'TAKE PRECAUTIONS AGAINST THE NATIVES': LIFE AS A SICK INDIAN AT LYTTON BC, 1910-1940.

by

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Take Precautions Against The Natives: Life As A Sick Indian At Lytton BC,

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'TAKE PRECAUTIONS AGAINST THE NATIVES'[1]: LIFE AS A SICK INDIAN AT LYTTON BC, 1910-1940.

Abstract.

A common criticism of the disease ecology tradition in medical geography is that little attention is paid to societal influences on people's health. In response to this, the thesis focuses on the development of a partial *dis-ease* ecology, where societal factors are examined - in particular, how they impacted on the health of native people. The thesis concentrates on how social relations, and their outcomes were mediated through Lytton, in the southern interior of British Columbia predominantly in the first half of the twentieth century. It is an attempt portray the dynamic that existed between racial discourse, institutional practice and space in the making of a racial category, and how these notions were linked with major health concerns of the day.

Using a qualitative methodology and emphasizing the validity of lay experiences, my purpose is to illustrate, by means of a case study, the social relations that influenced the experience of being both sick and native at this time and in this place. Recollections of infectious disease experiences told by native elders, form the body of the study, which is broadly divided into two parts. The first part shows how a native person's health may have been affected by factors that were often largely beyond his or her control, for instance, housing conditions or patterns of work. Secondly, issues of power and surveillance are scrutinized, as

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[1] *The Province*, November 9, 1909, p.1.

these form part of the societal *dis-ease* that the thesis set out to examine. The Indian Residential School is used as an example of a power relation, in an attempt to link notions of disease with notions of *dis-ease*. Oral histories show how the school became an effective agent of social control, producing a landscape where localities and relationships were constantly mapped. Questions of infectious disease became questions that dealt not so much with the environment or sanitation, but with questions of social relationships.

The thesis concludes by arguing that although it has often been assumed that societal *dis-ease* was uniformly cruel to the native population, evidence from oral histories suggests that this was not *always* the case.

Acknowledgements.

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To the people of Lytton who gave me their time and hospitality, not only those whose voices who are heard in this project, but to others, particularly Richard and Carol Swan.

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To my good friends Don and Chris McPhee and especially John Meligrana, all of whom have made my Canadian experience more enjoyable than I could ever have imagined.

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And to my parents who once again let their wayward daughter pursue yet another great adventure, without once raising their eyes to the ceiling.

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Preface.

Perhaps one of the most important influences on our lived experience is the degree to which we are healthy or ill. The experience of health and/or ill-health can mean not only the difference between life or death, but also our position on the continuum in between, as well as our ability to cope with everyday life. This study attempts to uncover some experiences in health and ill health, as lived by members of the Nlaka'pamux Nation in Lytton BC, in the first of of this century. Together, they form the underpinnings for this story.

The topic is important because, for too long, First Nations' versions of history and geography have been relegated to the margins, pushed aside by a European culture's predominantly colonial history. Often denied a voice and authenticity, First Nations' histories, were, until recently, rapidly becoming forgotten. This study is a modest attempt to reassert the validity of a history and geography other than a hegemonic group's. In terms of generalized BC historical and geographical studies, there has been relatively little research undertaken in this area, and in particular, little research has been done in terms of disease and what it was like to be Indian and sick (or healthy) in the place called Lytton. This is unfortunate as some of these issues are crucial to understanding the history and geography of that place.

Any research project needs to acknowledge the historical and political context within which it occurs. This project came about because of my interest in First Nations' peoples and the predicaments they find themselves in today. Rather than undertake a study of urban native people, I chose to work in the southern interior of British Columbia, in a relatively isolated community where jobs are few and kinship

tight, because such a community maybe more typical of the current reality faced by many of British Columbia's First Nations people (PCensus-Canada 1993, Stats Can 1992: 70). At the time, Lytton was a place where I knew no one and no one knew me, thus it was with a certain amount of trepidation that I entered into the research process, but my worries were not realized and I learned much from my time there. Thus this place became the focus of my research.

I chose Lytton because it was outside of the Lower Mainland of British Columbia, but still only a three and a half hour drive away from Vancouver, where I was based. I had been introduced to the area shortly after my arrival in the country and became very keen to learn more about that place. My interest in the First Nations and the situations they find themselves in today leant itself to working in the area, which has approximately three hundred 'white' people and a thousand native people in the vicinity. I had no prior knowledge or experience of working with First Nations people (although a wide experience of working with many different ethnic groups in the UK), but was aware that the research could be fraught with difficulties and problems because of the current situation with First Nation politics.

As a geographer interested in health and ill-health issues, an assessment of the contemporary literature was made in order to find some direction for the research project. I wanted to seek an understanding of the ways in which people made sense of their lives and the (social) worlds in which they live(d), and I wanted to assess extant power relationships that impacted upon this experience. But the medical geography literature by and large was not useful to me and I had to turn to the larger project of human geography in general in order to find some direction. Thus I am left feeling uneasy about calling this project an exercise in 'medical geography'. The

structure of the discipline is such that this work doesn't fit easily into any one sub-discipline, rather it goes against the grain, not fitting neatly into medical geography or historical geography or even cultural geography. This, however, I would argue can actually be seen as a strength of the project, revealing a broad based theoretical orientation and a flexible research strategy that enables some of my research goals to be attained.

Human geography over the last ten years has integrated new theoretical ideas from the social sciences into its own agenda with some very interesting results. New conceptions of space (Lefebvre 1991) have opened up new ways of seeing the world around us so that now, as geographers, we are no longer limited to Euclidian space concepts and statistical analyses, rather there is a whole multitude of approaches and philosophies that are viable within the geographical sphere. Ideas such as structuration theory (Giddens 1979, 1984), realism (Sayer 1984) and postmodernism (Cloke *et al.*, 1991; Rosenau 1992;), to name but a few, have enabled geography to assert an important position within the social sciences. But as yet, with few exceptions (Kearns and Joseph 1993) many of these notions do not appear to have entered the medical-geographical realm. Moreover, it is interesting to speculate on what a historical medical geography would look like. Up until now, studies have tended to be epidemiological in their approach (Ray 1975, 1976; Decker 1988, 1991; Wilson 1993), using traditional models, such as epidemic curves or disease diffusion models (see for example Meade 1988). This study is in part an attempt to formulate a new type of historical medical geography - one that takes on some of the ideas of the social theorists and explores, for instance, issues of social constructions of 'Others', of difference, of multiple truths as opposed to

just one overarching metanarrative. It looks at different explanations of society, realities, and social relations, but with specific reference to health issues. How did those 'Others' make sense of their social reality, of sickness and its links with social processes and social relations? Anderson (1987, 1988, 1991) has succeeded in doing this for Vancouver's Chinatown - not from a health related viewpoint but more generally, by showing how the construction of place through metaphor and hegemonic constructions of reality, can have very real effects on a population.

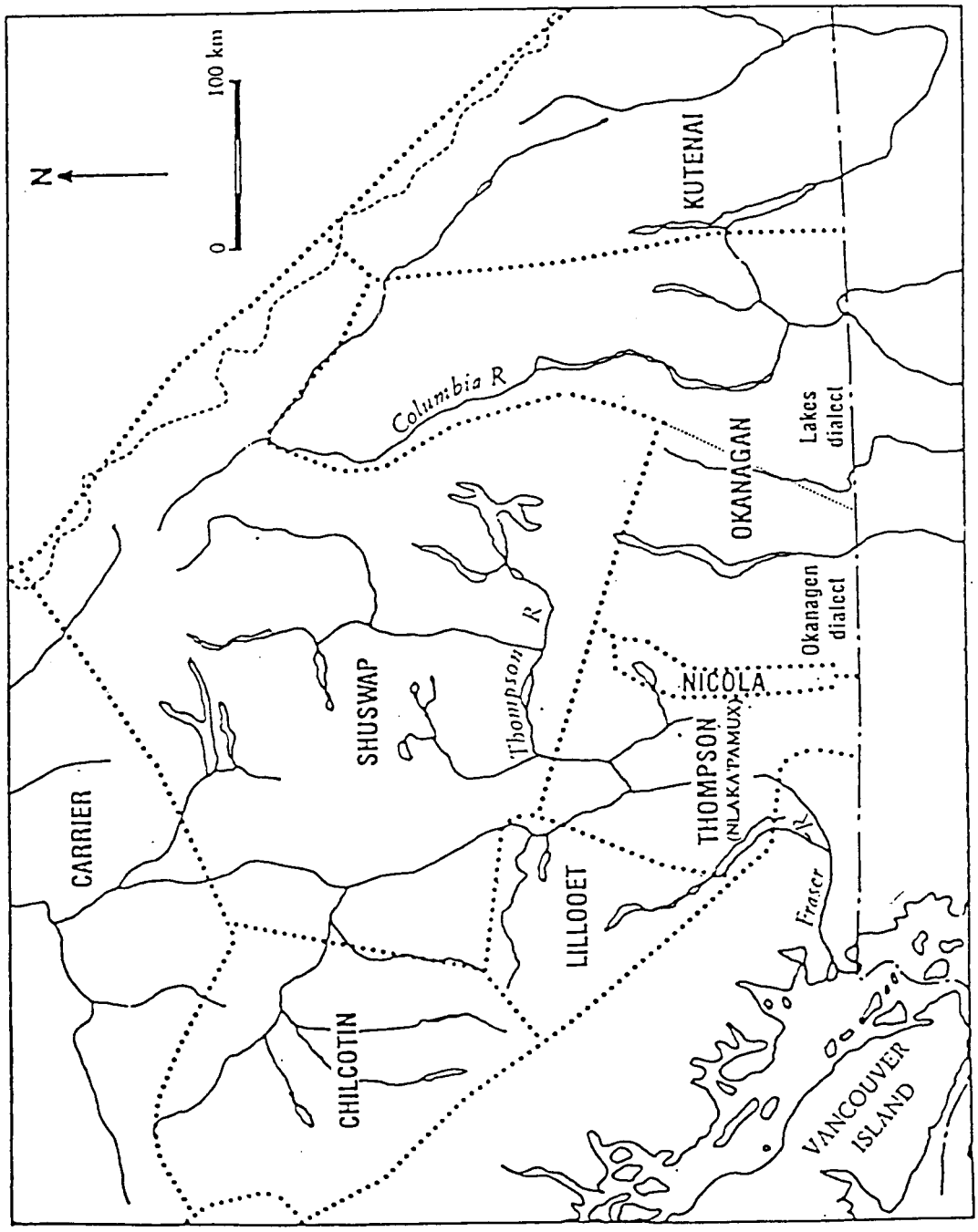
Following Anderson's lead, it might be fruitful to attempt a study that deals with the construction of place and the hegemonic constructions of the notion of 'Indian'. By taking on some of Anderson's ideas, it may be possible to bring us a step nearer to a medical geography that is sensitive to the some of the new turns in human geography mentioned above - a medical geography that is itself situated within the larger project of human geography and the social sciences in general, paying particular attention to new theoretical debates that are entering the academic field, whilst remaining empirically grounded. In this way, we can read into medical geography contemporary ideas of time and space, reasserting not only the validity of the social sciences in general, but also of medical geography in particular. At the same time, it may be possible to read out of medical geography into the broader literature new concepts concerning health and ill-health.

Chapter 1 introduces Lytton as the research area and set out the aims, objectives and specific research questions of the thesis. After briefly surveying the Indian Act, I discuss some of the problems encountered when using traditional medical geographical approaches in trying to understand native disease in BC. In view of this, the chapter then goes on to explore other potentially useful theoretical

frameworks. Chapter 2 covers methodological issues and develops the reasoning behind my use of a qualitative methodology. Sources of documentation that I used in this analysis are introduced and discussed and there is a critical reflection on the research process itself. Chapter 3 highlights limited facets of a *dis-ease* ecology of Lytton by looking at certain societal relations, for example housing, food and water and patterns of work. The chapter goes on to look at certain diseases in detail, such as tuberculosis and measles through the oral histories that were collected. Chapter 4 entails an assessment of the role of disciplinary powers, for example, Indian Agents, the Anglican Church and the Indian residential school and the effects they had on children's health. This is followed by an examination of social control and the racialization of disease. In the conclusion (Chapter 5), I recap on the main observations of the thesis and discuss the significance of the study. The closing comments of the conclusions then offer some suggestions for future research directions.

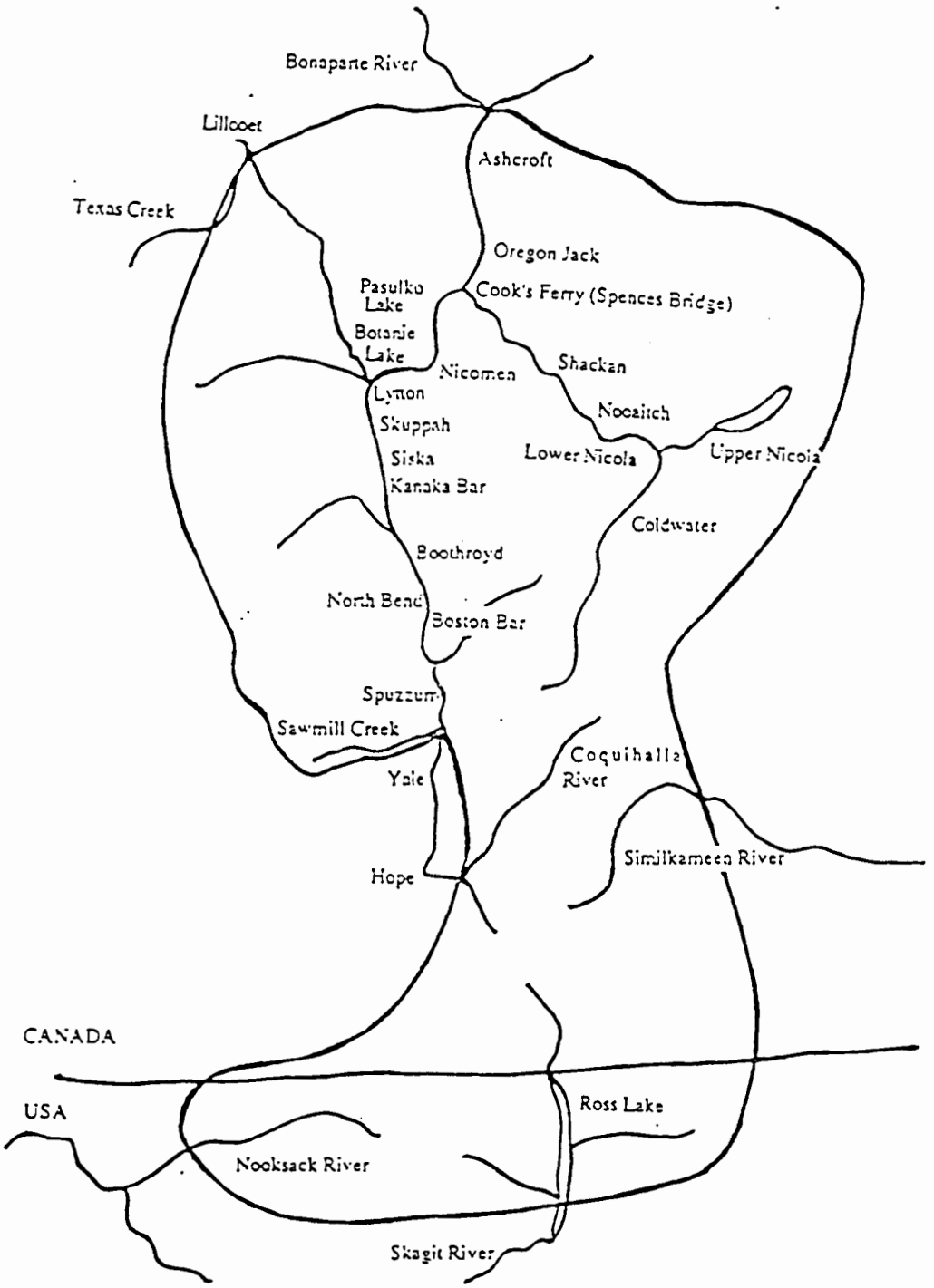
MAP 1: ETHNOGRAPHIC GROUPS IN THE CANADIAN PLATEAU

(Source: McMillan 1988.)



