

The Role of ‘Kijigabandan’ and ‘Manadjitowin’ in Understanding Harm Reduction Policies and Programs for Aboriginal Peoples¹

Colleen Anne Dell, PhD
Research Chair in Substance Abuse, University of Saskatchewan
& Senior Research Associate, Canadian Centre on Substance Abuse

Tara Lyons, PhD Candidate
Carleton University

Kathleen Cayer
Kitigan Zibi Anishnabeg Community Member

Abstract

Harm reduction policies and programs are gaining increasing acceptance as a promising practice to address high-risk substance use in Canada. A common premise of Western harm reduction initiatives is respect for substance users and their choices. An Aboriginal worldview extends this to understanding individuals, communities and their choices. This paper examines how the Algonquin concepts of ‘Kijigabandan’ and ‘Manadjitowin’ can be used to explore harm reduction’s value as a promising practice for Aboriginal social work. ‘Kijigabandan’ means to attempt to understand and develop personally from the process. ‘Manadjitowin’ means to honour someone or something once it is understood. This is a timely paper because at present there is no uniform starting place to address the value of harm reduction policies and programs as they relate to Aboriginal peoples.

Introduction

Harm reduction is a controversial term. It frequently incites debate and at times brings forth moral-based responses. For example, a very lively public dialogue has surrounded the establishment and operation of Canada's only supervised injection facility, Insite, in Vancouver's Downtown Eastside (Beirness et al., 2008; The Province, 2008; Wild, 2002). Empirical-based and opinion-based deliberation has variously surfaced; it has spanned from the corridors of federal and provincial legislatures, to academic journals and public newspapers. Similar debates, although of a lesser magnitude, surround other harm reduction programs and policies, such as the distribution of crack pipe kits and needle exchanges for injecting drugs. In spite of the controversy that surrounds harm reduction, one element remains constant: there is a wide disparity of understanding across the country and in various groupings, including among Aboriginal peoples, of what harm reduction is, and its value as a promising practice for Aboriginal social work.

The purpose of this paper is to examine how the Algonquin concepts of 'Kijigabandan' and 'Manadjitowin' can be used in Aboriginal social work to explore the role of harm reduction policies and programs in increasing the health and well-being of some Aboriginal peoples from problematic substance use. We begin by reviewing the extent and contexts of Aboriginal peoples' use of alcohol, drugs and other substances. This review relays the unambiguous need for efforts to address the harmful consequences of substance abuse. We then discuss harm reduction as an increasingly popular promising practice in Canada for high-risk substance use. We specifically consider what this means from a Western worldview¹, and in particular harm reduction's emphasis upon respect for users and their choices. We compare this concept of respect against that of 'Kijigabandan' and 'Manadjitowin' from an Aboriginal worldview. 'Kijigabandan' means to uninhibitedly look at and study something in an attempt to understand it, and develop personally from the process. 'Manadjitowin' means to honour someone or something once it is understood. An Aboriginal worldview indicates a need to understand the interconnectedness of individuals and communities and raises the question of why respect is being offered.

We use the example of needle exchange programs to illustrate the potential of the concept of 'Kijigabandan' to further understanding about harm reduction for Aboriginal peoples. Only once this undertaking (Kijigabandan) is achieved, can it be claimed that an individual 'Manadjija' (refers to someone) or 'Manadjito' (refers to something); that is, someone or something is honoured or celebrated. We also illustrate how the concepts can assist social work with addressing two key barriers that often impede Aboriginal-specific harm reduction discussions: widespread support for abstinence, and the entrenched belief that harm reduction and Aboriginal culture are incompatible.

The problematic use of alcohol, drugs and other substances²

Information on the general health status of Aboriginal peoples in Canada is lacking (Adelson, 2005; Cardinal & Adin, 2005). Data that does exist indicates that Aboriginal health is well below the national average (Health Council of Canada, 2005; National Aboriginal Health Organization, 2004a). There is a similar absence of data on the problematic use of alcohol and other drugs among Aboriginal peoples. That which exists does convey however that detrimental consequences may be greater for some Aboriginal peoples than among the general Canadian population.

*Alcohol*³. Although Aboriginal peoples have among the highest rates of abstinence from alcohol, and drink less often than the general population (17.8% vs. 44.0% reported drinking weekly), there are high levels of heavy use, such as binge drinking (Framework Sub-committee of the National Native Addictions Partnership Foundation & Thatcher, 2000). The 2002-2003 First Nations Regional Longitudinal Health Survey concluded that the proportion of heavy drinkers among First Nations adults is higher than in the general Canadian population (First Nations Centre, 2005). Although the relationship is complex, alcohol has a documented role in personal and social harms, including violence, injury and suicide. The rate of death due to alcohol abuse among Aboriginal peoples is nearly twice that of the general Canadian population: 43.7 per 100,000 vs. 23.6 per 100,000. Rates for alcohol-related hospitalization among First Nations and Inuit are also well above national and regional rates for the general Canadian population (Single, Robson, & Scott, 1997).

