A decolonizing approach to health promotion in Canada: the case of the Urban Aboriginal Community Kitchen Garden Project

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SUMMARY
Aboriginal people in Canada suffer ill-health at much higher rates compared with the rest of the population. A key challenge is the disjuncture between the dominant biomedical approach to health in Canada and the holistic and integrative understandings of and approaches to health in many Aboriginal cultures. More fundamentally, colonization is at the root of the health challenges faced by this population. Thus, effective approaches to health promotion with Aboriginal people will require decolonizing practices. In this paper, we look at one case study of a health promotion project, the Urban Aboriginal Community Kitchen Garden Project in Vancouver, Canada, which, guided by the teachings of the Medicine Wheel, aims to provide culturally appropriate health promotion. By drawing on Aboriginal approaches to healing, acknowledging the legacy of colonization and providing a context for cultural celebration, we suggest that the project can be seen as an example of what decolonizing health promotion could look like. Further, we suggest that a decolonizing approach to health promotion has the potential to address immediate needs while simultaneously beginning to address underlying causes of Aboriginal health inequities.

Key words: Aboriginal health; decolonization; traditional healing practices

INTRODUCTION
Aboriginal people in Canada experience ill-health disproportionately compared with the rest of the population (Newbold, 1998; Adelson, 2005; Statistics Canada, 2008). The Aboriginal population in Canada has a life expectancy 5–7 years lower than that of the Canadian population as a whole, and experiences higher levels of chronic respiratory disease, diabetes, obesity and cardiovascular disease (Estey et al., 2007; Statistics Canada, 2008). The roots of these health challenges arise from social, economic and political inequities and a history of colonization (Adelson, 2005). And yet, despite these enormous challenges, Aboriginal people in Canada continue to survive, a sign of their strength that is often unrecognized in academic and popular literature.

Those working to promote Aboriginal health have noted that the dominant Western biomedical approach contradicts Aboriginal understandings of and approaches to health (Smye and Browne, 2002; Arnold and Bruce, 2005; Sherwood and Edwards, 2006). For many Aboriginal cultures, health represents the physical, emotional, mental and spiritual wellbeing of individuals, their families and communities (Bopp et al., 1985). This model is distinct from biomedicine, which is characterized by scientific...
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While biomedicine has functioned as the dominant health discourse in Canada, the emergence of health promotion in the 1980s provided an alternative discourse, characterized by a socio-ecological understanding of health and its determinants (Robertson, 1998). Health promotion has been described as a process for enabling people to increase control over, and to improve, their health (WHO, 1986). Health promotion’s more holistic conceptualization of health (for example, addressing the needs of the whole person), its preventative focus and its acceptance of the need to change social and economic conditions in order to improve health suggest that it holds greater potential for promoting Aboriginal health than relying solely on biomedicine.

However, a key challenge has been putting health promotion theory into practice. While Canada has provided leadership in the conceptual development of health promotion and population health, it has failed to implement public policies and programmes that effectively address social determinants of health, leading to the persistence of a variety of health challenges, not least of which are Aboriginal health inequities (Raphael et al., 2003; Adelson, 2005; Wilson and Yellow Bird, 2005). In Canada, colonization involved creation of reserves, generally much smaller than the traditional territory of any given nation (Kelm, 1998), as well as various processes of forced assimilation, in particular residential schools where children were not allowed to speak their language and often suffered abuse (Kirmayer et al., 2003). Residential schools are now closed, but many Aboriginal children continue to be raised outside of their families, having been removed through the Child Welfare System (Kirmayer et al., 2003).