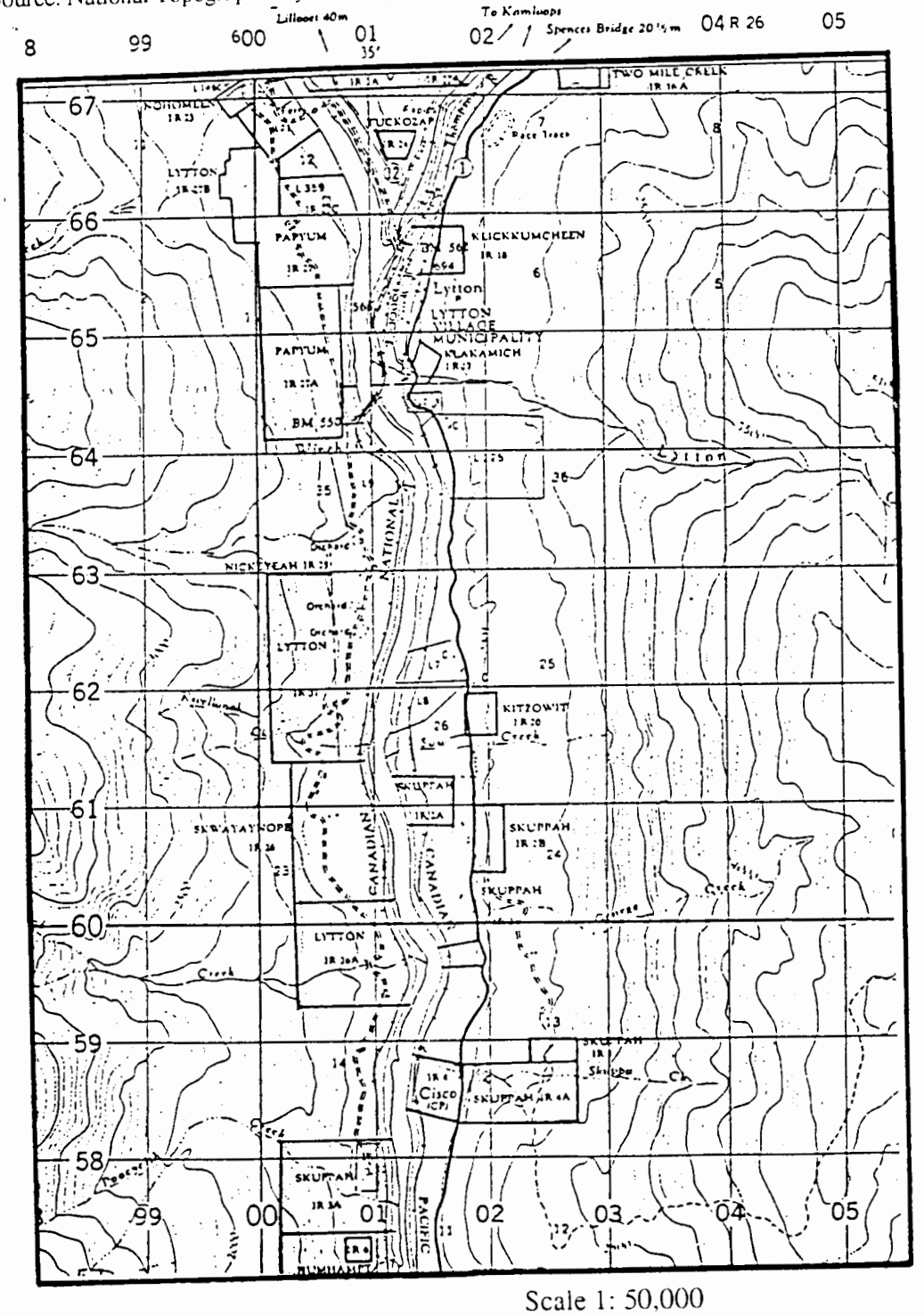
MAP 2: TRADITIONAL TERRITORY OF THE NLAKA'PAMUX NATION.

(Source: Nlaka'pamux Nation Tribal Council, Lytton BC 1993.)



MAP 3: RESERVES AROUND LYTTON.

(Source: National Topographic System Map 92 1/4 East Edition 1ASE Series A 721 1992.)



Scale 1: 50,000

Chapter 1: The Nlaka'pamux Nation and the Problems of Knowing Disease in Native BC.

1:1. Introduction.

Whenever and wherever "marginal peoples come into a historic or ethnographic space that has been defined by the western imagination", their distinct histories quickly vanish (Clifford 1988: 5). Becoming dominated by the capitalist west and no longer inventing their own futures, British Columbia's First Nations rapidly became a marginalized population -- economically, politically and socially. Herded onto tiny reserves, they became increasingly less able to maintain traditional lifestyles and name their own futures (Mickenberg 1971; Polsusns and Manuel 1974; Body 1981; Miller 1985; McMillan 1988; Drake-Terry 1989; Barman 1991; Dickason 1992). The case of First Nations people of Lytton, in the southern interior of British Columbia certainly proves no exception. Described by the first Bishop of New Westminster as 'the dreariest, dullest and driest place in the country'[1], Lytton's 'white' history has traditionally started with Simon Fraser who came down the river that was named after him in 1808. Of course, there was 'history' before that, as told in the songs and myths of the Nlaka'pamux Nation, but this became relegated to the status of fantasy and fable by the European settlers who came to stay, in the second half of the nineteenth century.

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[1] August 1881, quoted in *Lytton: A Story in Pictures,* compiled by the Lytton and District Centennial Society, 1966-67.

In some ways, Lytton's colonial history is typical of many communities in BC, where boom-or-bust towns such as Barkerville or Lillooet sporadically dotted the map as their fortunes waxed and waned. Like many other British Columbia communities, the legacies of an immigrant white culture are still apparent in Lytton today, some of which are manifested spatially - from the reserves that dot the landscape, to the derelict space where the Indian Residential School once stood; as well as the two Anglican churches that stand opposed to each other - one originally intended for natives, the other for white people. Moreover, from the gold rush on, there were deliberate efforts to 're-create' Lytton, to make it ever more a place that was constructed by and for the reality of a predominantly European culture. An example of this re-creation of place can be seen in the renaming of Lytton. Although it was originally called Kumsheen, 'The Forks' as it became commonly known was designated with its 'proper' name - Lytton - in 1858 by Sir James Douglas, Governor of the Colony of British Columbia, in honour of the Colonial Secretary Sir Edward Bulwer Lytton. In erasing the native name Kumsheen, the white population effectively began its systematic attempt to relegate the lives and experiences of native peoples, to recreate for themselves a more familiar landscape, one in which they perceived they had complete control.

In other ways, though, Lytton can be considered unique. Claimed as one of the longest inhabited places in North America, it has also been argued that it was also one of the most densely populated (Teit 1900, quoted in M'Gonigle and Wickwire 1988: 26). Moreover, historically and in the present, it has functioned as an important site within Nlaka'pamux territory, both as an important meeting place and as part of a larger symbolically important landscape. An understanding of geographically based

ties, coupled with a sensitivity to the importance of place, offers geographers a rich context for analysis (Muir and Weissman 1989: 81). This study pays attention to these notions in an attempt to untangle some of the social (and by extension spatial) relationships at Lytton. The uniqueness of this place means that it is a very important place for some people; a place that provided then, as now, the real and concrete settings in which the webs of peoples' daily lives were woven and enmeshed. Lytton was the place through which particular social relations were structured and mediated, where members of the Nlaka'pamux Nation saw their space being manipulated and recreated by forces that were often too powerful for them to control. Many of these changes were associated with the development of interior BC as a marginal area within the colony of British Columbia. The gold rush, followed by the later development of transcontinental railroads, laid the foundations for Lytton's entry into a wider capitalist system, whereby Lytton's economy became a small part of a larger colonial one.

For all its similarities and differences to other small communities, Lytton itself stood at a crucial crossroads in terms of colonial history. The effects of the 1858 gold rush and the coming of the missionaries and railroads meant drastic changes in ways of life for native and European peoples alike (Violette 1961; Ponting and Gibbons 1980; York 1989; Barman 1991). The Department of Indian Affairs (DIA) eventually had a full-time Indian Agent positioned at Lytton, which became the headquarters for the Lytton Indian Agency, and there were close ties between the DIA and the Anglican Residential School (St. George's) for native children. These broader issues went to make up the ingredients of a more general picture of Lytton, a place which because it was outside the lower mainland, was sometimes considered unimportant

by other residents of BC, many of whom resided in the cities of Victoria and Vancouver.

Partly because of it's geographic marginality and perhaps partly because of the assumed unimportance of things Native, there exists only scanty knowledge of Native disease in modernizing BC. For many years the only records that were kept were those of missionaries and the Department of Indian Affairs, neither with much precision or attention to detail. A glance at the official records shows that Indian Agents dutifully recorded everything that was pertinent to the Department's policy goals of civilization, assimilation, education and Christianity, but little else was included. In a way this is understandable - the Agents were busy men with little time for embellishing official reports. It may also indicate another viewpoint - that unless there was cause for public concern, issues of native native health were not considered a priority in the early twentieth century and thus little information was recorded. The story is similar for other non-European populations, as Anderson (1991) has so ably demonstrated. On the other hand, there are many written accounts of the European population's health for this period (Helmcken 1907; Meiklejohn 1910; Young 1911; Osler 1921; Heagerty 1928, 1940; Guiou 1930, 1934; Monroe 1931-32; Johansen 1937).

Thus little is known from European accounts about the impact of infectious diseases on the Native population in the Lytton area. Also, as much of the oral tradition of native culture has been lost, it is difficult to assess whether and how health issues were even significant to native peoples themselves. Even so, it may not be an entirely useless task to try and work out at least a provisional account of health and sickness in the community in times gone by, for the following reasons. Firstly,

for the people of the Nlaka'pamux Nation, previously unheard oral accounts may form an important and as yet unexplored part of their history, and may go some way to creating a more viable community spirit than exists at present. Secondly, the uncovering of new knowledge may expose me - and others - to new experiences, giving us a greater understanding of the role of the past in forming the situation that Lytton faces today.

It is within this context that the study aims to uncover some of the issues of sickness and health facing the Nlaka'pamux Nation in the early part of the twentieth century. I have chosen the earlier part of this century for two reasons. Firstly, because this is approximately as far back as Nlaka'pamux elders can remember, and secondly, because this was the period after the initial impact of the arrival of Europeans in the area, thus certain social relations were already well established by this time. Adding to the historical viewpoint, a geographic approach enables me to highlight some facets of the process that contextualize and situate the story within the wider picture of Native-European relations at a specific time and place.

1:2. Aims and Objectives.

Drawing from the ideas of Anderson (1987, 1988, 1991), I want to try and show the dynamic that existed between racial discourse, institutional practice and space in the making of a racial category, and how these notions were linked with the major health concerns of the day. The process can be seen as fundamentally geographic in that 'spatial structures are implicated in the production and reproduction of social relations in the sense that particular territorial forms both produce and reflect particular social processes' (Jackson 1988: 4).

The aims of the project are straight forward enough. Firstly, I would like to try and denaturalize common-sense assumptions about both 'Indians' and the hegemonic construction of health by relating oral accounts to official ones. By this I mean that taken for granted ideas about 'Indians' and health need to be challenged in order to expose the processes which form and structure these assumptions. One way of going about this is to compare official written accounts with lay oral ones.

Secondly, I want to assess the extent to which surveillance by the dominant society was operating behind the notion of health and the social construct of Indian, that is how sick Indians were monitored, observed and treated. One of the most expedient ways of going about this is to examine life at the Indian residential school, where large numbers of native children were gathered. The meanings that are attached to being Indian have been little questioned in previous research and this study aims to link the experience of being ill together with the experience of being Indian in an effort to try and make sense of those experiences. These experiences are necessarily multi-layered and contingent, both upon each other, and on other factors, and further constructed within a daily basis of wider issues such as class, gender, power, politics and economics.

1:3. Specific Research Questions.

The research questions I was asking were deliberately broad, because the study set out to be descriptive and exploratory, rather than tightly defined. Also, as I wanted elders do the talking, I did not want to constrain or restrict any information they might otherwise share with me. The first enquiry was whether the elders could remember any illnesses from their childhood, and whether they had had any personal

experiences of any of them. By opening conversations with these two issues, I hoped it would be possible to see if there were any specific diseases that I had not expected to be important to people, and also what it was like to be a sick native child in the earlier part of this century.

The second question I was asking was whether there were any differences between the official records of disease events and the oral accounts? The reason for this question was to see if there were contradictory accounts which may have been an indication of differing realities for different sections of Lytton's population. By this I am not accusing anyone of telling untruths, simply that different people with different priorities and agendas may have seen things in different ways, and that these contradictions may have manifested themselves in contrasting opinions.

Thirdly, I wanted to try and ascertain if there were any linkages between patterns of social relations and patterns of disease. By looking at this, I hoped to illustrate some of the concrete effects of the social construction of race, including the idea that systematic marginalization (because of 'race') *may* be a tenable explanation for the appalling health status of First Nations, both today and in the past. Thus I hope to examine *how* that marginality was felt - not only in terms of being sick and native, but also because they were children, who traditionally have less status than adults.

Lastly, I wanted to look at the relationship between the residential school and infectious diseases. The residential school was and still is an extremely important part of life at Lytton, and can be seen as a blatant example of societal *dis-ease*. By this I am referring to the condition of society and the circumstances under which

people went about their everyday lives. Where there any links between the notion of societal *dis-ease* and power and surveillance and illness at the school? Were there any mechanisms of surveillance set up to monitor and assess the progress of children, and if so what were they? Lastly, did the school contribute to the process by which ideas about health were connected with Indians in white discourse?

1:4. The Indian Act and the Legalities of Being Designated 'Indian'.

From a geographic perspective, perhaps one of the most important sites through which early twentieth century society's conceptions about Indians were constituted and reproduced was the Indian Act. Traditionally represented as a 'problem group' (Fisher 1977; Tennant 1990; Carstens 1991; Dyck 1991; Dickason 1992; Francis 1992) needing special institutions and legislation to deal with them, the geographies of the 'Indian problem' took concrete effects across Canada with the setting up of the Department of Indian Affairs and the spatial rearrangement of native spaces, primarily through the setting up of reserves and treaty lands. The six major goals of Indian policy were protection, assimilation, Christianity, self-sufficiency, enfranchisement and the setting up of treaties, although in BC, emphasis was placed mainly on the first four goals. Through the racial ideology of the state, native life in Canada became transformed into one that was geographically altered and constrained, continually monitored, recorded and catalogued.