Illicit drugs. Studies indicate that indigenous Canadians, as a group, also experience disproportionately high rates of illicit drug abuse (Scott, 1997; Framework Sub-committee of the National Native Addictions Partnership Foundation & Thatcher, 2000). According to the 2002-2003 First Nations Regional Longitudinal Health Survey, although the documented rate of illicit drug use in the past year is low (7.3%) among First Nations, it is still more than double the rate of the general Canadian population (3.0%) (First Nations Centre, 2005). The overall morbidity rate from illicit drug use is almost three times higher for Aboriginal peoples than for the general population: 7.0 per 100,000 vs. 2.6 per 100,000 (Scott, 1997).

Injecting illicit drugs is a key mode of transmission for the human immunodeficiency virus (HIV) among Aboriginal peoples in Canada (Public Health Agency of Canada, 2004). In a 2003 study of the residents of the Downtown Eastside in Vancouver, HIV infection was found to be double the rate of non-Aboriginals (Craib et al., 2003). Of specific concern, between 1998 and 2003, 66.9% of all HIV-positive tests among Aboriginal women in Canada were attributable to IDU (Poole and Dell, 2006). In a 2006 Vancouver study, the mortality rate for Aboriginal female injection drug users mainly from drug overdose, homicide and HIV/AIDS, was nearly 50 times that of the province's general female population (Spittal et al., 2006).

Prescription drugs. There is a need for increased understanding about the problematic use of prescription drugs among all Canadians (Health Canada, 2006). Although dated, a 1995 study found that prescription drug abuse “is increasing among First Nations and Inuit people who are referred to NNADAP (National Native Alcohol and Drug Abuse Program) in-patient treatment programs” (Framework Sub-committee of the National Native Addictions Partnership Foundation & Thatcher, 2000, p. 50). A more recent study (2002) carried out in Calgary, concluded that “[i]nappropriate prescription medication use was a significant problem among an Aboriginal population that sought addiction treatment” (Wardman, Khan & el-Guebaly, 2002, p. 355).

Volatile solvents. Similar to the situation with prescription drugs, there is a need for more understanding about volatile solvent abuse (VSA) in

Canada. The current rate of VSA among Canada's Aboriginal youth as a whole is not known (Dell and Beauchamp, 2006). High rates of VSA have been documented, however, among some First Nations and Inuit youth living in various rural and remote areas of the country. For example, a 2003 report from Pauingassi First Nation in Manitoba concluded that half the children under 18 living on reserve abused solvents (O'Brien, 2005, August 24).

The problematic use of substances by First Nations, Inuit and Métis is interrelated with historical experiences (Arbogast, 1995; Framework Subcommittee of the National Native Addictions Partnership Foundation & Thatcher, 2000; Inuit Circumpolar Conference & Inuit Tapiirit Kanatami, 2005; National Aboriginal Health Organization, 2004b). The erosion of a traditional way of life has had a negative impact on Aboriginal communities, families and individuals, including multi-generational losses of homeland, traditions, language and culture. This is very much rooted in government legislation (including the Indian Act), systemic racism and discrimination, the deliberate killing of wildlife and sled-dogs, placement on reserves and relocation, and the historic impact of residential schooling. These experiences have affected individuals' health and wellness in general, and have contributed to high rates of poverty, poor social and economic structures, violence, unemployment, crowded living conditions and family breakdown. Of particular importance is the health status of Aboriginal women; their lives are disproportionately affected by family violence, sexual harassment, inequality, discrimination, single parenting and poverty (Boyer, 2006; Canadian Aboriginal AIDS Network, 2002).

Together, the available data and recognition of the impact of historical influences on the current health and well-being of Aboriginal peoples indicate a need for efforts to address the problematic use of alcohol, drugs and other substances. Harm reduction policies and programs are gaining increasing acceptance in Canada as a promising practice for addressing high-risk substance use. Specific consideration must be given to harm reduction's value as a promising practice for social work with Aboriginal peoples.

Defining harm reduction

The concept of respect

Harm reduction is a “health-centred approach that seeks to reduce the health and social harms associated with alcohol and drug use, without necessarily requiring that users abstain. Harm reduction is a non-judgmental response that meets users ‘where they are’ with regard to their substance use...” (Thomas, 2005, p. 1). Harm reduction includes a broad continuum of responses, from safer substance use (e.g., needle exchange program) to abstinence (e.g., refraining from the consumption of alcohol). Essential to a harm reduction approach is that it offers users a choice of how they will minimize the harms from their substance use.

According to the Canadian Centre on Substance Abuse National Policy Working Group, harm reduction has five key features. They are:

- **Pragmatism:** Harm reduction accepts that some use of psychoactive substances is inevitable, and that some level of substance use is expected in a society.
- **Humane Values:** No moralistic judgment is made, either to condemn or to support the use of substances, regardless of level of use or mode of intake. The dignity and rights of the person who uses alcohol and other drugs are recognized.
- **Focus on Harms:** The extent of a person’s substance use is of secondary importance to the health, social and economic harms resulting from that use.
- **Balancing Costs and Benefits:** There is a need to assess the relative importance of drug-related problems, their associated harms and the costs/benefits of harm reduction interventions.
- **Hierarchy of Goals:** Most harm reduction programs have a hierarchy of goals; the most pressing needs are addressed first (1996).