Given the legacy of colonization, it has been suggested that attempts to improve the health status of Aboriginal people in Canada must be linked to decolonization efforts, a process that centres on regaining political, cultural, economic and social self-determination as well as positive identities as individuals, families, communities and nations (Verniest, 2006). Decolonization can be seen as a solution that draws on ‘colonized time’ and ‘pre-colonized time’ (Smith, 1999), addressing the legacy of colonialism and drawing on knowledge and practices from pre-colonial times. It is critical that both Indigenous and non-Indigenous people engage in this process, with colonizers needing to learn to respect and honour all relationships (McCaslin and Breton, 2008). Furthermore, it requires colonized peoples to begin to ‘recognize it when we are wearing the colonizer’s coat’ [(McCaslin and Breton, 2008), p. 513]. Wilson and Yellow Bird suggest that decolonization is a ‘project that begins with our minds . . . [that] has revolutionary potential’ [(Wilson and Yellow Bird, 2005), p. 3]. However, it is clearly more than a project of the mind; decolonization ultimately requires the dismantling of colonialism as the dominant model on which society operates (Wilson and Yellow Bird, 2005; McCaslin and Breton, 2008).

In working to understand alternatives to mainstream health promotion with urban Aboriginal peoples, a population which has been historically under-served and poorly understood (Adelson, 2005; Willows, 2005; Wilson and Young, 2008), we explore the question: What might a decolonizing approach to health promotion look like? To answer this question, we take an in-depth look at one case study, the Urban Aboriginal Community Kitchen Garden Project (the Garden Project) in Vancouver, on Canada’s west coast. The Garden Project yearly serves between 300 and 400 urban Aboriginal people from a variety of backgrounds and nations who live in Vancouver. It aims to be a ‘culturally and community-appropriate health promotion project’, and to this end is guided by the teachings of the Medicine Wheel. The Medicine Wheel is the most widely recognized symbol of Indigenous holism, emphasizing the interconnections between mental, emotional, physical and spiritual health and the health of the individual, community and universe (Bopp et al., 1985; Marsden, 2005). Its activities include weekly community kitchen and community gardening activities, with an emphasis on organic fruits and vegetables and traditional foods, as well as regular cultural celebrations and feasts.

Denzin and Lincoln have pointed out that Indigenous knowledge is often treated as quaint
and primitive in comparison with Western knowledge [(Denzin and Lincoln, 2008), p. 6]. In response, they suggest, ‘the decolonizing project reverses this equation, making Western systems of knowledge the object of critique and inquiry’. By acknowledging the limitations of biomedicine and health promotion and exploring the potential benefits of an approach to health promotion rooted in Aboriginal cultural teachings and healing practices, we aim to contribute to this decolonizing project.

METHODS

This case study was informed by participatory research methodologies. The majority of people who participate in the Garden Project are Aboriginal. In Canada and elsewhere, there has been a history of research being carried out on Aboriginal peoples and communities in insensitive and exploitative ways, often by outside white researchers (Castellano, 2004). Much of this research fails to fully involve those affected by the research in the research process. In contrast, participatory research methodologies have often received a positive response from Aboriginal communities because of their alternative and inclusive methods (Castellano, 2004). As a result, this research was carried out with attentiveness to a participatory mindset. The research was most participatory in the early stages, with project participants and leaders contributing to the development of research design and focus. The data analysis, while there was opportunity for feedback, was not as participatory. The research was approved by the Behavioural Research Ethics Board of the University of British Columbia (UBC). It also received written and verbal approval from the leadership of the Garden Project. Conducting research with urban Aboriginal populations can be challenging because, compared with some rural communities, urban Aboriginal populations may be more dispersed and culturally diverse, lacking any clear council with whom researchers can engage to ensure respectful research (Pyett et al., 2009). For this study, the first author worked closely with the Garden Project steering committee (which consists of project leaders and participants) throughout the study to ensure that the research was carried out in a respectful, useful and participatory manner.