Legal definitions of 'Indian' depended on whether a person was registered on an Indian band list and, in the case of an ethnically mixed marriage, which parent was native. A native father and a European mother destined a child to be designated 'Indian' for the rest of their life and all that that entailed, whereas a white father and

a native mother meant that the child was 'white' in the eyes of the law and thus potentially faced quite different life chances. Ultimately, the social construction of 'Indians' was fostered through the development of a large and unwieldy DIA and a whole bureaucracy was created to maintain this imagined 'race' in their place. Foucault (1967) has illustrated the role of bureaucracy in creating law, where the institution of law itself shapes the concept of madness; similarly the DIA and the Indian Act were largely responsible for stipulating what characteristics defined Indians. In western societies since the middle ages the exercise of power has been formulated primarily in terms of law, and this was carried over into an emergent Canadian society where legal discourses impacted greatly on the forms of local power relations and how they were worked out on the ground. In this way the Indian Act was used as a tool to support prevailing power relations. Surveillance of Indians via the Indian Act meant that this tool was a local (to Lytton) centre of power and knowledge, in a discourse where power and knowledge were inextricably linked. Through the Indian Act, the history of Indian-non-Indian relations became embodied in legislation and bureaucratic agencies to the extent that its impact upon the lives of individuals 'approximates what Goffman (1959) has called a 'total institution' (Ponting and Gibbons 1980: 9). As a comprehensive mechanism of social control, the Indian Act served to extend the regulatory reach of the federal government into native lives where all aspects of living could be monitored and closely scrutinized.

Throughout the last twenty years of the 19th century, the Department of Indian Affairs became concerned primarily with the extension of its work into western Canada, and this it did under the auspices of the Indian Act. Originally conceived as

piece-meal and *ad hoc* legislation, the act was consolidated in 1876 and was followed by years of additions. The Advancement Act in the Revised Statutes in 1886, for example, produced by-laws dealing with public health, school attendance and moral behaviour in the tribal community. The Indian Act amendments of 1914 allowed the Superintendent General to make sanitary regulations for prevention of disease, cleansing of streets, yards and houses, and to supply necessary medical aid, medicine and other articles to prevent disease. In 1936 the DIA was transferred from the Department of the Interior over to the Department of Mines and Resources - an interesting indicator perhaps of where native peoples were perceived to fit (or not to fit) into Canadian life.

In terms of health, the legalities of being designated Indian had very real consequences. The Provincial Police were required by law to carry out sanitary inspections of houses on reserves. Any medical assistance had to come from the DIA and this was a lengthy and complicated process. It is possible that the overall health of Nlaka'pamux children may have suffered by being forced into an overcrowded residential school where communicable diseases had an ample opportunity to spread. While the general health effects of becoming a disempowered and disenfranchised population may be impossible to measure, they should not be discounted.

1:5. Medical Geography as a Framework for Understanding Disease in Native BC.

As geographers, we are interested in notions of the spatial and temporal differentials of lived experiences and, by extension, the sub-discipline of medical geography pays particular attention to those experiences in terms of health and/or

disease. Medical geography is often characterized as being divided into the two main sub-fields (although they are by no means mutually exclusive) of disease ecology and health systems planning (Paul 1985; Mohan 1989; Eyles 1993). Both types of medical geography are premised on the notions of biomedicine, which remains the current hegemonic mode of thought and explanation of disease and ill-health today. The main principles of biomedicine are that there is a linear relationship between the cause of a disease, a lesion forming and a symptom becoming apparent, and that there exists a necessary relationship between a causative agent and the disease, that is the doctrine of specific aetiology (Jones and Moon 1987: 4). Paramount within the notion of biomedicine is the assumption that it is the causative agent which explains most successfully the process and nature of the disease. Much medical geography is based on this premise, largely as a result of its connections with its sister disciplines of medicine and epidemiology, both of which remain firmly entrenched within the biomedical paradigm.

Although one of the oldest sub-disciplines in geography, medical geography really came to the fore in the 1950s, mainly as a result of the efforts of Jaques May. A French physician, May moved to the United States and began to publish new and coherent concepts of the geographies of disease (1950, 1958), his goal being to study medical geography as a 'means of understanding and mastering disease' (James and Jones 1954: 467). Like other human geographers of the time, May's work was rooted in the regional tradition of the 1950s. Disease was defined as a complex phenomenon that only 'occurred if certain factors coincided in time and space' (1958: xvii). These factors were broadly divided into two categories which May called pathogens and geogens. Pathogens were described as the causative

agents and geogens were the environmental factors, which were then further divided into three categories; physical geogens, for example climate, relief, soils and hydrography; human or societal geogens such as population density, standard of living, transportation and communications and religious customs; and biological geogens such as vegetable life, parasitism (both animal and human), prevalent diseases and dominant blood groups. The coincidence of a combination of these various factors in time and space May termed the 'disease complex' and in this way, he set out to map disease complexes for many parts of the world, particularly Africa and Asia (see for example, May 1958).

Because he was trained within the traditions of biomedicine, May concentrated on pathogens as the primary causes of disease. When questions of geogens were addressed, it was only in terms of an individual's lifestyle, such as a person's housing or their diet. Questions of a wider significance, (of social structure such as political economy as a major determinant of health for example,) were never tackled. The result of these shortcomings was that the medical geography of the 1950s and 1960s shied away from tackling the potentially deeper causes of ill-health in a population. As May's medical geography did not address questions of a societal or critical nature, issues of equality and inequities within society in terms of access to resources for daily living were not considered. This then, I would argue, was not a critical endeavour, because it did nothing to challenge the status quo of a situation, although, having said this, May's work remains important as it 'represents the beginnings of what has become a multidimensional body of knowledge about spatial aspects of human health problems' (Pyle 1977: 679). Furthermore, drawing on May's concepts and methods, researchers have highlighted the nature of many

disease complexes, where certain pathogens and geogens coincide both in time and in space (McGlashan 1972; Learmonth 1978; Meade 1988) and some authors have further extended the ideas and methods of disease ecology whereby spatial analysis of the movement of disease through a population has been mapped (Cliff *et al.*, 1981).

A second tradition in medical geography can be referred to as health systems planning and medical care (Mayer 1982). Much of the work undertaken in the name of health systems planning was influenced by the course taken by the rest of human geography throughout the 1960s and 1970s, that is, it tended to be based on the quantitative revolution and its subsequent developments. Geographical analysis became statistically oriented and data driven, the result of which was that many of these studies have been criticized as having as their main objective the "maximization of the r^2 value" (Mayer 1982: 218). Both types of medical geography have a definite conception of space that is Euclidean, geometric and two dimensional, despite the fact that in the last ten years, human geography has reconceptualized space. Now, attention is increasingly focusing on how social life not only unfolds through space, but how space itself is constitutive of social processes (Thrift 1983; Pred 1984; Gregory and Urry 1985; Jackson 1989; Gregory 1991; Lefebvre 1991). Space is seen as mediating social processes as well as being a container of those processes, but medical geography has been slow to assess the potential and relevance of these new conceptions. It has also lagged behind in other theoretical developments within human geography such as postmodern theory or feminist theory.

In summary then, medical geography traditionally relies on the main premises of biomedicine, positivist conceptions of science and Euclidean space concepts. Within the medical geography literature there is a growing concern with the limits to these notions (Jones and Moon 1987; Kearns and Joseph 1993), as it becomes apparent that biomedicine as an explanatory mechanism for our understanding of the disease process is becoming ever more limited. In the 1950s, when an uncritical disease ecology was the main tradition in medical geography, these assumptions were relatively unproblematic because the conditions that disease ecology explained were primarily acute and infectious and these are the conditions that the biomedical model best accounts for.

Yet for my purposes, a biomedical framework remains unsatisfactory, even though the nature of this study is acute infectious disease. The reason for this is that traditional approaches do not allow me to consider the influences of power relations, or the social construction of disease, for example, as constituents of the nature of social relations. Because a biomedical approach does not account for these phenomena, I have had to look elsewhere for theoretical guidance.

1:6. Defining Health.

A contentious term and notoriously hard to define, health has different meanings for people. From the traditional biomedical approach it would be argued that health is simply the absence of disease. Disease itself is seen as something that 'exists independently and prior to their discovery and description by physicians...an abnormal biological functioning' (Jones and Moon 1987: 4). But we should begin to broaden our understanding of the determinants of health if we are ever to move

towards a critical appraisal of those determinants, by implicating a wide array of both societal and individual factors. A further progression in this understanding has arisen from the reconceptualization of illness itself (White 1981; Lee 1982; Evans and Stoddart 1990; CIAR 1991). Health is now viewed as much more than simply the absence of disease. Factors such as context, power relations and individual control over one's life are increasingly becoming implicated in the production and reproduction of health and ill-health.

In contrast to the biomedical definition of disease where disease exists prior to being discovered by physicians, a social constructionist view of health allows for diseases to be seen as 'human constructs which would not exist without someone describing and recognizing them' (Jones and Moon 1987: 4). A social constructionist approach to these types of conditions helps us understand the nature of a person's reality; moreover, using a social constructionist approach allows a critical stance to be adopted (Jones and Moon 1987), so that society can be more or less implicated in the examination of the illness-environment or disease process, for example. If a biomedical perspective is used uncritically, society is eliminated as a facet in the aetiology of disease or ill-health. A critical approach could contextualize our understandings of health and ill-health by including, for example, societal explanations being implicated in the causation of health or ill-health. Thus a critical approach could include reasons for ill-health such as material deprivation, whereas a biomedical perspective would not. Furthermore, this type of approach suggests an expanded role for theory development, which is one of the greatest challenges for contemporary medical geography (Kearns and Joseph 1993), a debate which continues to the present (Dorn and Laws 1994; Kearns 1994; Mayer

and Meade 1994). Whilst Kearns and Joseph (1993) advocate a structurationist approach, this study, in contrast, will look to other contemporary theoretical developments as a framework for analysis.

As our knowledge about the determinants of health has broadened and become evermore encompassing (White 1981; Evans and Stoddart 1990; CIAR 1991), it has become clear that dominant models of sickness-causation are not adequate for explanations of health and ill-health. Dissatisfaction with biomedical explanations in particular and medical geography in general as being too narrow suggests to me that we should extend the (medical) geographical sphere by considering questions that are outside its traditional bounds. In this way we could, perhaps, increase our understanding of the contextuality and contingency of social life as it relates to problems of health. As a framework for understanding disease in native BC, medical geography's traditional premises and methodologies (although useful in certain circumstances), do not allow me to uncover the nature of the experience of illness at Lytton. A traditional approach does not speak to the things I want to talk about - such as social relations, or the links between health, 'race' and surveillance, or what it was like to be native and sick. Even were I to attempt a traditional approach it would be unsuccessful because of the poor quality of records, coupled with a small numbers problem which would restrict any meaningful statistical analyses. For these reasons the study turns to a number of different theories and a particular methodology that are gaining popular currency within the social sciences in the hope that I may be able to make at least some sense of the past disease experiences of those who live in Lytton.

1:7. Theoretical Issues.

Throughout the eighties, new theoretical reconceptualizations and different directions, including a serious engagement with contemporary social theory, have furthered the critical edge of human geography, particularly in the subdisciplines of social and cultural geography (Cosgrove and Jackson 1987; Jackson 1989; Wolch and Dear 1989). These new engagements and applications have drawn on theoretical works and issues that previously have not been an integral feature of the research endeavour in human geography. They draw from a diverse fund of writings: for example, the works of Giddens (1976; 1984; 1985) and Foucault (1972; 1977; 1979; 1986); from literary criticism (Derrida 1967; Said 1978); and from anthropology (Geertz 1973; Clifford and Marcus 1984; Clifford 1988) to name but a few. It is claimed that these reconceptualizations have enabled human geography to reassert its vital place in the social sciences (Sayer, 1985; Soja, 1989), and the result of an intertwining of geographic and social theory has led to the development of what is often called 'the new social geography' or 'the new cultural geography' (see for example *Society and Space* 1988).

As well as a renewed appreciation of how social relations and spatial structures affect our daily lives (Gregory and Urry 1985), there has also been an interest in the dialectical links between social life and space (Pred 1984; 1990). There is now also the general acceptance that because human life and the lived experience are inexorably intertwined with wider issues of social structure, the two are not reducible and ultimately separable concepts (Giddens 1985). At the same time, theoretical debates are also addressing issues such as the simultaneity of lived

experience (Thrift 1983; Soja 1985, 1989; Gregory 1994), and how much of our reality is actually socially constructed through specific social practices and processes (Anderson 1987, 1991).

These new types of geographies are less inclined towards a traditional scientific viewpoint where statistical manipulation forms a large part of the analysis. Instead they concentrate on issues of interpretation and meaning, following a more critical agenda, questioning previously taken for granted ideas and concepts about the society in which we live (Soja 1985; Kobayashi and Mackenzie 1989; Jackson 1989). Tending to eschew broadly deterministic concepts once dominant in the literature, such as the ecological variants of the Chicago School or a highly structural account of social life, these new geographies instead take a new spin on social relations and social life by engaging in critical debate with theorists on such topics as the dialectical relationship between human agency and social structure (Eyles 1981; Gregory 1981; 1984; 1989, 1989b; Dyck 1992).

Bearing these comments in mind, this study draws on a number of theories that are influencing contemporary debates within the social sciences, where dissatisfaction with positivism and other 'grand theories' has signaled a move towards more humble and eclectic approaches. Positivist methods in social science are becoming increasingly regarded as being out of touch with reality, because they rest on certain assumptions that may not hold true in the real world, for example explanation being akin to prediction, or even that people behave in predictable ways. A further criticism that has been leveled at positivist research is that although it is claimed that the methods and theories are value free and thus neutral, they are in fact value laden with implicit assumptions that are seldom justified (Donovan

1986; Agnew and Duncan 1989; Kirby and McKenna 1989). Statistical techniques are often used uncritically, based on the assumption they are neutral tools in spite of the fact they have inbuilt biases that are rarely acknowledged. Moreover, a statistical explanation of some parts of society may mean very little - how do you choose what numbers to put on phenomena such as meanings or feelings, for example? It is extremely difficult to impose any kind of meaningful numerical measurement on the social world, and thus I would argue that in these cases statistical analyses are of little, if any value.

At the same time that positivism claims its superior position, it does little to criticize the status quo of society and spur on social change to change our world. Because the construction of knowledge is a political process, it may be that positivistic social research aids and abets the construction and legitimation of power and maintenance of current social relations. It may be that in this way, positivism supports the power bases of society, contributing relatively little to any worthwhile social analysis. It is partly because of the limitations of positivism that I have explored other theoretical approaches while undertaking this research. I wanted to take account of people's feelings and opinions throughout the research process - indeed, these were to be the raw data for my project, and in view of the fact they are unquantifiable, the task at hand was to find alternative appropriate theories and strategies. The study finally drew on several streams of thought, including interpretive sociology, ethnography and some theoretical propositions expounded most clearly under the umbrella of 'postmodernism' (Rosenau 1992). By so doing, an approach could be taken where everyday life experiences were the focus of the research, set within the wider context of native life in Lytton.

Within the school of interpretive sociology, there are several sub-groups for example, phenomenologists, symbolic interactionists and ethnomethodologists (Donovan 1986). Although they propose different methodological and/or theoretical frameworks, they all hold in common a similar view of the social world where meanings are the key to understanding. A technique often used by phenomenologists is ethnomethodology, whose focus tends to be on everyday life, on the 'taken-for granted-world' (Ley 1977). The basic aim of ethnomethodology is to promote a better understanding of everyday life through understanding people's definitions and perceptions of reality, thus as a technique it concentrates particularly on the meanings and uses of language. The emphasis on language and meanings has been of primary concern to some ethnomethodologists (Cicourel 1974; Garfinkel 1984; Heritage 1987) as well as geographers (Pred 1989), and, in contrast to positivist methodology, ethnomethodology considers lay language, perceptions and opinions to be as valid as professional ones.