A common premise of Western harm reduction initiatives is respecting users and their choices surrounding substance use. To illustrate, a 2002 background paper on harm reduction published by the Centre for Addiction and Mental Health states that “[a] central tenet of harm reduction that is

compatible with CAMH's mission and client-centered philosophy is the respect for individual decision-making and responsibility" (Erickson et al., 2002, p. 3). The Alberta Alcohol and Drug Abuse Council's (AADAC) policy on harm reduction similarly declares "...persons with alcohol, other drug, or gambling problems are [to be] treated respectfully as legitimate members of the community who need help..." (AADAC, 2004, p. 1). The work of Ormond (2002) in Manitoba with Aboriginal peoples likewise identifies that "[t]he central principle of respect and valuing the strengths of people should be the focal point of [harm reduction] initiatives" (p. 37).

Respect is defined in this context as feeling or showing deferential regard for someone or something (Funk & Wagnalls 1986, p. 1145). Respect is a deep-seated attribute in the Western worldview. It is evident, for example, in time-honored traditions (e.g., bowing or curtsying to the Queen of the British Monarchy) as well as in popular culture (e.g., Aretha Franklin's 1967 hit song 'respect' was celebrated among the feminist movement of the time). Central to contemporary applications of the term is that it is, in various ways, nearly void of understanding *why* respect is being offered.

The etymology of the term respect is the Latin term *respectus*, the past participle of Latin *respicere*, which refers to the act of looking back. More precise, it means to pay attention to or consider something (Ayto, 1990, p. 442). This is a very different meaning in comparison to our contemporary understanding that emphasizes deference, and in fact, the heritage of the term relates more closely to that of 'Kijigabandan' and 'Manadjitowin' from within an Aboriginal worldview.

The concepts of 'Kijigabandan' and 'Manadjitowin'

As illustrated above with the concept of respect, the meanings of words can change over time (Model Languages, 1995). The history of language is able to offer insight into a particular worldview of a particular historical period. The meanings of words among different languages can similarly offer understanding. As well, beliefs surrounding and the various roles of language (e.g., acquisition and transmission of traditional knowledge) can likewise relay important understanding. This is well illustrated in

a 1998 report of the BC First Nations Education Steering Committee. The report explains that “[t]he Aboriginal Languages were given by the Creator as an integral part of life. Embodied in Aboriginal languages is our unique relationship to the Creator, our attitudes, beliefs, values, and the fundamental notion of what is truth” (Ignace, 1998, np).

Given that the concept of respect is a common premise to most Western harm reduction initiatives, one of the authors of this paper, Kathleen Cayer, spoke with an Elder, linguist and language teacher in her home community⁴ of Kitigan Zibi Anishnabeg, near the town of Maniwaki, Quebec, to gain more insight into the term’s relationship with Aboriginal peoples. Through the wisdom of the Elder, linguist and language teacher, it was relayed that in the Algonquin language there is no comparable word to respect⁵. Aboriginal worldview centres on the interconnectedness of all life and life processes. The closest term to respect is the combination of ‘Kijigabandan’ and ‘Manadjitowin’. “Kijigabandan’ means to uninhibitedly look at and study something in an attempt to understand it. It suggests that while something is being studied, or looked at, understanding is being gained and an individual develops personally from the process. It does not take as a given, however, that understanding will be achieved. ‘Manadjitowin’ refers to bestowing honour onto someone or something once understanding has been gained. Clearly this does not parallel the individualized Western definition of respect, and in fact, certainly poses the question of why respect is being given.

To illustrate, consider Canada’s growing preoccupation with ‘protecting the environment’. We are told as members of a Western civil society that we are to respect the environment—we are to recycle, conserve energy, protect wildlife, celebrate Earth Day, and so on. However, if individuals do not have an engaged understanding of why they are ‘respecting’ the environment, it will impede their active participation in doing so. Partaking in an activity without fully internalizing its meaning, or understanding why you are involved in it, is not sustainable in the long-term. It also does not contribute to an individual’s personal development, and nor does it contribute to the honouring or celebration of animate beings and objects.

Conversely, consider what is meant within a traditional Aboriginal worldview to respect Mother Earth and all her gifts. There is a deep

sense of understanding of what this means, and it translates into actions. Aboriginal peoples traditionally pay reverence to earthly objects such as trees, herbs, and fruit because according to their belief system, these objects contain an honourable spirit. For example, the earth and its abundances are acknowledged in prayer and thanks are given for everything provided. Permission is asked to take from the earth and resources are not wasted (e.g., unneeded branches of a tree are used for firewood). Also, when resources are taken from the earth, such as trees, they are replenished (e.g., most First Nations today have by-laws that govern the number of trees that can be cut and replanting is mandatory). Applying this logic to an examination of the potential for any Aboriginal-specific harm reduction initiative to contribute to individuals' health and well-being, it is possible that applying the terms 'Kijigabandan' and 'Manadjitowin' offers an important starting place.