From September 2006 to July 2008, the first author participated in and observed the activities of the Garden Project, including weekly community kitchen and garden sessions as well as seasonal cultural celebrations. She also regularly attended steering committee meetings and community consultations, interacting with over 200 Garden Project participants and leaders. Field notes were recorded following each interaction (Patton, 2002). The first author also conducted 10 semi-structured interviews, five with project leaders and five with project participants, as well as numerous follow-up interviews. Guiding questions for the interviews were developed in conversation with project participants and leaders and informed by (but not limited to) the key deliverables in the project’s outcome measurement framework. While similar questions were asked of all interview participants, the order and wording varied depending on interviewee responses. Interviewees were also encouraged to provide reflections beyond the interview guide. All project participants were given the option of participating in an interview; however, it was generally the longer term and most regular participants who chose to be interviewed. Project leaders interviewed included the Project Coordinator, the Cultural Coordinator, the resident Elders on the steering committee, a dietician who chaired the steering committee and the Program Coordinator at the UBC Farm. Project participants interviewed ranged in age from mid-20s to mid-70s. Most were women and came from a range of socioeconomic backgrounds. They tended to be longer-term participants but were otherwise fairly representative of project participants. Recorded interviews were transcribed verbatim. Transcriptions and notes from follow-up interviews were coded and meaningful categories and themes were identified (Rubin and Rubin, 1995). Once themes were identified, ‘member checking’ (Guba and Lincoln, 1989) was employed, to see whether research participants felt the themes were appropriate.

FINDINGS

Site and activities of the Garden Project

The Garden Project is a partnership between Vancouver Native Health Society (VNHS), an organization focused on the health needs of Aboriginal residents of Vancouver’s eastside,
and the UBC Farm, a 24 ha farm on UBC Vancouver’s Point Grey campus. UBC is located on traditional territory of the Musqueam Aboriginal nation. Its activities centre on communally tending a 1/2 acre organic garden plot which grows mainly vegetables, some fruits, as well as traditional medicinal and culinary herbs and plants such as salmonberries, huckleberries, Camus and tobacco. There are also abundant berries and other wild edibles in the surrounding forest. The food from this garden and the forest forms the base of the meals cooked in the regular community kitchen sessions. University students who worked and studied at the UBC Farm were often invited to join in on the communal meals of the Garden Project. Leftovers from the community kitchen and produce from the garden are taken home by participants to be used throughout the following week. During the fall and winter, indoor activities such as canning, pickling, drying and other preserving techniques become a more central focus. The project emphasizes growing and gathering traditional foods and medicines and celebrates eating traditional foods, such as salmon or ooligan grease, even though they are not produced in the garden plot.

Weekly kitchen/garden sessions were generally attended by 7–20 participants. Of those who attended over the year, the research was conducted, approximately one-quarter were regular participants, coming to many weekly sessions. The remainder came to large events such as Aboriginal preschool visits and the Garden Project’s two main cultural celebrations, a spring feast to bless the land and a fall feast to celebrate and give thanks for the harvest. These cultural celebrations are conducted by Aboriginal spiritual leaders and include a feast which blends culturally significant foods with food from the garden. Project participants have tended to be the main cooks for these feasts, with upwards of 100 people attending.

The Garden Project as a health promotion project

In this section, we focus on findings that demonstrate how the Garden Project functions as a health promotion project. In the following section, while there is significant overlap, we focus on findings that demonstrate how the Garden Project is connected to Aboriginal health teachings and healing practices in its programming and outcomes.

Project leaders emphasized the importance of treating the whole person. Corinne, a resident Elder with the project, suggested that an essential part of her work was ‘understanding where community is at, what they’re having to do’. Reflecting this, Peggy, a dedicated project participant, explained that part of what made the project feel like a comfortable and welcoming place was the way project leaders seemed to ‘get’ her and understand her context, a sentiment expressed by many other participants. Project leaders and participants often spoke of the project as addressing multiple interconnected health needs.