Donovan argues that ethnomethodologists 'take as a subject for study the difference between public and private accounts' (1986: 81). As one of the aims of this study is an attempt to examine the differences between lay and professional accounts, it is well suited to the strategies of ethnomethodology as a technique for data gathering and analysis. Thus the major characteristic of an ethnographic case study such as this is that it can capture the 'wholeness' of the individual or group and locate them in the wider context more successfully than a positivistic framework could allow. It is the context in which people are placed that influences their lives and health, as they themselves relate. Used often in social science research, ethnographic methods include observation and un-structured or semi-

structured interviews, and in this study I have used a mixture of unstructured interviews and a life history approach, allowing people to tell me their story. I have also encouraged them on occasion to be more specific when telling me stories that relate to health or disease. This approach is valuable because it means that the person telling the story has the power to direct the conversation to a large degree. In this way, rather than extracting information only, the conversation becomes a situation where the speaker gives out what information they want the listener to hear, thus it is not the interviewer so much who has the power to direct the conversation but the interviewee.

Linked with the issue of who holds the power in an interview and one that is often ignored by researchers is that the dress, appearance, accent, class, ethnicity, age and sex of both people involved in the conversation can have a large impact in determining the nature of the conversation. This was especially important for the context of this study, where many people in Lytton see me as a privileged white female who has a university education and an English accent, which automatically separated me from the participants in the study. In this way, my personal characteristics became an integral part of the research and doubtless had some influence on my data gathering. This is something which is often understated in qualitative studies, but in view of its effects in determining the success of the conversation, its importance should not be underestimated (Donovan 1986; Eyles 1986a; Kirby and MacKenna 1989).

Like the qualitative frameworks mentioned above, a recent direction of the post modern movement has been to refocus our attention on what has until now been taken for granted. These are areas that social scientists have not prioritized as

likely subjects for research, and include for example, areas that have been neglected, such as strategies of resistance and other 'mundane' aspects of life. A postmodern approach underlies the realization that while the notion of 'race' may be a social construct, undoubtedly, differences do exist between peoples (Cloke et al., 1991; Sibley 1992). This study examines both written and oral texts in order to try and make sense of the health and disease environment of the Nlaka'pamux Nation at Lytton in the first half of this century. In this way, the study may improve our understanding of local and small scale phenomena by showing what matters and what is important, to the people of a particular place, and this, I think, is a vitally important point for the project.

1:8. Constructions and Representations of Social Reality.

Kirby and McKenna (1989) suggest that in attempting to explain the realities of social life there must be a questioning of the knowledge that currently exists - that is we need to understand who created that knowledge and for what purpose, as well as what concepts and rules were used and whose meanings and experiences are being represented. Moreover, they argue that knowledge should be built out of a basic understanding that social reality is constructed by members of a society and that those on the margins and those within the status quo experience quite different social worlds. In the past, it has been the typical practice in social science research for those within the status quo to represent and speak for those who are 'on the margins', that is those people who are disempowered in some way or ways. However, I would challenge this, arguing that good research should develop an understanding of the complex and subtle ways in which people on the margins may be kept more or less invisible and/or silenced. By so doing, attempts to right this

process can be made, enabling those on the margins to participate in naming their own reality by participating in research that is relevant to them.

Getting people to speak about their own reality raises the issue of who is putting the story together and what the end results will be. The task of recounting experiences of one culture to members of another has traditionally fallen to anthropologists, who until recently claimed to provide authoritative interpretations of culture. This notion of 'expert' when dealing with cultures is now being challenged widely from both within the discipline and without and I would argue that anthropologists can no longer consider themselves the sole producers of knowledge in the 'cultural field'.

Postmodern theory tackles issues of representation that are concerned with the problems of how to convey authentically the experience of 'Others'. As already pointed out, these 'Others' are often minority groups such as people of colour or some other characteristic that makes them 'different'. We are socialized to think that 'Others' are proper and scientific subjects of an objective and empirical social science, and yet as much research shows, this difference is socially constructed (Berger and Luckman, 1967; Said 1978; Jackson, 1987, 1989, 1992; Anderson, 1987, 1988, 1991). An awareness of the social nature of these constructions indicates an awareness of the arbitrariness of them as categories for analysis, although it should be remembered that even though these categories are social constructions, their effects are nevertheless very real. Thus Anderson (1987, 1988, 1991) has shown that the way in which Vancouver's Chinatown was perceived led to real events and effects taking place there. A postmodern attitude accepts these

social constructions, celebrates people's differences and shows how they are played out in the arena of daily life.

Representations and descriptions of social realities are, however, notoriously difficult. For Geertz (1973) social reality can be understood through ethnographic description; in grasping the complexities of context and the significance of local knowledge. This he refers to as 'thick description'. Because the social world is multifaceted, it is necessary to reveal possible differing knowledges when we do research; in the context of this study, an attempt is made to get at differing knowledges by recording oral histories and subsequently revealing different realities for different people. But the issue of accurately representing different people's realities is a central problem for the social sciences because it is impossible ever to put forward the exact nature of a subject's social reality, so when dealing with ethnographies we are inevitably faced with what Clifford has called 'partial truths' (1988: 7). Although this may be the nearest we can get to knowing and constructing different group's or individual's realities, it is not to say it is a worthless exercise, as in and of itself the attempt shows an appreciation that different realities do exist for different people.

There is no one 'best way' to deal with the problems of representation, and different authors have different priorities and agendas. For Geertz (1973) as already mentioned, representation is undertaken through 'thick description' where lives and stories are documented in as much detail as possible. Rabinow (1986) argues that the discourses and practices of representation are inherently political with concrete effects, agreeing with Foucault (1977) who has demonstrated how correct representations have informed many social practices such as proposals for prison

reform. The question of how to 'represent' those about which one is writing is a lively area of discussion particularly in anthropology (Clifford 1988; Cruickshank 1990; Wickwire 1991), although the effects of this debate are being felt in other areas - in geography (Jackson 1992; Sibley 1992) and the social sciences in general. For any claim by one group to 'represent' another is itself a form of power, exercised over subordinate groups by those more powerful than themselves (Jackson 1992: 89) and recent years have witnessed some significant challenges to this virtual hegemony in the power of representation, with the development of 'history-from-below' and the growing realization that there is a 'crisis of representation' becoming apparent throughout the human sciences (Marcus and Fischer 1986; Clifford 1988).

1:8.a. The Social Construction of 'Others'.

Said (1978; 1993) has demonstrated the effect to which representations of 'Other' cultures reflect the 'domestic' concerns of their author's own society rather than providing a faithful portrait of those they claim to represent. Yet with few exceptions (e.g. Anderson 1987, 1988, 1991; Jackson 1992), geographers have shown little interest in turning their analytical gaze onto their own society's constructions of cultural difference or applying a comparative perspective to their own culture as well as to those of more 'exotic' societies overseas. In this study I hope to expand on some of these ideas to show how notions of 'Indian' were a European idea and how this European idea was translated into a reality for native people in terms of their health and ill-health experiences.

The social construction of 'Others' is formulated in a way whereby society sees others as 'deviant' or 'different' to the dominant societal 'norm', for example, the mentally ill, or those with a different skin colour. In this way, authors have argued that the ideas of 'Indian' (Clifton 1990) or 'Chinese' (Anderson 1987,1988, 1991) or 'Oriental' (Said 1978) were originally ideas that belonged to a white European cultural tradition. In the words of Clifford (1988: 5) "marginal peoples come into a historic or ethnographic space that has been defined by the western imagination", but because anthropology's traditional authority is breaking up, anthropologists (particularly Western ones), can no longer claim a privileged position in the interpretation of cultures. Said (1978) and others (Geertz, 1973; Clifford and Marcus 1984; Spivak 1987) have cast doubt on this tradition of authority, showing how images of the 'Other' are constituted and represented by (usually) colonialism which is itself situated in specific historical and geographical relations of dominance. The social construction of 'Others' in the context of this study concentrates specifically on the social construction of 'race' (Indians) and the concrete effects that this social construction had at Lytton BC in the first half of the century, with specific reference to the experiences of being ill.

1:8.b. The Social Construction of 'Race'.

Social constructions of 'race' and notions of cultural difference have developed throughout history. The question is why did these constructions arise and from whence did they originate? The belief in the natural existence of 'race' became firmly established in the nineteenth century as natural scientists began increasingly to assume that the world's 'races' were immutable and fixed, thus each 'race' could be defined by its unique biological and cultural characteristics. Although there was

never any conclusive agreement on the typologies used to classify different 'races' (Anderson 1991: 11) skin colour was probably the easiest and most often used classificatory scheme. This was the basis for 'scientific racism' where experts began to search for regularities and differences within and between populations by various techniques, such as measuring skull size etcetera (Gould 1981). In the Canadian context, the idea of 'races' as fundamentally different from each other took hold in the colonial mind, where images of 'the noble savage', and 'barbarians' led to the establishment of elaborate rules and rituals for dealing with indigenous peoples. Although this type of science has since been largely discredited, its legacy remains to this day, in 'common sense' assumptions about 'races' and the differences that exist therein.

The notion that we socially construct our view of others has led to many questioning the notion of 'race' as a viable category of analysis and indeed Jackson (1987: 6) has argued that 'race' has no explanatory value and serves 'little if any analytical purpose'. I would agree with Jackson's assertion, that 'race' is fundamentally a social construction rather than a natural division of humankind, but I would further argue that in view of the fact that this social construction has been so enduring, and that the reality of its effects have been so harsh, we should study the process in order to try and understand why it is, that to a greater or lesser extent it continues to this day.

Thus the process of racialization is situated in history and society - not biology and nature (Anderson 1991). Although the classificatory scheme of race as a category for analysis is not a useful one, there are nevertheless some very concrete effects of this social construction. Anderson (1987, 1988, 1991) has admirably

demonstrated this in her study of Vancouver's Chinatown, where the culturally ascribed labels of 'Chinese' and 'Chinatown' were given to the Chinese by the dominant (white) community. It was the hegemonic white community that conferred identity on the Chinese and the area in which they lived. Another example of the concrete effects of the social construction of 'race' can be seen through the practice and institutions of the law. Like the Chinese, Japanese people have also been discriminated against in Canadian law (Kobayashi 1990). Furthermore, native peoples were deemed different enough to have whole legal and federal institutions set up for their 'benefit' (Washburn 1971; Sanders 1974; Falkowski 1992). In the next section I want briefly to address the nature of being 'Indian' and what this social construction meant for native people in Lytton.

1:8.c. The Social Construction of 'Indians'.

The image of native Canadians as barbaric and uncivilized may not be as common today as it was in the nineteenth century, but racial stereotyping is still prevalent throughout contemporary Canadian (and other) societies. The dominant image of a 'Red Indian' is one of either living on Skid Row, drunk and begging for money, or in a teepee with a peace pipe (Clifton 1990; Francis 1992). Because these images have been so enduring, stereotypes have shaped attitudes and influenced behaviour both in the past and in the present, playing a prominent part in guaranteeing the salience of 'race' in the structuring and restructuring of social relations. It may also be true that as an administered *indigenous* peoples a special case should be made for natives. Kobayashi (1990: 452) has argued that social constructions of 'race' reinforce common sense justifications of racial difference and natural acceptance, thus people become legally designated according to their 'race'.

It was this process that pushed native people to the edges of a variety of Canadian landscapes - physical, social, economic and political - until they no longer had a place in Canadian society. What started out as colonially inspired ideas about 'race' still serve to form and direct contemporary processes, entering into the complex cultural landscapes of reality today.

It is important to understand how socially constructed meanings of 'race' have become naturalized as common sense assumptions through time and space. The idea of 'Indian' belongs to a European colonial cultural tradition that over the last one hundred years has reinforced and legitimated ideas of 'Indians' as 'different' and 'deviant' from the 'norm'. Common sense assumptions of racialized theories gained political and popular acceptance in no small part to rationalize the economic and social problems of the period, and this rationalization was undertaken by both the federal government and the public alike (Banton 1987; Clifton 1990; Francis 1992; Jackson 1992). Conceptions of the 'Indian race' became inscribed in institutional practice and were reconstituted through the spaces of the locality, produced as Indian reserves and residential schools - thus social relations become spatial ones.

1:9. 'Race' and the Language of Racism

Patterns of knowledge, whether lay or professional, are intimately linked with social and material conditions, and I would argue that the discourse and language of racism is necessarily intertwined with the wider contexts of society, economy and politics, as well as with notions of health and illness. In view of this, this study makes some attempt to link the broader issues with the details of people's lived experiences in order to contextualize the stories that make up the data for this study.

Our differing realities are couched in a particular language or discourse which allows us to convey meanings to each other, and in, turn to reach a form of common understanding. The language of 'race', that is racial discourse, served to shape colonial society's understanding of the world that led to 'white' people to see themselves as superior to others such as Chinese or native (Anderson 1991). Framed within racial discourse, ideas about 'Indians' had become solidly entrenched in white society by the turn of the century (Knight 1978; Clifton 1990, Francis 1992; Jackson 1992).

In charting the language of racism and racial discourse, various themes and ideologies can be mapped, providing a sense of what racism is and how it may be countered. Themes and ideologies are mediated through representation of others (Wetherall and Potter 1992: 1) and via the discourse that surrounds these processes. This is not to say that racism and its effects are simply a matter of linguistic practice, but are also necessarily concerned with institutions and social structures, with social divisions and with individual practices that are time and place specific. Thus it is through discourse and everyday language, but situated within a wider, societal context, that 'Indians' historically have been categorized as a 'race' and placed within a racial hierarchy. Even today this is still apparent: '...some of us are still inferior to the white people - we sort of keep to ourselves you know...'[2] and:

> The white man is always aloof, they're top dogs. The black fellow is a slave. You don't come from the same - you're not on the same par as them, no, no. And its carried on through with who you mix with. Even today, royalty or the rich don't mix

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[2]Sarah, 25.8.93. Lytton, BC.

with the poor. When I was growing up I was called a "Siwash" and "Bloody Indian". Siwash - I had to fight like hell![3].

Well the majority - when they saw us coming they wouldn't talk to us. Some were very very nice, some of the white people were very very nice. They'd stop and chit chat. And other people would look at them as if to say "Well, what are you talking to them dirty Indians for" - just the look they'd give. They wouldn't allow us into school[4].

1:10. Conclusions.

Only in the latter half of the twentieth century has it come to be generally acknowledged that the concept of 'race' has no sound biological basis (Banton 1987; Rex and Mason 1986). To speak as though separate 'races' exist other than as social constructions is to perpetuate the kind of racist ideology from which discriminatory practices inevitably follow. Jackson (1992) has shown how photographs of Indians may perpetuate stereotypes of natives and native culture, moreover, authoritative interpretations of these photographs provides a good example of what anthropologists now refer to as a 'crisis of representation' (Marcus and Fischer 1986) within the social sciences.

This study, however, aims to piece stories together so that the reader can judge them for him or herself, thus getting round some of the problems of speaking for others. It sets out to try and make sense of the ways in which some members of the Nlaka'pamux Nation coped with infectious diseases in the earlier part of this century, when they were children. Finding traditional methods of medical geography to be inadequate in this case, I have turned to alternative theoretical

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[3]Sam, 9.8.93. Spences Bridge, BC.

[4]Delores, 19.10.93. New Westminster, BC.

strategies that will, I hope, enable me to get at some of the questions I am interested in - namely the experience of being native and being ill within the context of a colonial society. The strategies I have used include a postmodern attitude and the reassertion of the importance of qualitative methodologies in medical geography. The study does not attempt to describe a complete picture of social reality, as this can only ever be partially explained, but I am aiming to give a general (if somewhat tentative and provisional), historical, qualitative and contextualized account of the disease environment at Lytton, BC.