Although it has been suggested that an insightful understanding of why respect is being offered is generally lacking in contemporary Western applications of harm reduction, there is recent indication of progress. Drug user groups and individuals' lived experiences are increasingly being included in consultations on problematic substance use (Canadian HIV/AIDS Legal Network, 2005). Canada's national user's group was established in 2006 and held its inaugural meeting in conjunction with the International Harm Reduction Conference in British Columbia. The experiences and expertise of localized user groups across the country have also been recognized. The Vancouver Area Network of Drug Users (VANDU), for example, has been instrumental in the establishment of harm reduction programs, such as Insite, in Vancouver's Downtown Eastside. Incorporating lived realities into discussions of harm reduction programming and policy naturally contributes to increased and discerning understanding of the potential need for and value of such initiatives.

Considering community

An Aboriginal worldview not only contributes to understanding harm reduction through the concepts of 'Kijigabandan' and 'Manadjitowin', it also offers insight into the role of and the need to provide choice to communities alongside individuals. As discussed, a Western approach to

harm reduction emphasizes the offering of choice to users on how they will minimize the harms from their substance use. Aboriginal worldview indicates a need to understand the interconnections between individuals, communities and their choices. “An individual’s inner spirit is [understood to be] intertwined with their family, community, and the land and cannot be understood apart from them” (Dell et al., 2008:86). Once again this highlights the importance of acknowledging the interconnectedness of all life—individuals cannot be separated from their communities. An individual is understood to be at the same time their inner spirit (internal) and relations with their collective community (Dell et al., 2006)

It follows that any discussion of harm reduction measures among Aboriginal peoples must start by acknowledging that the development of effective policies and programs needs to be founded and directed by communities and their members. The work of Gray and Sputore (1998) supports the “open negotiation of realistic, achievable project goals, that are responsive to the needs of Aboriginal communities as they define them, instead of forcing them into the mould of uniform program objectives” (Gray and Sputore, 1998, p.46). The importance of this is illustrated in a 2004 study on the use of stop-smoking aids by First Nations. The study found that aids developed by Western society were rarely used among First Nations and concluded that “medication use, [such as the nicotine patch], may not be appropriate for [First Nations] smokers whose beliefs involve primarily behavioral modification” (Wardman & Khan, 2004, p. 691). The size and scope of needs and strengths (e.g., ranging from the historical impacts of colonization through to the importance of cultural knowledge and tradition to healing) specific to Aboriginal peoples and their communities must be acknowledged in any discussion of harm reduction. This highlights the necessity of community consultation in discussions of harm reduction policies and programs (Wardman & Quantz, 2006; Canadian Aboriginal AIDS Network, 1998). This understanding is generally practiced in Aboriginal social work’s holistic approach (e.g., account for the impact of colonization and indigenous ways of knowing) (McKenzie & Morrissette, 200)

Learning from 'Kijigabandan' and 'Manadjitowin'

A range of harm reduction policies and practices specific to substance abuse are in use by Aboriginal peoples and their communities (both urban and rural) across the country.⁶ For example, the Western Aboriginal Harm Reduction Society has a managed alcohol consumption program where it provides beer to alcohol-dependent individuals to prevent them from using more harmful substances when they cannot obtain beverage alcohol (Vancouver Area Network of Drug Users, n.d.). Some Aboriginal communities have implemented regulated consumption harm reduction policies. These are instances where policies that support moderate drinking practices and reduce problems related to alcohol misuse have been designed and implemented by the community (e.g., not allowing youth to attend community events where alcohol is being sold) (Drake, 2002; Landau, 1996; Lauzon et al., 1998).

Just as there is a range of accessible harm reduction policies and programs, so too is there diversity in degrees of understanding of harm reduction generally and offering services specifically to Aboriginal peoples and communities, including within Aboriginal social work (Landau, 1996; Korhonen, 2004). It is well known that within social work programs generally in Canada, substance abuse specific courses are not widely available. The concepts of 'Kijigabandan' and 'Manadjitowin', coupled with recognition of the interconnectedness of individuals to their communities, will be the starting point for discussing the potential of harm reduction initiatives to contribute to the health and well-being of Aboriginal peoples. Initiating this discussion from an Aboriginal worldview should prove to be more meaningful in comparison to a Western worldview's concentration on the individualized concept of respect. The example of needle exchange programs (NEPs) for intravenous drug users will be used.

Our aim with the NEP illustration is to provide information that relays understanding about them. Again, from the perspective of 'Kijigabandan' and 'Manadjitowin', not only is the goal to examine NEPs in an attempt to relay information about and thus understand them, but it is also to develop personally from the process of doing so, and ultimately develop honour for someone and/or something. Although the reader will likely not

be able to achieve ‘Manadjija’ or ‘Manadjito’ with our brief example, it does relay the potential utility of this as a starting point.

