixed rural hospitals where academic and traditional doctors meet: but above all we emphasize the importance of the Regional Health Program, which is the framework within which the problem is defined. Thus the hospital becomes part of that program.

On the other hand, we just finished modifying Article 4 of the Constitution; with these changes Mexico defines itself as a multicultural country, encouraging the development of Indigenous peoples. The new text refers to justice, culture, language and customs; the state has to encourage their development. We are now discussing the regulatory law of article 4 and it is expected that traditional Indigenous medicine will be recognized.

Chief Sydney Garrioch (Canada)

Chief Sydney Garrioch described the strengths and limitations of a health transfer initiative involving the Swampy Cree Tribal Council in Manitoba. Speaking as Chair of the Chiefs' Committee on Health of the Assembly of Manitoba Chiefs, Garrioch expressed concern that the transfer plan as it is currently formulated gives the community administrative authority over certain health services, but does not provide overall jurisdiction in the area of Indigenous health.

Key areas of control in the transfer agreement include staffing, local transportation, nursing services, operating and maintenance budgets, and capital spending. But "the larger devolution that we're looking at is the self-government approach, to give us the ownership and the means to develop our own policies and regulations," Garrioch said. One specific concern is that the transfer agreement would limit the community's jurisdiction to reserve residents, when Manitoba First Nations feel an obligation to serve urban dwellers, as well. In some cases, federal and provincial regulations even prevent individual First Nations from serving members who live on different sides of a river.

Financial cutbacks have also limited the health services available to Indigenous people in Manitoba, Garrioch said: in many cases, people have been sent home from health facilities before they were well, or when appropriate aftercare was not available in their home community. For example, disabled people are told to arrange home care in communities that lack the resources to run proper programs. The result is that the patients "get worse before they get well," he said.

Garrioch said it's important to ensure that devolution procedures allow for holistic health practices. "We're trying to make governments realize that the traditional component should be recognized," he said. "Right now it's not recognizable, and it's very difficult for traditional healers and traditional healing processes to work within the system." Western nurses and physicians working from on-reserve health centres typically refer to western treatments and specialists, and often refuse to see people who have sought advice from traditional healers.

"Generally speaking, there's too much concentration on treatment and not enough public awareness of prevention," he said. "There are not enough resources made available to develop a better form of public awareness of health, of all aspects and at all ages, in the home environment and in the community as well."

The best hope of change, Garrioch said, will come from legislation that enshrines Indigenous control. "If it's just a policy, it's nothing. It's got to be recognized within that government system. Not to take anything away from the existing medical institutions, or the physicians who are in place — it's just a matter that the people will have a choice, and a chance to decide their direction."

Marcos A. Guimaràes (Brazil)

During the 70's, law 6001 was passed in Brazil. Also known as the "Status of the Indian", this law establishes amongst other things, that health has to be extended to Indigenous peoples without discrimination. Since then, there have been some efforts to solve health problems in the Brazilian Amazon, such as the establishment of some Indigenous health districts.

The Brazilian Health Ministry has recognized its responsibility for the promotion of Indigenous health. In that vein, I was able, within the boundary of the Health Ministry, to implement a project called "Coordination of Indigenous Health" as a way of working more effectively in that field.

However, health initiatives have frequently been affected by the economic crisis facing Brazil.

6. How do Indigenous organizations follow up on the Winnipeg resolutions?

Nilo Cayuqueo (South and Meso American Indian Information Center - SAIIC)

With the arrival of five hundred years of Indigenous resistance, there was a lot of interest in Indigenous people exchanging information between villages. We have been oppressed and marginalized and therefore have a lot in common.

The health problem is of much concern to us, for the world is unaware of the genocide caused by the poor health of the Indigenous peoples. Health problems are a direct consequence of these injustices. In that sense, I believe it to be of utmost importance to maintain a communication network for the exchange of information and offering of solutions to international organizations such as PAHO and WHO.

It is important that Indigenous Peoples participate in the decision-making process, not only in health policies but also in the management and control of funds in order to avoid their misuse.

One of the immediate tasks of the participants is to introduce communication strategies to share, and thereby better grasp the Indigenous reality.

This conference is only the beginning. PAHO is willing to listen to us and that is a positive step, but for the goals to become reality it is necessary to put them into practice. In this context, traditional Indigenous medicine must not only be recognized but also be supported, even legalized, for in some countries like Argentina and Chile, it is considered illegal.

Juan Reategui (AIDESEP), Peru

To empower the resolutions of this conference, the resolution that Indigenous Peoples can develop their own health programs must be included. If this is possible, the resolutions will be more effective. We must also recognize the essence of Indigenous people's problems and base it on a clear statement of the meaning of Indigenous health.

I believe that, like any other science, traditional Indigenous medicine should be given the opportunity to develop; any health initiative for our people has to turn around that core, including programs that contain "occidental" medicine.

It is necessary to establish a direct relation between PAHO and Indigenous organizations so that the programs and health projects to be implemented in the future can have Indigenous support, for our people can more clearly define the necessities and the means to be used in those programs.

Jean Goodwill (Canada)

For Jean Goodwill, former President of the Indian and Inuit Nurses of Canada, the first step for delegates in the weeks following the conference will be to bring the final resolutions back to their local leadership. She also stressed the importance of ongoing communication and organizing. "It will be very important for Indigenous people to try to develop some kind of link among themselves as a group, though not necessarily at an organizational level," she said. "I think we're over-organized, but we can still have a communication link among ourselves with the different interested groups."

Information exchange will be critically important for delegates who want to ensure that the conference resolutions are implemented, Goodwill said. "The responsibility is really on us," she stressed. "A lot of the time, we rely too much on our organizations and governments, and we should know by now that they don't always take action. So I think we should really make an effort ourselves, even if it's just two or three key people here and there."

After a lifetime of working in organizations, Goodwill said, "my interest now is in the traditional health area. I'm really more than pleased that this whole process is evolving everywhere. It's not just North America that's taking an interest. It's also South America, and to me that's very encouraging, because this is what I've come home to." Since returning to Saskatchewan after a period working in Ottawa, "I've renewed my ties with my culture, my cultural activities and ceremonies, and I'm really glad that it's happening, that other people are doing the same thing." In addition to practicing traditional medicine, Goodwill is teaching traditional approaches in a university program to promote health careers for indigenous students.

"Personally, I think that's where it's at," she said. "We've all tried the other way, we've tried to use the western model of health care, and as long as traditional health and medicine are still 'alive and well', I think we should try and maintain them as much as possible." She stressed that the people who attended the conference are the ones who will keep the Indigenous health movement going. "We really have a lot of responsibility to do things for ourselves. That's where it has to be."

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