Chapter 2: Research Strategies.

2:1. Introduction.

Statistics do not bleed or feel pain, frustration and hopelessness...'[1].

In this chapter I wish to formulate strategies and methodologies that are in keeping with some of the theoretical ideas expressed in the previous chapter. Methodology involves the gathering of data and making sense of it in an orderly way; it is intertwined with theory and ideology. This means that how you go about doing research is necessarily intertwined with how you see the world. As such, all methods are value laden, containing implicit assumptions about the world. However, alternative philosophies and methods have recently revitalized the discipline, with the result that human geography today is suffused with a variety of methods and research designs, all of which have their own respective merits and pitfalls. Within medical geography however, this process has not been reflected, resulting in a sub-discipline that remains excessively quantitative and nomothetic (Cliff, Haggett and Ord 1981; Wilson 1993; though cf. Eyles and Donovan 1986; Donovan 1986; Dyck 1990; Hayes 1992; Eyles and Perri 1993; Kearns and Joseph 1993). By and large, explanation still lies in prediction through statistical manipulation, with the result that medical geography has done little to incorporate new conceptions within social theory into its research agenda. Moreover, there has, as yet, there has been little development in terms

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[1]Bradford W. Morse 1985: 11.

of a critical medical geography (although see for example Jones and Moon, 1987).

Within human geography writ large, considerable work has been undertaken in developing alternative techniques to positivist methodology (see for example Cloke *et al.*, 1991). A variety of qualitative techniques have emerged, including for example collection of life histories (that is ethnographies) (Donovan 1986; Eyles and Perri 1993), in-depth interviewing (Porteous 1988), participant observation (Evans 1988), and the interpretation of literary texts (Burgess 1985). The aim of these types of geographies is to explain 'the nature of social reality' (Eyles 1988: 1) for those involved. The nature of this social reality varies greatly between people, depending on their circumstances and position within society, for example, the experience of reality for white middle class males can be seen to be quite different from that of native women.

Much of mainstream social science research, including geography, can be criticized for not explicitly addressing issues of differences within society. By this I mean that often studies do not take into account the pluralities of experience that exist within society, for instance, experiences of people of colour, people with disabilities, women, or homosexual people. In other words, with only a few exceptions, in our academic endeavours, we are not speaking to those on the 'margins'. By margins I mean 'the context in which those who suffer injustice, inequality and exploitation of their lives' (Kirby and McKenna, 1989: 33) to a greater or lesser degree. This concept refers not only to physical material deprivation, but also to power relationships in other social settings, such as differential access to knowledge, or to the production of knowledge. Mainstream

research tends not to be self-critical, in that it tends to eschew questions about those whose experience is not covered by their models and research programmes. This is a commonly put forward as part of the feminist crtitique of 'science' (Reinhartz 1992; Nast 1994; Kobayashi 1994).

This study focuses on the social relations which may have helped to construct the experience of living on the margins in the past, therefore, reality is described from the perspective of those who were traditionally excluded as producers of research. This kind of research requires intersubjectivity: an authentic dialogue between all participants in the research process in which they are all respected as equally knowing subjects. It also requires critical reflection, which involves an examination of people's social reality, for as Freire has pointed out, 'this is the real, concrete context of facts' (quoted in McKenna and Kirby 1989: 28). In an attempt to depict other people's realities, this study has concentrated on the oral testimonies of native elders. Until recently, little attention has been given to the value of oral history in the social sciences (although ethnography has long used it). In the past it has assumed a less 'scientific' status than more traditional methodologies such as positivist analyses. This study attempts to give people 'voice', that is, the emphasis throughout the study is on what people themselves have to say about their experiences; it is these experiences and stories that form the basis of the data for this study. In this way, the aim of the research is to describe and explain the research focus (experiences of infectious disease) through subjective interpretations provided by peoples' own definitions and explanations of such experiences. My part in this as researcher should also be acknowledged in that the finished study will of necessity contain my voice too.

In attempting to explain the realities of social life, Kirby and McKenna (1989) suggest four main tasks that should be attempted. Firstly, there must be a questioning of the knowledge that currently exists, that is to understand who created that knowledge and why as well as what concepts and rules were used and whose meanings and experiences are being represented. Secondly, knowledge should be built out of a basic understanding that social reality is constructed by privileged members of society and that those on the margins and those within the status quo experience different social worlds. The third task of research is affirming, that is developing an understanding of the complex and subtle ways in which people on the margins may be kept invisible and silenced; to affirm those on the margins by participating in naming that social reality in a way that remains faithful to that experience and does not further exploit it. The last task of research is that of sharing and reconstructing. This means that the researcher must act as a responsible knower, using her research skills to create knowledge for social change, to combine knowledge with action. Kirby and McKenna (1989) suggest that researching should entail gathering data about people in interaction with each other and finding about how they understand their own social reality. The task is to look for information, not for representatives of a specific sample or population. But how can social reality be represented or described by a person who is not directly experiencing it? For Geertz (1973) 'thick description' is the answer to grasping the complexities of context and the significance of local knowledge. Because the social world is multifaceted, it is necessary to reveal possible differing knowledges when we do research; within this study, the revelation of differing knowledges is made possible by relating oral histories that reveal differing realities for different people.

From a critical viewpoint, any research should be undertaken by incorporating within the theory and/or method, the actual experiences of people, if any social change is to be effected. We have to gather and make sense of information and critically analyze it. If the information is not critically scrutinized, if it does not reflect on and analyze the social context from which it springs, it will simply maintain the social status quo. If the research maintains the status quo, problematic assumptions may go unchallenged leaving us ill-equipped to understand, interact, and alter the society in which we live.

Everyone who does research is essentially doing science, that is, creating knowledge. In creating knowledge by doing research, it is necessary to record both the information sought and gathered (the content) and how the research is done (the process). Research activities should empower the people who are usually merely the objects of research and in order to try and meet this assertion, the interview tapes and a copy of the study has been given to the Nlaka'pamux Nation Tribal Council. Moreover, critical research should be a continuous process that begins with a concern that is rooted in experience. It is important to understand the experiences of people and how they differ from our own, in order to construct our own version of reality. But different people experience different social worlds and, as will become apparent throughout the study, the people involved do not always share a common perspective.

2:2. Research Design.

It was assumed that the data collected could lead to a variety of conclusions specific to the setting in which they had been gathered. It was hoped that

information gathered from a variety of sources (in this case oral and written records) would take its own shape and lead me as a researcher to particular conclusions. In other words, since there was no pre-established hypothesis to jeopardize, it would be possible to allow the data to speak with their own voice. Since the purpose of this study was to observe, assemble, describe and explore previously unexamined knowledge, the most appropriate research design would seem to be descriptive, exploratory and qualitative.

Qualitative research methodology can be more flexible than positivist methodology, because it has as its aim an understanding of the lived human experience. This experience does not occur in a vacuum, thus it cannot and should not be separated from the wider context in which it occurs. Qualitative research seeks to understand the 'messiness' of human life - to understand the contingencies and simultaneities of the multitude of complex interlocking pieces that make up our lives (Ley 1977; Eyles and Smith 1988; Jackson 1989). Because of the complexities of the lived experience, positivist techniques are of little value in deepening our understanding of this. Moreover, since there are very little data in terms of 'hard numbers' available for the time period and area under study, it would not be feasible to undertake a quantitative design, and a strictly epidemiological or traditional medical geography approach (as discussed in Section 1:5.) may forsake the richness of people's living for quantitative rigor, excluding the human element in the way people approach illness and cope with death.

This does not mean that parts of the data cannot be counted and thus quantified, but it does mean that the emphasis in the study is on interpretation and meaning, because the *experience* of disease is notoriously hard to quantify (Seaman

1987: 168), as experiences assume different degrees of importance and meaning for different people. A qualitative design also enables an examination of the traits and characteristics that distinguish the uniqueness of places and the experiences of individuals in those places. The study is not aiming to search for generalities between places, rather it looks to the individual experiences of certain wider societal processes and the experiences of people in a particular locality - the area around Lytton, BC. Getting sick is a complex interaction of many variables - only one of which is the disease agent, so the research design needs to be structured in such a way that it looks for what is special and unique about this place and the experiences within. Because meaning, subjectivity and experience are all essential features of social life, I would argue that this type of approach is most suitable in this case.

2;3. Methodology.

The methodology comprised recording Nlaka'pamux elders stories and then transcribing them. A large amount of data had been gathered in a comparatively short time, and I had to somehow make sense of it. Following Kirby and McKenna (1989) I coded the data by making subject category files into which I put appropriate extracts of the interviews. The categories were: ethnicity; gender; Indian Agents; making sense of illness; native medicine; pre contact; prostitution; social relations; sexually transmitted diseases and surveillance. I also made files for the specific diseases that were mentioned in conversations, such as tuberculosis, measles and venereal diseases. Although they may be may be arbitrary, these categories are based on the divisions that the elders themselves used.

Moreover, these divisions were well suited to the way in which people told their stories and linked them together. Inevitably I had far too much information for the scope of this project, and much of it was regrettably not used. But by grouping together certain bits of information, the project became much more manageable and it was then possible to ascertain whether any general or specific patterns could be detected. I constantly arranged and rearranged the data until some coherence and linkages became apparent. The data were probed and reworked until patterns presented themselves, and the analysis was further developed by moving between and within categories looking for common and uncommon traits. In looking closely at the data, I examined the margins, looking for contradictions and inconsistencies, so that spaces could be opened up to explore what was being said and, as importantly - what was not being said. Finally, a description of the research results was written.

2:4. Written Documents.

The written records of the Department of Indian Affairs are notoriously complicated and unsorted, which means that when trying to research a particular topic, there is an enormous amount of microfilm through which to plough, with often all too little reward. The scattered and non-quantitative nature of the evidence ensures that any conclusions drawn must necessarily be tentative and provisional because of the fragmentation of records and the ethnocentrism and racism inherent in the written record - a reminder of the Indian Agents' social realities.

Documentation used for the study was collected throughout the Fall of 1992 and Spring 1993, the primary sources used being the DIA Annual Reports, the

Provincial Officer of Health Reports, British Columbia Provincial Police Reports, and the McKenna McBride Commission, all of which are housed at the Provincial Archives at Victoria. These documents are all available for public use, with the exception of the BC Police reports which became classified documents in August 1993. As well as microfilm, the DIA Annual Reports also comprise bound volumes, published by the Federal Government in Ottawa. Although the precise format changed from time to time, they record very basic information on what Indian Affairs has achieved in the previous year. Usually, this would include chapters covering broad issues such as education, agriculture and DIA accounts, but the bulk of the book would be in the form of tables. Every Agency throughout Canada was covered, and each Agency was broken down further by band. The tables record in detail certain statistics, for example the amount of farm machinery owned by a band, or the yield of their crops as well as demographics and religious affiliations.

The Provincial Officer of Health Reports contains some of the correspondence of H. Esson Young, Provincial Health Officer for the bulk of the time period covered in this study. This archive includes some of the papers that passed through his office and was a valuable (albeit accidental) find in the Provincial Archives. Extracts from the correspondence have been used as part of the contemporary 'official record' where appropriate, as have extracts from the BC Provincial Police Reports. 'The Provincials', as they were known, were obliged to keep a log book on all the day's occurrences and events. These diaries are extremely detailed, and provide much useful information, not only about disease but also life on the railway construction camps, about local offences and court cases and even local gossip.

Perhaps the best known historical document concerning BC is the McKenna McBride Commission which dealt with land claims from 1912-1914. All the proceedings have been transcribed and microfilmed, and the data include much more than simply questions of a territorial nature. The commission visited every band and most reserves (in this area at least) in an effort to end the land claims saga. In so doing, they also extracted much information on local education and health situations, as well as more general grievances aimed at the Department of Indian Affairs.

From the Diocese of the Cariboo Archives at Kamloops, St. George's School records (or at least, what remains of them) were studied. Although these are far from complete, they gave me a useful insight to the world of education at that time and place. It is bizarre to say the least, to see the dental records of a seven year old who turns out to be the person (now aged eighty) I had been swapping stories with the night before! In true DIA form, much of the school record concentrates on the agricultural and homemaking sides of life, but there were also several quarterly returns from the school sanitorium. It is a sobering experience indeed to count how many were sick at any one time, and how many didn't get better at all. Lastly, in order to get a feel for the information available to the general population at that time, some newspaper articles were scanned, for any prevailing attitudes and opinions about native people. The BC Newspapers Index was used and any potential leads were followed up. The newspapers I looked at were the Province, the Sun and the Colonist. These were the most popular newspapers of the day, and so may well have presented and informed opinions of the time.

Overall, there turned out to be relatively little documentary information on the Lytton area. The bias towards the Lower Mainland in both record keeping and news reportage means that, much of the interior experience was relatively under reported. Partly because of this and partly because of an awareness of the need for others to tell of their own experiences rather than someone else put together the picture, it became clear that the study would have to rely mostly on oral testament of the people in the area.

2:5. Interviews and Oral Histories.

One way of finding out about and recording the dimensions of everyday life is through interviews and oral histories. This project is particularly suited to this method of researching, as there is very little information in the written record about the subject matter in question. Moreover, although documentation can be a major source of information, traditionally, what has been written and documented has not incorporated the voices or experiences of those who have been traditionally placed on the margins. All too often, research documents don't speak to the actualities of our own or others lives, even though they may claim to represent that experience. The oral information for the study was obtained during the summer months of 1993. The first step in the process of seeking and gathering information was to introduce myself to the Nlaka'pamux Nation Tribal Council (hereafter NNTC), based at Lytton, and to gain permission from them to be working with some of the older members of the nation. This was done with a letter of introduction which also stated what my intentions were. Fortunately, Council members were very interested in the type of study I wished to undertake and I had no problem in securing permission.

After securing approval for this project, I spent the summer of 1993 living in Lytton, getting to know the area and the people. I worked with ten elders of the Nlaka'pamux Nation, and the recorded conversations we had formed the core of the data for this study. I was introduced to others using the 'snowball' technique (Kirby and McKenna 1989: 99) where each person I talked to I asked if they knew anyone else who may be interested in sharing their experiences with me[2].

The awareness that I was seeking information about a potentially sensitive and emotional topic meant that I had to ensure that all work was done in a safe and supportive environment. In order to try and meet this demand of the research, I tried to work with people in their own homes, encouraging loved ones to stay, and join in if they wanted to do so. Only two interviews were conducted out of the collaborator's own home; on both these occasions, younger relatives came with the person. Dot,[3] who was interviewed at Lytton First Nation Band Office brought her grown-up daughter with her. Sarah came to my home, bringing with her her grown-up niece. In both situations the younger relatives played active parts in the conversations, clarifying things for me and also asking their relatives questions pertinent to the research topic in a way that would have been inappropriate for me to ask. It is important to learn to listen and in this I felt somewhat fortunate, as my experiences as an RN working in the field of oncology had prepared me for this. I

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[2]I am deeply indebted to Wendy Wickwire who was the original vital link in my meeting people in Lytton.

[3]In view of the fact that some of the information gathered was of an extremely personal nature, the names of the people with whom I worked have been changed to maintain anonymity.

listened to what was said and, as importantly, thought about perhaps what was not said, for in working with some people there were often long silences or periods without speech - sometimes whilst they tried to remember things, other times whilst they fought back tears or sobbed. These parts of the interview were not interrupted, rather the collaborator made the decision as to how the encounter should proceed.