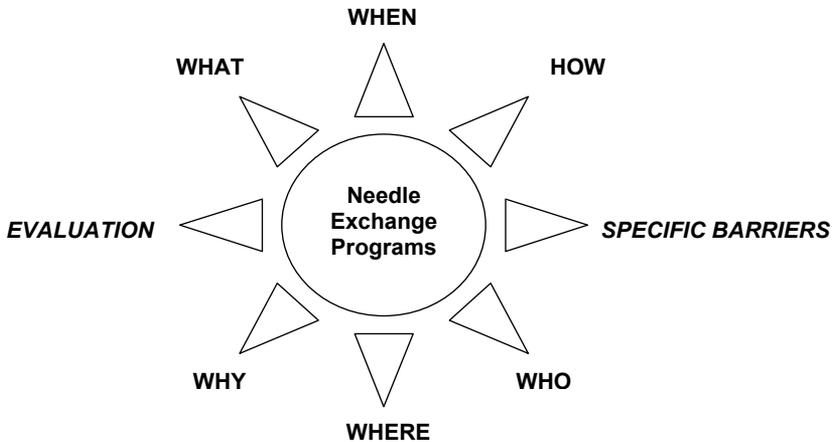
To initiate an understanding of NEPs, we applied the framework of Acoose’s (2007) writing on her personal experiences as a First Nations woman healing from illicit drug and alcohol abuse. The intent of Acoose’s work is to have the reader gain an ‘in-depth’ understanding of her lived experiences. She communicates this in her introduction:

This...will be a window to review the past and a means to discover what it was like living in a world that was dark, bleak and filled with alcohol, drugs and crime. It will give you a wealth of information and help you gain a better understanding of why Indian women drink, do drugs and commit crime(s). There is a world out there that many people will never understand no matter how many books they read or how many University degrees they have. Education does not reveal why, when, where, how or what an Indian woman endures living in violence and/or running and hiding from the law or her man or herself or a combination of these things. Finally, it is important for people to understand that as Indian women we did not just wake up one morning and say: “Hey, I think I will become addicted to drugs” or “Hey, I think I want to be an alcoholic” or “Hey, I think I will sell my body and become a prostitute”! NO, hell no, we did not just wake up one morning and make these decisions. It was all there waiting for us lurking in the dark. Eventually, without care, compassion or anyone to love us, we would follow a spiral staircase, and evolve ever so gently, sensually, and maliciously into a life of crime (Acoose 2007, 1).

Acoose’s work relays how imparting understanding can be facilitated by providing insightful information in six key areas: who, what, when, where, why and how. We have added a seventh and eighth area: methodologically-sound and culturally-appropriate evaluation, and addressing specific barriers (see Diagram A). Evaluating the outcomes, impacts, benefits and weaknesses of harm reduction programs and policies are a fundamental part of ‘Kijigabandan’, and if achieved, then ‘Manadjitowin’. Without systematic empirical review, it is not possible to determine the effectiveness and appropriateness of harm reduction

programs for Aboriginal peoples (Dell & Lyons, 2007). In addition, when attempting to gain understanding about an issue, it is important that key barriers to understanding, whether individually-based or socially-based and specific to the issue at hand or not, must be acknowledged. This recognizes the inter-connectedness of individuals with their communities. Again, although the needle exchange example below does not provide in-depth information, it is a starting point for relaying information for Aboriginal social work, alongside its grounding within Aboriginal culture, values and philosophy, to initiate discussions and further understanding.

Diagram A



What is a needle exchange program?⁷

Generally, NEPs provide injection drug users (IDU's) with clean needles and injection equipment as well as safe disposal for used needles. NEPs also offer information on safer injecting practices and addiction resource services that span an individual's physical, emotional, social and spiritual well-being. Federal, provincial/territorial and local governments fund NEPs across Canada (Weekes and Palmer, 2004). There are a variety of funding arrangements with cities and health authorities and the organizations that serve them (e.g., AIDS PEI in Atlantic Canada).

When was the needle exchange program introduced?

The first official NEP opened in 1989 in Vancouver, British Columbia. Unofficial NEPs were operating prior to this (e.g., Toronto). NEPs were introduced in response to the spread of blood borne diseases, particularly HIV, through needle sharing. Today there are more than 100 official NEPs operating across Canada (Kaiser Foundation, 2003). There are many other satellite NEPs in operation at drop in centres, shelters, and community health offices. There are also ad hoc exchange programs available at Aboriginal AIDS service organizations serving on and off reserve populations, as well as at local health centres and nursing stations (e.g., Atahkakoop, Saskatchewan) (Dell and Lyons, 2007). NEPs are more much common in urban than rural communities, with key reasons being the stigma attached to accessing them, too high a cost for small populations, and the proximity of urban centres to many small communities, including reserves.

With mobile NEP services, workers distribute needles and supplies to IDUs by foot or van. These NEPs meet users at various locations ‘on the street’ and are open a range of hours not offered at a fixed NEP. The mobile vans frequently have a social worker and nurse on staff.