Empowerment and increased capacities were perceived as important project outcomes. Cease, the project’s cultural coordinator, described it as ‘an empowerment tool for Indigenous people’ which ‘empowers [participants] because it is their own experience, and nobody is telling them how to react’. Ron, the Garden Project coordinator, promoted this sense of participants’ freedom to make decisions in project activities through ensuring that ‘the work is shared [and] the decision making is shared’. The skill development in the Garden Project resulted from participants and project leaders mutually sharing skills. One participant explained this skill sharing saying: ‘I learn a lot from [the Elders]. I really appreciate my Elders. I like their energy, it’s very mellow, very learned … I like being able to help them too’.

This mutual skill sharing and the informal learning environment it creates, allowed participants who had previously had negative educational experiences to enjoy learning with the Garden Project: ‘This is like a real learning experience, it’s not like anybody’s twisting my arm to go there’. Participants also felt confident in the skills that they were developing and many found that the project demystified cooking for them: ‘I think I’m learning to cook … I’m noticing that it doesn’t have to be this really expensive recipe. It can be very tasteful and healthy’. Participants spoke of increased food growing skills, although many had less confidence around these skills than they did with the cooking skills, often because the Garden Project was their first exposure to gardening. As Val explained, ‘I’m just learning right now, these are the first ones I’ve planted’.
Beyond developing food skills, the Garden Project was seen as building health-supporting relationships. Ron proposed that the project creates a safe space for people to talk and get support: ‘and we’re not therapists … but we talk about things and we allow people to have a forum to talk to each other and us about things’. These conversations, over lunch or in the garden, would often include non-Aboriginal university students who were at the farm working on other projects, but invited to join in for a meal. For many participants, the Garden Project became family, providing them emotional support both within and beyond the project. As Curtis suggested: ‘it’s community, it’s love, it’s family, it’s belonging’.

The relationships developed between project leaders and participants also became a means through which participants were able to access important resources and opportunities. For example, when one participant broke her hip in the winter of 2008, the project coordinator regularly visited her in the hospital with other project participants, and worked to make sure that she got an appropriate wheel chair and walker. Other participants and their families started accessing other services provided through VNHS, such as medical and dental services. Two participants, through the recommendation and support of the project coordinator, were able to participate in a community development short course aimed at career development.

The Garden Project and Aboriginal approaches to health and healing

The Garden Project is guided by the teachings of the Medicine Wheel and other cultural health teachings. The Medicine Wheel’s approach to health is explained in the Garden Project’s promotional material, which states: ‘Health will only be realized when the mental, emotional, physical and spiritual health of the individual, community and Universe are in balance’. This approach to health was referenced by project leaders and project participants. For example, Corinne emphasized that the Garden Project is a way of promoting holistic health in a culturally appropriate way: ‘we use the English word of holistic. Holistic health. We really try, but in our way. You know when we weren’t allowed to practice our spirituality, the mental anguish around that … who are we?’ Thus the Garden Project is seen not simply as a health promotion project with Aboriginal participants, but rather as a project designed specifically by and for Aboriginal people, based on cultural teachings and functioning in awareness of colonization. As Ron explained: ‘there needs to be culturally appropriate programming of this sort, for Aboriginal people, not just, okay here’s a model and let’s invite Aboriginal people’.

Most project participants referenced concepts related to the Medicine Wheel. In particular, they articulated how the Garden Project had an impact on the four key areas of physical, mental, emotional and spiritual health. They generally saw their physical health being affected through increased activity levels and increased consumption of ‘healthy foods’ such as garden vegetables. Peggy explained: ‘I think I’d probably be in a scooter by now [if it weren’t for the Garden Project], I’ve been through so much pain.’ Another participant reflected that through growing vegetables she has come to appreciate them more: ‘I think I’ve fallen in love with vegetables. It’s like, wow, I grew this?’ Almost all participants spoke of the mental and emotional health impacts of the project saying ‘it’s truly therapy to be there’ or ‘I feel at peace when I’m there.’ Participants saw the Garden Project influencing their spiritual health through its being a sanctuary, or a place where their spirit was happy.