My intention was to use a technique loosely based on both the unstructured interview, where the encounter could divulge all manner of information, not necessarily just that which concerned my research questions, and the guided interview, where "there is no set of scheduled questions but a check list of all topics to be covered with all subjects" (Eyles 1986: 238). In this way I thought it would be possible to tease out the main points that were important not only to the thesis, but also what was significant to the people I was working with. Moreover, as McDowell (1992: 212) argues, this type of in-depth research is essential to identifying and understanding 'the underlying causal mechanisms and structures that lie behind observed behaviour'. Eyles (1986: 238) points out how an unstructured interview can explore in depth the lives of other people but on their own terms and in their own words. Informal interviews thus allow the recording of everyday life by allowing people to describe and talk about what is important to them using language they are familiar with. The notion of language is important for several reasons.

Firstly, if the interviews are structured via language by both researcher and informant, some attempt is made towards redressing the power relationships inherent in any interviewing process. In this way, participation of informed subjects ensures that research is done with and for the participants rather than on them and

can thus be seen as an empowering process. Thus collaborators could tell me exactly what they wished, with the knowledge that all the recordings were to stay in the Tribal Council's Office. By taking this approach, I thought that the power relationship inherent in all interviewing work might be alleviated as much as possible.

Secondly, the language which is used in everyday conversation embodies specific views or theories of reality (Fowler *et al.*, 1979; Tuan 1991). The variation in types of discourse is inseparable from social and economic factors, so that different strata and groups have somewhat different languages available to them (Fowler *et al.*, 1979: 1). Linguistic differences reflect and actively express the structured social differences from which they arise, and because language expresses meanings, language is implicated in the production and reproduction of social life (Pred 1990: Ch. 8). Thus, as expected, the language used in the official accounts differs from that used in the oral ones.

Oral history has traditionally been regarded as a marginal research methodology, viewed as 'unscientific' and contributing merely anecdotal evidence or supplementary material to a research problem. But recent years have witnessed a challenge to this view by many disciplines within the social sciences, particularly anthropology and sociology. Instead of seeing oral history as mere stories, perceptions have changed to those of validity and authenticity, one that accurately portrays somebody's reality (Cruickshank 1990; Wickwire 1991; Eyles and Perri 1993). As a result, oral histories are increasingly becoming accepted as an appropriate way of undertaking research in certain circumstances.

We turn to oral history and to those who tell it, but we are also restoring those story tellers to a place in history. Oral history can be viewed as a process that reasserts the place of those who have traditionally been excluded form the realm of knowledge production. Rather than getting at 'facts', oral histories are useful for getting at experience in that they compel researchers to confront how individuals and groups create meaning in their lives. Since each person makes her or his own sense of the world, and that is the 'stuff' of life histories, every effort should be made to give priority to the person's own voice. Oral histories are often successfully undertaken with older people or those traditionally viewed as relatively powerless who often lack access to publication, or choose not to express themselves in written form.

2:6. Whose Voice in Oral Histories?

Within the research process who you are as a researcher has a central place because you bring your own thoughts and opinions as well as your own ethnicity, gender and class to the research. In this way, I as author will influence the final story by making decisions on what is put in and what is left out, as well as the way in which the project is written up. There is a need to account for my own experience in the research, but at the same time priority must be given to the voices of the participants, which enables a more egalitarian research process and a further contextualization of the research. Following McDowell (1989), quoted in Reinharz (1992: 139), I would agree that there are three voices in an oral history text. Firstly there is the voice of the person talking about their own experiences, in this case native elders of the Nlaka'pamux nation; secondly, there is the voice of the researcher, that is me as a geographer, and thirdly there is my

voice again, but this time as an English white female, experiencing another world. It is important to be explicit about including my voice because as a collector of these stories I am already implicated in their production. I decided what topics I would encourage people to talk about and by doing so have already influenced the nature and direction of the stories I was told. Thus if I didn't accept my own voice in the study, it would be denying something that is already there.

2:7. Interpretation.

Any qualitative research project involves interpretation, and the gathering and presentation of oral history is no exception. In a postmodern world, no one interpretation is given superiority over another, so there are opportunities for many differing interpretations of the same information. Rather than a weakness, I would see this as a strength of postmodernism as it opens up spaces of compromise and understanding, rather than forcing one viewpoint onto those who might disagree. There is no doubt that facts about the social world do exist, but how we construct meaning for them is a matter of interpretation (Geertz 1973; Rabinow 1986; Cloke *et al.*, 1991: 91-92) and the aim of this research is to describe and explain the research focus (infectious disease) through the subjective interpretations provided by people's own definitions and explanations of such experience. As such, I would argue that human geography, as a part of a critical and interpretive social science should not only utilise qualitative approaches, but that an interpretive geography must necessarily be concerned with description and inductive methods because the aim of such a geography is to understand and explain the nature of social reality. Thus it becomes possible to uncover the nature of the social world through an

understanding of how people act in and give meaning to their own lives. An interpretive geography is concerned with the understanding and analysis of meanings in specific contexts (Eyles 1988: 2); where the importance of locality is stressed as well as the individuality of human affairs.

Within the context of this study, I believe this is an important point, because the idea of multiple interpretations is in complete accordance with the postmodern spirit of the study. Thus other people's stories are taken very seriously, and placed alongside the dominant story for this area. Furthermore, interpretation of the ethnographic evidence allows one to appreciate the significance of these differences by providing a more detailed understanding of the material circumstances of people's everyday experience. Analysis of the stories is a problematic issue. Although I have said they can stand on their own, they have been put together by me, so that I am implicated in their ordering. This, raises difficulties around representation, because by ordering them in this way, I need to be aware that I am highlighting some things and downplaying (perhaps) others. Thus there is of necessity a degree of analysis already implicit in the way the stories have been presented throughout the study.

2:8. The Research Participants.

Ten Nlaka'pamux elders were interviewed, two men and eight women. Although it would have been ideal to interview an equal number of men and women, it was not possible because of the 'snowballing' technique used to contact people. Given the nature of the project and the fact that this is not, nor was it ever meant to be, a representative sample of the population, this

imbalance was not perceived as a major problem for the research. The people who contributed to this research project all had spent their entire lives in the Lytton area and as such, there are many similarities among them. Shared group experiences and cultural knowledge form the broad context of their social realities, for instance they all belong to the same nation (although they belong to different bands), thus they have a common language and culture[4]. As children they all went to the residential school, with the exception of Mabel who lived in a highland area inaccessible to the Indian Agent. The ages of the informants fell into two age categories. There were those in their eighties (Charlie, Sam, Amelia, Delores, Dot and Mabel) and there were those in their sixties (Rebecca, Mae, Lucy and Sarah). There were certain familial relationships among the group; Sam is Delores's brother, Amelia is Rebecca's step-mother (and has been for sixty-odd years) and Lucy and Sarah are first cousins. Within the community these people are of differing official importance. Mae is a long standing Band Councillor and teacher. Charlie was destined to become a village chief, but ran away from his training as a little boy. He didn't undertake the training, so he didn't become chief. Lucy and Amelia both worked at the residential school, but at different times. Delores is reputed as a skilled entrepreneur, and has spent much of her life dealing in horses. (The Nlaka'pamux are renowned for their

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[4]Raymond Williams describes culture as 'one of the two or three most complicated words in the English language' (1988: 87) and I use it here as an umbrella term for a particular way of life. Culture is 'contested, temporal, and emergent' (Clifford 1986: 19) therefore it is time and place specific. In the context of this study, culture is used in its broadest meaning to define a whole range of practices that structure everyday life, so that 'taken in its widest ethnographic sense, it is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man [sic] as a member of society' (Asad 1986: 141).

equestrian skills). Her nephew is chief of the Cook's Ferry (Spences Bridge) Band. Given the close kinship ties many of these people have and the fact that this is a small community, it is therefore not surprising that notwithstanding these differences, there are many shared experiences; these, as well as individual experiences will become apparent throughout the course of the study.

2:9. The Research Process.

The research process basically amounts to how the research is done and I think it is important to include some information about this, as well as some critical reflections on this process. Following Kirby and McKenna (1989) I worked through certain priorities in order to give the process some structure and internal coherence. I thought about what information I would give priority to and what I deemed would be important for the study. In this case I was looking for stories that highlighted the differing realities of the experience of infectious disease between the hegemonic (European) group and the less powerful native group; for stories that related to mechanisms of surveillance through the Foucauldian notion of 'bio-power' (1976); and to the structure of social relations in a specific place - Lytton, at a specific time, that may have impacted on patterns of and experience of disease.

Attention was given to who might be helped or hindered by this information. In terms of who might be helped, a study of this nature may go some way to reclaiming the importance of the Nlaka'pamux experiences in the first half of the century. By this I mean certain stories may have been exposed that were hitherto untold, thereby recognizing these experiences and stories as authentic and valid for those involved. Traditionally First Nations' history has been allocated a marginal

role in British Columbia's history, and this role needs to be challenged, thereby reasserting this side of history to a position of prominence. Secondly, the Nlaka'pamux Nation Tribal Council received the recordings of all work done and they are stored with other recorded oral histories, so that this information is not leaving the community. For myself, this work has helped me make sense of a place and time with which I was relatively unfamiliar. I also hope that this study would help others to better understand Lytton, and perhaps dispel some of the myth and reputation that surrounds it and the people who live there.

2:10. Problems Encountered During the Research Process.

Any research endeavour can be fraught with difficulties. This is simply the nature of research, and this study was no exception. The first problem I encountered was the death of one of the best known oral historians of the Nlaka'pamux Nation. This was a crushing blow, as I had heard he had many stories to tell, and I was sure that he had could have recounted experiences that would have been pertinent to the project. Although there were other elders to talk with, I was disappointed that one of the most prominent figures in the area was no longer to share some time and history with me.

A second problem encountered was that when I was talking to many people, they simply did not have many memories of disease and sickness *per se* . Because I was researching the first half of the century when these people were at school, overwhelmingly their memories were overshadowed by the experience of residential school. When starting this project, I intended to avoid all references to the school for fear of dredging up difficult and painful memories from the past. As

an outsider I was not at all confident that I wanted to broach such sensitive and emotional topics. But I found that avoidance was impossible because the past for so many of those I worked with was inextricably linked with the school. How could I have imagined it possible to ask elders about their childhood memories of sickness without them talking about their school experiences? After all, often they were at school when they were sick. One of the NNTC employees with whom I discussed this dilemma suggested that it was actually important for people to talk about these experiences as part of their own healing process. After my initial discomfort, I found that some people wanted to talk about their school experiences and I let them. Although many tears were shed in the process, not everybody had painful times at St. George's and I believe it was important to let people share the information about the school that they wanted. The impact of St. George's School on the community far surpassed my initial assessment of it, and it is a subject to which I will return later on.

Of a more practical nature, the third problem I encountered was a result of Lytton's geographical location. Situated at the side of Highway 1 and straddled between the Canadian Pacific Railway on the east and the Canadian National Railway on the west, Lytton is not a quiet bucolic community by any stretch of the imagination. The amount of noise generated by road and rail traffic is not usually an issue, unless, of course you are trying to record someone, especially if you are sitting outside. Many's the time I lost a good story at a crucial point because of a train or an articulated truck going by, to say nothing of the helicopter fire crews working in this area. In the end, I got used to this kind of occupational hazard and eventually became quite good at finding quiet spots in which to work, but all the

same, I feel that some good stories were never told as well as the first time I heard them - and often their impact was consequently lost.

Interviewing in summer meant that many of the women were busy canning and berry picking and many of the men were out fishing. Canning and drying fish is still practiced on a fairly large scale in the area. People are extremely busy getting winter supplies ready and, as a result, more than once I was told to call by in a couple of weeks as they would have finished canning then. This was not a problem as I was living in the area, but with hindsight, I think should have tried to interview winter when people have more time to spare.

An unexpected problem I encountered was a language barrier. Some of the elders of the Nation do not speak good English (not all of the children went to residential school and even some who did still speak Nlaka'pamux) and this I had not anticipated. On a couple of occasions I found that although people were willing to talk, they did not have the words they needed in English. I was not worried about this - a friend had already agreed to translate for me, but I found that the people involved were uncomfortable when talking to me. As a result I did not push these people into being interviewed, or telling me any stories of their past, nor did I record any of them.

The final problem was that some of the elders were beginning to tire of being interviewed. Given my earlier comments about the paucity of native BC history, I found this surprising, until I found out that the Tribal Council itself has recently started to record some oral histories, and that certain people have given up large amounts of time to this project. Although still in its early stages, it is possible that

this marks the beginning of a new era in terms of Nlaka'pamux history. It was quite understandable that they were not over-enthusiastic to spend yet more time with me. In these cases, I did not encourage people to do something they didn't want to do, but I did ask them if they knew of anyone else who may be interested in my project. In this way, I managed to meet some new people without inconveniencing others.

To my surprise, there was a low level of general suspicion about my activities within the community. I had anticipated a certain amount of resistance or indifference to this project, but my encountered little of either. In part I think this is because I went with fairly low key expectations - I did not think I was going to uncover some earth shattering discovery, nor did I expect everyone to bend over backwards and share my enthusiasm for the project. This I think helped me in the long-run, because the information I received was always rather like a bonus,and I was not disappointed because a collaborator wanted to talk about something else. All the information I collected was meaningful - not only to the person sharing that information with me, but because it enabled me to further contextualize the story that this study tells.

As a concluding comment on the theory and practice of collecting oral histories I think it is important to reflect on one crucial point. This is, that on the whole those who tell their stories are those who made it through the experience. They are the survivors, and those who did not survive do not record their testimony. So although oral history is good for getting at groups that are traditionally marginalized, such as the poor or the elderly, I would argue that oral histories rarely include the most distressed. Thus in this study, for example, there are no voices of those who did not survive the residential school experience, whether they died from

an infectious disease such as measles, or from early accidental death. But some of their stories are told by those who did survive, and it is hoped that this may go some way to trying to represent those who have been most disenfranchised of all.

2:11. Conclusions.

The qualitative methodologies used in this study, drawn mainly from sociology and anthropology, provide a means of getting at some of the issues I wish to address. These include experiences of infectious disease as well as meanings, perceptions and opinions which are only recoverable through qualitative means. Assumptions contained within a positivist framework are inappropriate for this type of study, moreover, as there exists little in terms of 'hard data' (i.e. numbers) a positivist analysis would not be possible even were it desirable. Since a research strategy must be theoretically informed in order to avoid the error of empiricism, but a theoretical examination must be strongly rooted in the very experience it claims to explain, this study attempts to integrate some of the recent theoretical developments within human geography into medical geography, in order to develop a better understanding of the actualities of the lived experiences of some of the elders of the Nlaka'pamux Nation at Lytton, BC. The aim is thus to move towards a contextualized understanding of the geography of health in that place in the first half of the century.

In summary, the research set out to collect and examine written and oral records on the experiences of being sick as an attempt to produce a contextualized medical geography of the Lytton area. In order to produce the account, the project must acknowledge the historical and political context in

which the research occurs, moreover as one of the main aims of the study is to reassert the validity of experiences of a traditionally marginalized group, a research strategy was employed that would enable experiences, meanings and emotions to be described in the study. Thus the study employs qualitative techniques drawing from theoretical innovations grounded in phenomenology, ethnohistory and postmodernism. The study itself is a pioneer undertaking in BC studies and also methodologically speaking. The next chapters turn to the Nlaka'pamux disease environment, to landscapes of social control and the racialization of disease. These make up the main body of the thesis from which it is hoped a general sense of the health of the Nlaka'pamux Nation in the early half of this century may be gleaned.