How does a needle exchange program work?

When an individual attends a NEP at a fixed location they ask to see the person in charge of the service. They go in a designated room and request the supplies they need, including needles, vitamin C8, sterilized water, disinfectant, cookers, and cases to carry needles. The supplies are then packaged and issued at no charge. Some places have injection kits already made up with supplies. Condoms are also commonly distributed (Weekes & Palmer, 2004). It is generally a quick process. As mentioned, there are also mobile NEPs that distribute the same materials.

Who uses a needle exchange program?

People who inject drugs use needle exchange programs. People who do not have access to or do not feel comfortable obtaining needles from pharmacies also use NEPs. Although site-specific information is often collected for funding purposes, generalized characteristics and backgrounds

of individuals who use NEPs are not available (Weekes & Palmer, 2004). There are specific studies, however, that offer some insight, including the Vancouver Injection Drug User Survey that found Aboriginal peoples (First Nations, Inuit and Métis) made up 25% of IDUs in Vancouver and of which 79% lived in unstable housing (cited in Nguyen et al., 1999).

Where are needle exchange programs located?

Needle exchange programs are located throughout Canada. As discussed, they exist at fixed addresses, in mobile vans, and through community outreach workers. As well, there are examples of ad hoc exchange programs available at Aboriginal AIDS service organizations serving on and off reserve populations, as well as at local health centres and nursing stations (e.g., Atahkakoop, Saskatchewan).

As discussed above, it is imperative that decisions about the locations and appropriateness of harm reduction programs begin at the community-level. Aboriginal harm reduction programs and policies need to be directed by Aboriginal communities and their members (Gray and Sputore, 1998; Canadian Aboriginal AIDS Network, 1998).

Why is a needle exchange program important?

Intravenous drug use through the sharing of used needles is a prominent mode of transmission of HIV, Hepatitis C and other blood borne diseases among Aboriginal peoples in Canada (Prentice, 2004). Before 1993, 10.9% of reported AIDS cases among Aboriginal peoples were attributed to injecting drugs and by 2003 this rate increased to 58.3% (Public Health Agency of Canada, 2004). This is especially true for Aboriginal women; they make up a disproportionate percentage of HIV and AIDS cases (Spittal et al., 2006). As discussed, NEPs reduce risk to IDUs through the exchange of needles and supplies, along with offering prevention and education strategies such as providing information on safer injecting and high-risk behaviours. NEPs also act as a bridge to other services, such as health, housing, counselling and mental health. For example, the Quesnel Tillicum Society Native Friendship Centre in northern British Columbia provides a needle exchange program where needles, condoms and needle disposal containers are provided at no charge to community members. They also offer harm reduction education, including prevention informa-

tion and awareness about HIV/AIDS and Hepatitis C.

Needle exchange programs are important specifically at the community level, as injection drug use is a serious public and social problem. There are broad public health impacts, ranging from dirty needles discarded in the streets to the transmission of blood-borne pathogens, such as HIV and Hepatitis C.

What has the evaluation literature found?

The majority of evaluations have found that NEPs result in less high risk practices such as needle sharing and decreased rates of HIV and Hepatitis C among IDUs (Hurley, 1997; Des Jarlais et al., 1995; Gibson et al., 2001; Ouellet, 2004). Others have found that NEPs also increase the likelihood of individuals accessing treatment (Wodak and Cooney, 2006). Some studies have however questioned the ability of NEPs to reduce rates of HIV transmission (Bruneau et al., 1997) and needle sharing among IDUs (Strathdee et al., 1997).

It is important to consider the methodologies used in evaluations to determine whether they are empirically-based and culturally relevant for Aboriginal peoples. It is recommended that evaluations of Aboriginal harm reduction programs be undertaken and conducted by, for, and with Aboriginal communities and organizations.

We have attempted to show with the NEP illustration that by addressing the questions of who, what, when, where, why, how and evaluation, that understanding about harm reduction and its relationship to Aboriginal social work practice can be furthered. The concepts of 'Kijigabandan' and 'Manadjitowin' focus on attaining an in-depth understanding for individuals and communities, personal development, and ultimately applying honour. This extends beyond Western harm reduction's emphasis on respecting users and their choices. 'Kijigabandan' and 'Manadjitowin' help to relay *why* respect is being offered. This is a necessary starting point for exploring harm reduction as a promising practice for Aboriginal social work. It allows for the focus of Aboriginal social work on indigenous ways of knowing, addressing colonization and supporting indigenous practice, for example, to be accounted for in this discussion.

Barriers to understanding

As relayed, individuals and their communities are interconnected in an Aboriginal worldview; they cannot be separated from one another. In this final section of the paper, we identify how addressing two intertwined individual/community grounded barriers may also assist Aboriginal social work with initiating Aboriginal-specific harm reduction discussions, including needle exchange. They are: (1) wide-spread support for abstinence among First Nations, Métis and Inuit peoples and communities (Canadian Aboriginal AIDS Network, 1998; Erickson, 1992; Wardman & Quantz, 2006), and (2) an entrenched belief that harm reduction is incompatible with Aboriginal culture (Dell & Lyons, 2007; Wardman & Quantz, 2006).