The Garden Project was also seen as serving more than individual health, including a focus on the health of the community and the ecosystem or universe. The Garden Project’s outcome measurement framework (OMF) included a desired outcome related to increasing participants’ awareness of the connection between the health of Mother Earth and human health. Ron explained: ‘One thing that we try to do is to show people that healing your relationship with the earth, or healing people’s relationship with the earth is one key to healing people’. The Garden Project OMF also placed emphasis on fostering connections between participants, their communities, their culture and Mother Earth.

Ron emphasized that ‘growing a diversity of crops…is good for human health, but …it’s good for the earth too’ a message which he regularly worked to convey to project participants. Often project leaders linked increased connections with the natural world to renewing connections with culture. Cease explained this saying that, while gardening may not be
traditional for some participants involved, ‘we’ve always gathered, we’ve always worked with plants, we’ve always had this connection with the earth.’ She saw this connection with nature and with cultural practices being consciously fostered: ‘we bring in spiritual people to do ceremonies, to teach us cultural teachings, bringing us back to the land, back to old stories of our people . . . encouraging and nurturing that spiritual and cultural element of the program’.

Participants also spoke of the importance of connecting with their cultures through time spent in nature and engaging in Garden Project activities. Some linked project activities to the movement for decolonization. For example, Curtis pointed out that the skills he saw himself gaining were directly linked to decolonization, suggesting that the Garden Project ‘is decolonization because part of the colonization that we live in is dependency’. While other participants did not speak of decolonization explicitly, most emphasized the cultural importance of the project in terms of how it (re)connected them with nature and with cultural practices, both ceremonial and quotidian practices of communal cooking, gathering/growing and eating. Some saw the project as fostering a reciprocal relationship between humans and Mother Nature: ‘it’s a relationship. The land loves us, we love the land’. Participants spoke of ‘being with nature’ and ‘doing what we’ve always done’ as integral to their experiences with the Garden Project.

**DISCUSSION AND CONCLUSIONS**

Canada’s Royal Commission on Aboriginal Peoples defined healing as: ‘Personal and societal recovery from the lasting effects of oppression and systemic racism experienced over generations. Many Aboriginal people are suffering not simply from specific diseases and social problems, but also from a depression of spirit resulting from 200 or more years of damage to their cultures, languages, identities and self-respect’ (RCAP, 1996, section 3). Sherwood and Edwards suggest that for healing to happen, a decolonizing approach to health is necessary, which will involve a radically different way of promoting health (Sherwood and Edwards, 2006).

In Corinne’s words, the Garden Project’s alternative way of promoting health is health promotion done ‘our way’ or as Curtis put it, it is decolonization. Thus, while the Garden Project could be seen as a health promotion project, it is also distinct from many mainstream health promotion projects. For example, very little empirical or theoretical health promotion literature discusses the role of spirituality in promoting health. Similarly, while the health promotion discourse references a socio-ecological approach, much of the literature in this area is reliant on a definition of ecology that underemphasizes the role of the natural environment in health (Dooris, 2005; Green and Kreuter, 2005). In contrast, many Aboriginal healing practices draw on spirituality, ceremony and time spent with others and in nature to promote health and healing (Kirmayer et al., 2003; McCormick, 2005). Thus, the natural setting, the presence of spiritual leaders and cultural ceremonies are a few key ways that the Garden Project becomes distinct from mainstream health promotion as it engages with cultural teachings for health and healing.

Garden Project participants were also able to increase health promoting capacities related to cooking and growing food and create health-supporting social networks, particularly for longer-term participants. There is evidence that many health issues experienced by Aboriginal peoples can be related to diet (Willows, 2005) and that thriving health in Aboriginal communities is positively correlated with social support (Richmond 2007; Richmond et al., 2007). Thus, increased food-related capacities and social support are examples of the pathways by which the Garden Project may positively influence health within a health promotion frame. However, a key critique of health promotion that these outcomes may point to is its tendency to emphasize an individual-focused ‘lifestyle approach’ to improving health despite its more holistic discourse (Robertson, 1998; Thorogood, 2002). The lifestyle approach emphasizes educating individuals to make ‘healthier’ lifestyle choices, for example, by eating ‘right’, in order to avoid health problems. It neither recognizes the contextual factors which influence lifestyle ‘choices’, nor the myriad other factors beyond lifestyle which impact health.