Chapter 3: The Nlaka'pamux Disease Environment.

3:1. Introduction.

In this chapter I want to introduce and explore some of the 'bigger-picture' social factors that contributed to the *dis-ease* ecology of Lytton as well as the smaller scale and traditional disease ecology. By *dis-ease* I mean the social factors that may have influenced illness, for example, contemporary social relations. Drawing from both oral and official written accounts, information is structured in such a way as to attempt a necessarily brief but contextualized picture of disease events and processes. The chapter is broadly divided into two parts. The first part highlights issues that to a large extent were out of an individual's control, but nevertheless issues that more or less impacted on the health status of native people, for instance their legal place within society, their standards of housing and nutrition, and patterns of work. The second part deals with stories of specific diseases as told by official and oral accounts. In this way, the chapter aims to get a feel for a generalized sense of health of the Nlaka'pamux, as well as highlighting some of the specific problems faced by these people during the earlier part of this century. It should be realized, though, that the account will necessarily be partial and incomplete because of the nature of the data. At the risk of seeming somewhat self-indulgent, I want to take this opportunity to let the voices of those I talked with set the picture of life at Lytton at this time. Consequently, I have contributed relatively little in terms of text, rather I want to practice what I have been preaching in previous chapters - that is to let the data speak for themselves and to encourage the reader to interpret for themselves what is presented here.

3:2. The *Dis-ease* Environment.

Lytton is a village which lies roughly half way between Vancouver and Kamloops. Situated in the Fraser Canyon, it has a current population of 335 white people and 115 off-reserve native people. This constitutes the Canada census definition of the village, although there are a further 972 on-reserve native people who live in the vicinity. The biggest employers in the area are the saw-mill which employs about sixty men, and the hospital which has a work force of approximately fifty. Lytton lies in the rain shadow of the Coastal Mountains of BC, it is a desert area that suffers seasonal extremes of temperature (as I write this it is is currently 42° Centigrade in Lytton).

Today, for many of us, the social environment at Lytton in the first half of this century is unimaginable. Caught between a modernizing and increasingly European BC and a 'traditional lifestyle', this was a time of great upheaval and change for the native population as the changes wrought by a settler population became firmly entrenched on their social and physical landscape. Changing housing forms and patterns of work, for example, may have affected certain diseases in specific ways; a process that was largely dependent on then contemporary social relations. Furthermore, the social and legal construction of Indians as 'different' and 'deviant' from the European 'race' had many ramifications for native lives in terms of health and welfare. Because it was thought that they needed 'rescuing' from a life of debauchery and heathenism, the:

> ...Indians of Canada [became] wards of the Dominion government, which ha[d] an Indian department especially organized to guard their interests. An Indian, in the eyes of the law, is an infant, and has not heretofore in British Columbia been permitted to pre-empt land or vote...[however] they are slowly advancing towards

modern civilized conditions...[although it] is perhaps inevitable that the red man should gradually retire before the white race...[1].

Indians, as wards of the state, were a kind of property belonging to a state who claimed only good intentions in acting as a parent in the process of 'making progress'. The paternalism of the government over native 'races' was justified and couched in terms of the guardianship of (what was perceived to be a) doomed peoples, peoples who were destined to die out, largely because of their inability to cope with the effects of infectious disease. Guardianship of native lives filtered into the provision of certain types of housing, changing diets and patterns of work, changing the social landscape. These are some of the wider issues I wish to discuss in the following section.

3:2.a. Housing.

Traditionally, the Nlaka'pamux had lived in 'keekwillie (pit) houses' although this practice had largely died out by the turn of the century. This style of housing is at least 4000 years old and indicates a stable and somewhat sedentary way of life. According to the Thompson ethnographer James Teit, these houses were built by women using digging sticks and flat-bladed scrapers and, later, imported metal tools (McMillan 1988: 157). Convinced they were unhealthy places in which to live, the Department of Indian Affairs from its inception encouraged Indian Agents to make native people build log cabins and live like the 'civilized' European population. By 1917 the Department of Indian Affairs Annual report noted that '[t]here [had been] a constant betterment from year to year in the health of these Indians, which is

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[1]Year Book of British Columbia 1914: 159.

attributed in great measure to the better class of dwellings that they are erecting, and the consequent improvement in sanitary conditions'[2]. Houses were obliged to be inspected under the Health Act and the local officer of the British Columbia Provincial Police recorded his efforts in his daily journal. For example on April 14th, 1915, W. B. Stewart reported that he had '...[m]ade Health and Sanitary Inspection[s] of all Dwellings, Barns, Shacks etc., in Town [and s]erved notices on several parties for Contraventions of the Health and Sanitary Act...'[3].

Apparently somewhat aware of a relationship between health and housing, the DIA firmly believed that the change in housing types would improve the lot of the Indian, as they argued that previously smoke holes in keekwillie houses often provided inadequate ventilation, the result of which was a perennial problem of red and sore eyes. Extended families crowding into these small homes increased the likelihood of catching an infectious disease - particularly tuberculosis. Although there was concern for the native population, tuberculosis was also regarded as a drain on the resources of the Indian Department (to say nothing of the threat it presented to the white population in the neighbouring area).

Although the motives may have been questionable, there was thus a deliberate effort to improve housing conditions and the state of sanitation therein. As part of the drive to improve the circumstances of the native population, the Indian Agent was advised to ensure that instruction was given regarding the sanitary arrangements of homes and that building log-cabins was to be encouraged. In 1914 when the Royal

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[2]Department of Indian Affairs Annual Report, 1917: 31

[3]BC Provincial Police Records, PABC, GR 455 Box 23 F7.

Commission on Indian Affairs (The McKenna-McBride Report) was making enquiries into the land question, standards of on-reserve housing were also assessed and by 1924 Duncan C. Scott, the Deputy Superintendent General for Indian Affairs was able to report that '...the [BC] Indians have built comfortable and modern dwellings and outbuildings. Their progress in this respect has been perhaps more rapid that any other Indians of the Dominion...'[4]. By 1932:

> ...the erection of comfortable and more commodious dwellings during the last few years ha[d] been a feature in the growth of civilizing influences among the Indians...[t]hese new homes provide many conveniences and the light and ventilation that was lacking in the old...and has encouraged the owners to appreciate the value of other pursuits...These are all distinctive factors in the gradual breaking down of the barriers between indolence and useful industry.

Although the links between health and housing are well established in the current literature (Wolch and Dear 1989; Smith 1990; Dear and Takahashi 1992) in the earlier part of this century, the relationship was considered much more tenuous. Housing, although important in terms of health, was seen as a sign of 'civilization' by adopting European ways and habits. As a visible change on the landscape, housing enabled Indian Agents to report on the degree of progress that 'their' Indians were making in comparison to others. Part of this progress, indeed, referred to levels of health, and the sanitary state of new dwellings; for instance, in 1910, the Indian Agent reported that 'The new houses are a great advance on the old ones...There has been no unusual sickness in the band. Sanitation is good.' and by 1912 'the old log buildings have of late years been replaced by comfortable frame structures...from material supplied by the government...No epidemic has visited these Indians. Sanitation is good.' Moreover, '...health during the past year has been very good and

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[4]Deputy Superintendent General of Indian Affairs 1924: 20.

the sanitary arrangements are improving, the girls after being educated at All Hallows School[5] show signs of improving the conditions of their houses...'[6] - a skill that Rebecca remembers well:

> ...I mean I was sick but I had an education - I learned how to keep a house clean and to do cookin', and er, sewing, things like that I was taught there. I might have been taught at home but I see it isn't workin' - nowadays it isn't workin' to be taught at home. You see a lot of these younger girls nowadays their house is just like a pigpen! They don't know how - nobody taught them. How to keep themselves clean - keep their house clean. How to cook. How to look after themselves - mostly themselves. They can dress up nice, go out in the street, but their house is just like a pigpen!

The early half of this century saw a change from the traditional types of housing to the more modern frame buildings. Perceived by many as a relative improvement in living conditions, the houses remained cold and draughty, with dirt floors and, of course, no running water. But the modernization of housing was undertaken for reasons other than simply improving health; housing, or at least European-style housing was used as a most valuable indicator in monitoring the progress and civilization of the Nlaka'pamux Nation, as the DIA Annual Reports attest. This, in turn, was often used as a measure of the Indian Agent's success in his job.

Whether the push to change housing was borne out of genuine health and progress concerns or not, is a difficult question to answer. I think perhaps that the reasoning behind it was at least in part a desire to improve the 'lot of the Indian',

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[5]All Hallow's School was at Yale, approximately sixty miles south of Lytton. It was run by Anglican nuns for both European and native girls, who lived and learned in the same building, although it had a partition down the middle to separate them.

[6]Department of Indian Affairs Annual Report 1910: 219; 1912: 216.

because if the Department of Indian Affairs were disinterested, there would have been no incentive to change over at all. But I also think it made the job of monitoring the native population much easier - pit houses were never intended as year-round accommodation, and once frame cabins were in use, the population became more fixed.

In terms of the spread of disease, I do not know whether the change over in housing helped or hindered - indeed, it may depend on the disease in question. As ventilation was supposedly improved, things might have got better, but Delores's comments highlight the fact that people did not always like the idea of improved ventilation:

> My grandad was ill and the doctor came. And he said "He's got pneumonia". Did he give him medicine? No! No! No! Did they take him to the hospital? Absolutely not. Keeping the - keep the windows open. Dad says "You don't have to keep it open just to freeze to death. Open it once in a while then close it quick".

Ultimately, it may not have been the change in housing type so much as the structure of kinship ties that affected the spread of disease. In view of the fact that children and parents often shared the same bed, there was ample opportunity for communicable diseases to spread to other family members. Rebecca remembers how she liked to lie next to her mother when she was very young even though her mother was extremely sick:

> So anyway, after that I remember she was in bed a lot and then er, I remember little bits of here and there - she seemed to be - now I know what it was - she was hurting and she was moaning and groaning...my dad was feeding her in order to get her to eat coz my mother wasn't eating. And then I remember she didn't like the bed, she wanted to get on the floor. So my dad took the bed out and laid her on the floor. I used to love just laying beside her - you know that's how come I got the TB. I used to lay beside her. My brothers and sisters had already died - I was the only one. I remember being pulled away from her. It all seems like a dream now. But I remember being pulled away from my mother...I was so close to her and she was

dead. I remember that. I guess I was trying to go lay with her you know, like I used to, and fall asleep.

Moreover, in times of crisis the family would come together, furthering the potential spread of any disease. Amelia remembers that:

...my mother passed away when I was four years old...all I know is that there was a lot of our relatives came and stayed with us and we were all sick, apparently, because we were all in the bed most of the time. And everyone that was in that house - my grandmother's sister and her children - they all came there, we were all gathered together - to be together - so we'd know what was happening to each other...we mostly survived and of course, those that came from other places like my grandmother's sister and her nieces and her nephews, they all went home...

Perhaps then, the fact that housing type changed was not as relevant as the fact that social relations within the four walls hadn't. The perpetuation of certain traditional family and social practices, such as regular visiting, may have been enough to assure the continuity of specific infectious disease processes, regardless of whether people lived in traditional pit houses or the newer log cabins.

3:2.b. Food and Water.

School life taught girls not only how to clean their new houses, but also to cook in new ways with the hope that they would go home and teach their own mothers how to can fish and vegetables for instance, for the winter months. As a rule it seems that most of the Nlaka'pamux were well fed mainly because of the abundance of salmon and the enthusiasm for keeping a garden. Delores recalls:

We ate well. We didn't have any money but we ate well. In the morning, every morning, we had porridge. My mother would cook the porridge and we'd all have porridge. And toast. We didn't have a toaster, my mother just toasted on the thing you put in the oven - put that on the stove and make toast. Always had butter. No margarine in my day. And if there was a bit of jam. We didn't always have milk - we had canned milk. They didn't sell fresh milk in the stores, so we had canned milk. Everybody had canned milk - no fresh milk. No wonder we got strong bones! And that's what we'd have. Always had dinner at twelve. And then when my dad came

home from work around five or half past five - we couldn't have fresh meat all the time, because we didn't know how to can it. We either had dry meat or dry salmon. Salt salmon was going in my day. I remember a great big barrel and when the fish is on, they open it up and take the guts out and put it in the barrel and salt it with rock salt. And that would keep for years. But they only keep it a year and they throw it out if there's any left. And they'll take that before they cook it - a day before and put it down by the riverside or where there's running water, to take the salt out. And nearly all the salt comes out. It was remarkable. And you could barely taste the salt. My mother would have go down to the water's edge and tie the fish onto a rock and leave it there one or two days - what ever she wanted, and you would barely taste the salt. And then when I came from school I learned how to can. And I taught my mother. And she was an expert by the time I left home. [W]e always had a little farm of some kind, always had a few head of cattle. And when we killed beef, the whole reserve got a slice. They got a couple of roasts or something like that. But then when they learned to can - you know - my mother had everything canned that could be canned...[a]nd people had - they always had potatoes. They always had a garden of some kind. And of course, they always had rice that I can remember. And of course, they grew cabbage, carrots, peas, onions...now, they don't do that. The gardens is standing still and nobody - very few of them have gardens.

In general the nutritional state of the Nlaka'pamux Nation seems to have been relatively good. Fresh and canned vegetables as well as meat and fish suggests vitamin deficiencies may have been uncommon. The change over from a traditional diet to one of predominantly preserved and dry goods was made easier by the fact that people continued to fish and learned to grow their own fresh produce, in part a deliberate effort on behalf of the Indian Department, who saw agriculture as one of the main channels through which to 'civilize' Indians. This process was well established by the 1920s, where:

Instead of thinking only of daily needs, they are being taught to provide for the future: for instance they are instructed in the methods of canning fruit and vegetables for the winter months, and they are encouraged to cultivate gardens, the department supplying the necessary seed[7].

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[7]Report of the Superintendent General, Department of Indian Affairs 1922: 15.

And this was just as well, because by the late Twenties the Depression had begun to hit the area. It would seem that Lytton and the surrounding area perhaps did not suffer as much as other areas, possibly because the area was self-sufficient in food production. During that time, as Amelia describes it,:

> ...people started traveling the roads and I wondered why there were so many people, mostly men. With little packs. Some with nothing, some with maybe just a couple of large cans you know, where they boil their tea if they get any. There was a lot of them, which I was told later it was the hungry thirties. On the farm you didn't know hunger, you went out and you had fruit, you had vegetables, you had your animals, you had chickens you didn't need for anything.