1. Wide-spread support for abstinence

Many Aboriginal communities and treatment programs today adhere to models of abstinence (Chalmers et al., 2002; Daisy et al., 1998; Korhonen, 2006; Landau, 1996; Lauzon et al., 1998). There are a number of reasons for this, including the destructive impact of the introduction of alcohol on the lives of Aboriginal peoples, a desire by Aboriginal peoples to redefine themselves as distinct from the assimilative practices of mainstream society, and the devastating level of alcohol and drug abuse a number of communities face today (Canadian Aboriginal AIDS Network, 1998; Korhonen, 2006). The abstinence-based focus of many of the National Native Alcohol and Drug Abuse Program (NNADAP) treatment centres stems in part from the fact that they were established at a time when disease-based theories and abstinence models were the norm.⁹ There also exists a belief that the identification of problematic substance use as a disease adds legitimacy to it, and without this label there would be an increased risk of losing treatment funding. Underlying these tensions and concerns is a common belief that abstinence and harm reduction are incompatible.

Contrary to what many people believe, abstinence and harm reduction are not totally incompatible. Common to both is the goal of assisting individuals with the harms they are experiencing because of their problematic substance use. It is not well-known that some programs and policies offer clients a continuum of approaches. For example, All My

Relations, a harm reduction program for Aboriginal injection drug users in Manitoba, offers abstinence as a potential goal, but does not make it a requirement (McLeod, 2001). Similarly, the Mamisarvik Healing Centre, one of only a few Inuit-specific residential substance abuse programs in Canada, offers its clients the choice of a harm reduction treatment program or a treatment program based on abstinence. As well, Canada's national Inuit organization, Inuit Tapiriit Kanatami, notes in its alcohol policies that there is a need to develop effective, community-based alcohol counselling programs based on both harm reduction and abstinence strategies that are appropriate to Inuit situation, culture, language and values (Inuit Tapiriit Kanatami, 2005a).

Further, abstinence-based programs and policies that exclude any attention to the reduction of harm still share commonalities with harm reduction. Consider, for example, Alkali Lake, a Shuswap Indian Reserve near Williams Lake, B.C. that took action against problematic alcohol use through leadership, commitment, support and honouring spiritual and cultural foundations (Four Worlds International Institute, n.d.). Probably the best-known example of self-imposed alcohol prohibition by an Aboriginal community, Alkali Lake looks at first like a clear example of an abstinence-based approach, yet it drew upon features that are common to harm reduction. For example, the community reduced its overall level of drinking over a period of several years and, in the spirit of harm reduction (see 5 key features reviewed), rarely resorted to exiling users.

2. Incompatibility of harm reduction and Aboriginal culture

The concept and practice of harm reduction has generally evolved outside of Aboriginal culture. The need to reduce harm because of substances was not an original concern for Aboriginal peoples. It was only with European contact and the introduction of alcohol that associated problems began to surface. This does not mean, however, that harm reduction and Aboriginal peoples and culture are incompatible. In fact, fundamental features of harm reduction, such as its focus on humane values, overlap with traditional Aboriginal values and the Seven Gifts of Aboriginal peoples' ancestors (Kindness, Understanding, Acceptance, Truth, Humility, Courage, and Generosity) (Banni, nd). The principles of harm reduction are not unknown to Aboriginal peoples and some observers have pointed

to similarities between harm reduction and a holistic Aboriginal approach to substance abuse treatment, including the importance of links between community and individuals (Peele, 2003).

There have also been notable accomplishments in incorporating harm reduction features into social work with Aboriginal peoples and the provision of culturally-appropriate services (Jackson, 2005). This includes incorporating Aboriginal culture, history and language into available and emerging services; developing culturally-specific programs and policies for First Nations, Métis and Inuit; and increased awareness and understanding about Aboriginal peoples among non-Aboriginal specific harm reduction services. It is well-recognized that if programs are not culturally appropriate and holistic, they will not be accessed or show to be effective (Canadian Aboriginal AIDS Network, 1998; Wardman & Quantz, 2005). Organizations such as Anishnawbe Health Toronto adheres to a holistic model of care in which individuals set their personal goals for healing and wellness in consultation with their health care providers. People are given a choice of the best way for them to minimize potential harms related to their substance use.