In light of this critique, the Garden Project again is different from many other mainstream health promotion projects. Take, for example, the case of healthy eating. Although Garden Project activities promote increased
consumption of fruits and vegetables, the aim of the project is not simply about making healthier individual lifestyle choices. Instead, Ron emphasized the relationship between growing and eating a diversity of crops for the mutual health of humans and the land. The act of gardening, while certainly not traditional for all the Aboriginal cultures, was explained by Cease as a way of reconnecting with the earth and plants, a more common cultural tradition. Cooking and eating together was understood by project participants and leaders as being about connecting with traditional practices of communal cooking and eating. Furthermore, the project explicitly sought out and celebrated traditional food from different Aboriginal cultures, such as bison, salmon, wild berries and ooligan grease. Efforts to return to more traditional diets and food practices have been understood by others as an important way of promoting health through decolonizing Indigenous diets (Waziyatawin, 2005), or an approach to Indigenous nutrition rooted in Indigenous ways of knowing (Milburn, 2004). Thus, the project’s agenda with respect to food can be seen as much broader and more encompassing than educating participants to make healthy food choices. Instead, food is a means through which participants reconnect with tradition, with the land, and with each other with the ultimate goal of healing for individuals, communities and the environment.

As the Garden Project celebrates traditional approaches to healing and helps participants reclaim daily and seasonal cultural practices related to communal food work, it does not ignore participants’ varied experiences of colonization. When Ron spoke of the project providing a forum for people to ‘talk about things’, the things discussed often revolved around common experiences in residential schools, challenges with children being taken into care, frustrations with subsidized Native housing and lack of access to traditional foods. As these conversations happened, non-Aboriginal students who were invited to join for the meal and conversation were thus educated about the challenges facing colonized people. Through this combination of providing a forum to openly discuss and educate others about experiences of colonization while celebrating traditions, the Garden Project is able to contribute to the healing process of decolonization (Smith, 1999; Kirmayer et al., 2003).

In this way, the Garden Project takes aim at the root cause for Aboriginal health inequities, colonization. However, the decolonization process is not about ‘tweaking the existing colonial system to make it more Indigenous-friendly or a little less oppressive’ (Wilson and Yellow Bird, 2005, p.4). It is ultimately about creating a new system. We have suggested that decolonization can involve activities such as the Garden Project; however, it will also require activities that are more directly oppositional to the colonial system, such as the signing and honouring of treaties as a way to assert sovereignty that has been denied but never ceded (McCaslin and Breton, 2008). For example, UBC is on unceded traditional Musqueam territory (a fact which is explicitly recognized and honoured by the Garden Project during daily and ceremonial activities). In situations such as these, treaties which recognize and honour peoples’ sovereignty may be an integral part of the decolonization process (McCaslin and Breton, 2008).

In conclusion, projects like the Garden Project provide direction in the challenge of reducing Aboriginal health inequities. Despite the relatively small number of people directly affected by the project, the implications of its distinct approach to health promotion are profound. Health promotion aims to increase people’s control over their health and thereby improve it. Yet in the case of Aboriginal people in Canada, health and healing will not result simply through increased individual capacities or social networks. There are structural and historical reasons for the health challenges faced by the Aboriginal population and serious attempts to promote health with this population need to take these factors into account. By providing a place in an urban context for Aboriginal people to discuss and educate others about experiences of being colonized while celebrating and engaging in cultural teachings and practices, the Garden Project serves as one example of what decolonizing health promotion could look like and how such an approach might facilitate healing. Projects such as these can be an important step in the much larger and all-encompassing project of decolonizing Canadian society.

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