It is important to acknowledge in any discussion of harm reduction among Aboriginal peoples that for some, Aboriginal traditions, customs and cultural ways are incompatible with the use of mood-altering substances. Individuals who use substances such as alcohol or methadone are often viewed as being "out of balance". This does not imply however that these individuals are to be shunned from their community and culture. The Ontario Aboriginal HIV/AIDS Strategy explains that "[h]aving an addiction ... mean[s] that the Body will always speak first. But this does not mean that the Heart, Mind and Spirit cannot be reached while the Body is under the influence of a substance" (n.d., p. 1). In a Centre for Addiction and Mental Health harm reduction document discussing drug use as a personal choice, it explains that "[t]he philosophy of harm reduction encourages us, [Aboriginal peoples], to reach those outside of the circle and welcome them back in... [we] recognize that everyone in the circle is affected and thus has a responsibility to make this circle whole." (n.d., p. 1). The same is true of the majority of abstinence-based NNADAP treatment programs; individuals are regularly welcomed back into treatment after relapsing and attending to the required length of absence from the program.

Conclusion

For problematic substance use to be addressed in a comprehensive manner, fundamental inequalities faced by Aboriginal peoples must be addressed. In Australia, for example, organizations are starting harm reduction programs that “aim to minimize the use of alcohol by improving the overall social, political and economic well-being of Aboriginal people” through job creation and recovering land rights (Gray & Sputore, 1998, p. 43). There are also many examples in Canada of tribal councils and bands adopting economic development, job creation and business entrepreneurship as part of a population health strategy. Such harm reduction models must be grounded in community choice, consultation, understanding and leadership. Societal factors, including the social determinants of health and their links to problematic substance use, also play a role in developing effective, long-term responses.

The interconnectedness of all life must be acknowledged. In other words, harm reduction is “important, but not enough” (Sellman et al., 1997, p. 87). Aboriginal approaches to social work, by their very nature (e.g., accounting for the impacts of colonization and indigenous knowledge), can offer a starting point for furthering understanding of harm reduction programs and policies and exploring their value as they relate to Aboriginal peoples.

We began this paper with acknowledging, through a review of the extent of and reasons for Aboriginal peoples’ problematic substance use, that there is a need for efforts to address the harmful consequences of substance use among Aboriginal peoples and within their communities. An increasingly popular promising practice in Canada to high-risk substance use is harm reduction. Aboriginal specific harm reduction initiatives exist, but they are limited. A key barrier to their development is the absence of an in-depth understanding about what harm reduction is, and its value as a promising practice, including within Aboriginal social work. We proposed that an Aboriginal worldview may help to address this, in comparison to the contemporary Western world’s concentration on giving respect to individuals and their choices. To address this, we suggested gaining an in-depth understanding through the concepts of ‘Kijigabandan’ and ‘Manadjitowin’. The concepts focus on attaining in-depth understanding for individuals and communities, personal development, and ultimately applying honour. We used the example of needle exchange programs to

illustrate the potential of 'Kijigabandan' and 'Manadjitowin' to further understanding about harm reduction for Aboriginal peoples. We also suggested how the concepts can assist Aboriginal social work to address two key barriers that often impede Aboriginal-specific harm reduction discussions: widespread support for abstinence and prohibition, and belief that harm reduction and Aboriginal culture are incompatible.

Although the example of a needle exchange program appears at first glance to be an individualized approach to dealing with problems that arise from problematic substance use (e.g., an individual exchanges a used needle for a clean one to reduce the risk of HIV transmission when injecting drugs), when viewed through a holistic lens it is about an individual, their community and choice. Hopefully, the discussion of 'Kijigabandan' and 'Manadjitowin' in this paper, and their potential for contributing to understanding harm reduction for Aboriginal peoples, will provide a starting point for Aboriginal social work to move the discussion beyond the individual, and into a framework that is more reflective of the worldviews of Aboriginal peoples.

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Endnotes

1 There is no one Western or Aboriginal worldview, but for the sake of presentation, the commonalities within each are focussed upon and presented as one in this paper.

2 The majority of available information in this section of the paper is specific to First Nations, in particular Status Indians living on-reserve. The unique histories and vast differences between First Nations, Inuit and Métis, as well as the commonalities, must be kept in mind when reviewing the data.

3 Substances are separated here by category (alcohol, illicit drugs, prescription drugs, volatile solvents) but they are frequently used in combination.

4 Thank you to the following individuals for sharing their wisdom and expertise for this paper: Pauline Deconti, Elder and Algonquin Linguist/Language Professor; Annette Odjick-Smith, Algonquin Linguist; and Joan Tennesco, Algonquin Language Teacher. Without their contributions this paper would not have been written.

5 This is not meant to imply that respect is not an important part of Aboriginal people's lives and teachings in contemporary society.

6 For a comprehensive review of Aboriginal-specific programs and policies, see **Dell, C.A. & T. Lyons** (2007). *Harm Reduction Policies and Programs for Persons of Aboriginal Descent*. Ottawa: Canadian Centre on Substance Abuse.

7 Thank you to Wendy Hyndman for sharing her expertise and time in developing this section.

8 Helps with dissolving heroin and crack cocaine.

9 NNADAP is a network of 54 treatment centres located in First Nations and Inuit communities across Canada. NNADAP is largely controlled by First Nations communities and organizations and is the main source of treatment for Aboriginal peoples in Canada for all forms of substance abuse.

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**NISHNAABE KINOOMAADWIN
NAADMAADWIN**