The implementation of the reserve system greatly affected traditional patterns of mobility and an earlier economy. Yet it was through the insistence of the Indian Department, (and before that, missionaries), that natives learned agricultural techniques (as well as the retaining of salmon as a principal dietary source). These contributed in large part to Lytton being relatively unaffected during the Depression years in terms of nutritional status. In this regard, I would argue that while beset with difficulties in the short term,, for example, problems in obtaining seed, the long term effects of being taught agricultural techniques may be seen, at least in part, as beneficial to the native population. Perhaps then, the Department of Indian Affairs was not always a detrimental experience. Thanks to the Department, people by and large did not go hungry, and survived on a well balanced diet of predominantly fish, meat, vegetables (particularly beans and potatoes) and rice. The Annual Reports of the Department of Indian Affairs tend to agree with these oral testimonies - for BC at least, although this was certainly not the case elsewhere in Canada, particularly for native peoples who lived on the Prairies. But if food was not a problem however, water definitely was. Lying in the rain shadow of British Columbia's Coast Mountain range, Lytton is an extremely dry area and there was constant worry over who was

getting what water and from what source, for both domestic and agriculture. Questions of water for drinking and irrigation were an important part of daily life, where a racial hierarchy structured people's entitlements to amount and quality of water. Delores remembers two stories about water, the first concerns irrigation water, the second story is about water for drinking and illustrates the racial hierarchy[8] that existed for water rights:

> ...we fought each other over irrigation water - if it was short or if you were irrigating your garden longer than what you should - we'd have a good fight about it - argument - we wouldn't fight about it, we'd argue about it. We'd say "I'm taking the water whether you've finished or not, you've had it so many days now, and my garden is drying up".
>
> ...let's see what year that would be I was..... I was 19 - 19 - 9,10,11,12,13,14.....1914 my sister was...in the year about 1914 my sister Esther was five years old. I am Delores, I was seven years old. ...there was raw sewage coming from the houses on the townsite of Spences Bridge where the white people lived - there was no Indian people on the townsite - we were lower down...all the raw sewage was going into the river. The Thompson River - the drinking water for the people on the Indian reserve. All the swill was going into the water. And we were drinking it...[and] seventeen people died from typhoid fever. My sister Esther Walkem was the seventeenth - there were sixteen other people living on the Indian reserve either living on the Indian reserve or visiting and then went home and died. There were seventeen all together. So the Indian Agent and the Dr. said - the Dr. especially said - "These Indians are *not* to drink the Thompson River...you will have to get water from the same place where the white people in Spences Bridge are getting their water...from the water falls - the Murray water falls on the CNR side - which flows from the mountain down and that water - some of that water was piped into the towns-people in Spences Bridge. And it was arranged that the Indian people were to get only the waste water from the tall water tank for the CPR. They were not to get the water from the main pipe where it flows all the time. They were to get it - get their drinking water from the waste water from the water tank of the CPR...everytime the train took water from the water tank to fill their engines with water they drained the water and no water would flow - it wasn't a steady flow into the Indians' water pipe because the CPR engine would take that water and there would be no water flowing, not steady, and the pipes froze.

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[8]There was a formalized system for drawing water from the creeks in the area. 'White' people had first access to water, followed by the 'Chinese' then native peoples. In the DIA Records, there are documents which state how many inches of water native people were allowed to take form the various streams.

Yet in contrast to Delores's story, the official one paints quite a different picture, reflecting previous comments about different realities for different people. Although Delores reports the deaths of seventeen native people, the Indian Agent's report suggests otherwise:

> There was an epidemic of typhoid fever among the Cook's Ferry band during the past summer, which resulted in one death. All the other cases were treated successfully ...and every precaution was taken not only to stop its spreading, but to stamp out the disease[9].

Dot remembers the deaths of her brother and father being caused by contaminated drinking water:

> My mum went and got some water you know, from a ditch up there, you know we had a running ditch and we had to carry our own water in them days, you know - she told us not to touch the water while she's gone out - we had outside toilets see, she went and then she come back. I tasted the water - and it tasted sweet - awful sweet and I spit it out. But my brother - he was younger - he just takes the water and he gobbles it down. And he died...it all went in - the cold water - it all went inside him...my brother died. But I was saved because I spit mine out you know. Willie shouldn't have drunk the water and I guess it all went inside him - the cold water right from the ditch you know.
>
> My father died in 1925 of dysentery you know. You know that dysentery that's coming around? Lots of flies comin'...it seemed to eat all your stomach and bleed you know. It all come out you know - and he died. He didn't die with that, he died of going to the bathroom and then laying down in the grass...[m]y father died from dysentery you know. Flies - oh God! The table would just be black. Houses on the roofs - they were just black with flies. I can see them all now. They'd get on the table and we'd chase them away! I hope there's no more of that - flies coming to kill everybody again.

Water rights were a thorny issue in an area so dry and usually the racial hierarchy determined who got what. Needless to say, natives were at the bottom of a list that was headed by the white population, with the Chinese population

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[9]Report of J. F. Smith, Indian Agent for Kamloops Agency, BC, Department of Indian Affairs Annual Report, 1914/15: 89.

sandwiched in the middle. Only after these two groups had what they required, were natives entitled to draw water from the major creeks. However, although the stories told above imply that this had a detrimental effect on the native population of the area, none could be verified through the existing and available official records. Thus the links between racial hierarchies, drinking water, and illness, must remain speculative.

3:2.c. Patterns of Work.

By the early 1880s, land had been surveyed for the building of the Canadian Pacific Railway which was opened by 1885. By 1910 plans were underway for a second railroad through the canyon, the Canadian National Railway. Both routes had an enormous impact on the community,. Those who worked on it - mainly the settler population became more prosperous. It also meant more change and confusion for natives, in that much of the land the railways used was appropriated from, or ran straight through, reserves. Both projects damaged and expropriated native lands and resources as part of a deal that was thrashed out between provincial and federal governments with, of course, little if any input from native peoples themselves. In order to build the railroads as quickly and efficiently as possible, a great deal of labour was imported - some from Europe but predominantly from China and a few native men were also employed. With this new influx and concentration of people to the region came new fears and possibly realities of specific diseases. The predominance of male labourers in the area, coupled with the lack of opportunities for native women meant that venereal disease became a major problem. Other diseases that thrived in the railway environment of the Fraser Canyon were smallpox and, to a lesser extent, typhoid fever. Because of these diseases and the deplorable

conditions in the construction camps, the Provincial Police kept the town under constant surveillance in an attempt to control both the behaviour of the railway builders and the spread of disease. For native people, diseases that were often attributed to the work environment included venereal disease, measles and pneumonia, especially for those who worked in hop-fields (in the Fraser Valley) or other outdoor pursuits. Patterns of work that involved close contact with others were sometimes the cause of the quick spread of infectious disease. In 1914 it was reported that:

> The health of the Indians on the whole ha[d] been fairly good, with the exception of a short time last fall when they were all busy in the hop-yards, and it rained so much that a great many took sick, but soon recovered when they got back home from the hop-fields and canneries[10].

In 1917, Duncan C. Scott, Deputy Superintendent General of Indian Affairs noted that '...[measles] took the form of a severe epidemic among the Indians engaged in the hop fields at Agassiz...[and] was frequently followed by pneumonia...'[11].

But many (and quite possibly most) native people did not have regular employment and so it would seem that rather than patterns of employment being the main cause of rapid spread of infectious diseases, patterns of socializing were at least as important if not more so than working circumstances. Ultimately, of course, the two were intertwined and it would be unlikely that either official records or people's memories could untangle the webs of social relations that operated at this time.

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[10]Report of H. Graham, Indian Agent for Lytton Agency BC, Department of Indian Affairs Annual Report, 1914/15: 91.

[11]DIA Annual Report 1916/1917: 31.

Perhaps then, a better way of trying to get at the nature of infectious diseases at Lytton is to look at specific diseases in their contexts.

3:3. The Disease Environment.

3:3.a. Pre- and Early-Contact Health: The Coming of Infectious Diseases.

> We didn't blame nobody but the white people. What do you call that guy? Columbus. And another one? They're the ones that brings all the disease. They sure got the natives going. Our system before the white people were good. There was no disease[12].

By way of introduction to this second part of the chapter, I wish to pick up on some of the comments that were made to me about the origins of infectious diseases in the area. Although before the main period of interest, I think these stories are worth repeating, as they introduce and highlight some of the contextual details that made up part of the lived experiences of various members of the Nlaka'pamux Nation. In pre- and early-contact times, Lytton was a densely populated place - in 1808 the explorer Simon Fraser remarked on the sheer numbers of Indians at Lytton when he came down the river that was eventually named after him, yet on his return, these numbers were considerably diminished, *possibly* from an epidemic, or seasonal mobility. Native peoples had prospered here because of the abundance of salmon on which they could live all year round, with little fear of hunger. As Sam says '...whenever they eat - everything was just about perfect. Nothing about overcooking or mixing it up or stuff like that they'd just eat it directly from nature. That's why we were a healthy lot of people before the white man came.'

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[12]Mabel 10.8.93.

Well nourished people, (according to Sam), with no evidence of pre-contact infectious diseases were well suited to the environment of the Fraser Canyon. But the coming of the gold rush in 1858 changed a way of life for ever, as the influx of gold-seekers modified and changed the landscape, not only by mining for gold but also by building settlements and planting orchards and fields. The early contact period saw a dramatically changed landscape and lifestyle in and around Lytton, where the impact of the gold rush and the diseases that came with it (possibly even prior to it) permanently altered the area in ways hitherto unimaginable. Lytton was created and put in place by a predominantly white population; native people (and Chinese) although part of it, were more or less powerless to have much influence on this new landscape, in ways both physical and social. The gold rush came and went but left behind as its legacy a markedly different community.

The changing face of Lytton had many ramifications for the native population. Landscape alteration in terms of population depletion accelerated as the native population succumbed to the onslaughts of infectious disease. Smallpox was a major killer, striking fear in the hearts of both native and white people alike. It still stirs vivid stories and it was even being reported in the area as late as the 1920s and 1930s. Sam remarked that, '...when the smallpox business came during the gold rush - oh! They died just like fleas!', highlighting a theme running throughout many of the conversations I had, namely that smallpox and the gold rush are closely linked in many people's minds. According to Charlie:

> Smallpox...was passed onto the Indians round about 1800, and the people passing by, looking for gold - they were afraid of the Indians and they tried to get rid of the Indians before they moved in, by giving them smallpox. Well, they did give them the smallpox all right and wiped them all out - there was nobody left. They all died. They put - what was left of them - they moved down to the United States of America. When they found out that they were over there - they still giving them the

smallpox over there, and wiped them out. In one or two weeks There's sixty thousand left and very few of them left today of the sixty thousand. They're the peoples from here - from Lytton.

There is no evidence for the deliberate introduction of smallpox in BC, although some authors would deny the effects of this devastating disease, for lack of documentation and written records (Fisher 1977; 1992). Yet throughout many of the conversations, there is no doubt about the ravages of infectious diseases and how they were transmitted. In Charlie's opinion:

...how did they give them the smallpox? Well over there they picked up a guy that was dying of smallpox. He was pretty sick. So they told him what to do and he was afraid to do it, but he walked into a tribe of a hundred thousand - hundred and sixty thousand and this guy that had the sickness, he went all through the village of that tribe, to give them - he must have got the main body of the village - you know the houses are all close together. So he wiped out one hundred thousand in one scoop, just by visiting them. He has the smallpox and he visits all these poor Indians, he killed a hundred thousand. Wiped out, leaving seven thousand up the river here.

Whether or not the figures are 'accurate', it seems that these types of story are told in a way to try and drive home the sheer impact of smallpox in the area.

Dotted down the benches on the sides of the Fraser are the remains of many, many traditional 'keekwillie houses' that the Nlaka'pamux lived in and many of these show archaeological evidence that they were abandoned suddenly or even razed to the ground. It is possible that one of the reasons for their fate might indeed have been infectious disease. This speculation is supported by Charlie's story:

Oh yes. Oh that's bad, bad sickness that smallpox. Yeah. They all got spotted - their bodies and everyone of them they died. So the leader, the Chief said, "It's no use doing anything about it, we'll just burn every house". He sent one with a torch and that's what he did. Lit the steps to the house - pitch steps - he lit every one of them and he left. And the steps burned and all the outside of the building was burned and then...buried about three or four [families]. After that everything was finished. The men - they moved. They went to North Dakota. That's it.

Mabel talks of one keekwillie house in particular. It is still there today, on the west bank of the Fraser, where the ferry moors, the dip of its floor just discernible:

There's a big keekwillie house - that dug out house - that's where they lived. One family in there died from smallpox. Killed them all. Some people survived. White people - they're the ones that brought the disease. You see they wanted to kill us all off!

Smallpox was probably the major killer of the native population in the nineteenth century, but by the advent of the twentieth century, its ravages were much diminished, giving way to other exotic infections brought into the area by travelers and migrant workers (Heagerty 1928, 1940; Violette 1961; Decker 1991; Dickason 1992). Yet as can be seen from the above testimonies, stories about smallpox retain a prominent place within Nlaka'pamux oral tradition.

3:3.b. Venereal Disease.

After the gold rush, and generally associated with the coming of the railroads, was the arrival of venereal disease at Lytton. Lack of work opportunities particularly for native women meant that, for many, prostitution was a most reliable source of income. In Delores' words:

...there's no work...it's such a small place...there was no other work...I'll tell you - they didn't have to go very far to get a man! There was all kinds of them because they were building the railroad. Well there was all kinds of men - there was Chinese - there was no wives...of course the men wouldn't leave you alone. They slept with the women and the women got - if they got a few dollars they thought this is the way to make a living, there is no other job. Oh yes, oh, there was no work. There was no work I'm telling you. And the white men that came from the old country or wherever they come from - Sweden or whatever, they didn't have the money to bring their wives over, so they chased - they chased the Indian women.

And if you became a prostitute, continues Delores:

[venereal disease] kill[ed] our Indian women and made them so they couldn't have any children. Venereal - all the young Indian girls didn't have any children

because they all had this venereal disease. They spread that...[t]here was a fire - outside fire. Beside the fire where the logs were burning there was three or four young Indian girls. Anywhere from sixteen to twenty four or whatever. They were sitting besides this warm fire and...they all had venereal disease, they had no pants, no panties, they were sitting down with their legs up - their knees up, sitting.....their legs spread out no pants - no bloomers, they were in pain they all had venereal disease and they were trying to keep warm from the fire. They were destitute. It was venereal disease.

And yet, according to Mabel, you didn't have to be a prostitute to end up with venereal disease:

...they used to get taken to school down in Yale somewhere. And when they go home they get sick and died for some reason. Some kind of disease that you get from running around with boys - you know, I don't know what you'd call them at that time and they'd get diseased and that's what killed them. At that time. And all those people are going to school down there - they got that. The white man brought that disease when he come, they say "Spread it to the women. Give the women the disease". And that's where it spread out from for many years.

Although people remember venereal disease and its ravages well, the Department of Indian Affairs Annual Reports have little to say on the matter. The clearest reference to its effects was made in 1930:

Venereal disease exists among Indians as among the white population. During the year under review special effort has been made to discover and bring under treatment all cases of syphilis. It has not been found that there is any cause for alarm in the situation. Many reserves do not appear to have any cases, and where the disease does exist, the affected Indians submit willingly to treatment[13].

While the Indian Department argued that venereal diseases were not a cause for concern, those I spoke to had quite a different viewpoint. Most of the elders I talked to attributed a declining population at that time to infertility from sexually transmitted diseases, which had taken over from smallpox as a major population check around the turn of the century.

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[13]Department of Indian Affairs Annual Report 1930: 10.

In contrast to this, the Department of India Affairs was very keen to stamp out trachoma (an eye infection) which it perceived as a major problem in the Indian population, but, when asked, native elders at Lytton could not remember ever having or seeing anyone with sore or infected eyes - an interesting point because the DIA constantly stressed that trachoma's greatest incidence was in the dry areas of British Columbia (1931; 1933; 1937; 1939)

3:3.c. Trachoma.

During the summer of 1930 a survey of eye diseases, specifically trachoma, in Indians was carried out at the request of the Department of Indian Affairs. It is unlikely that this was a new health problem, rather that because there had been no other outbreaks or epidemics of noteworthy proportions, the Indian Department was able to turn its attention to rather more insidious infections. The report, in the words of the DIA, was 'disturbing' (DIA AR 1931: 8) not only because of the extent of trachoma but also because of the risk it presented to white people in the vicinity. The image of trachoma being a disease of 'Others' was well entrenched in Canadian Society, where in 1932 the BC Provincial Officer of Health was advised by the Medical Doctor of the Indian Department (Dr. Wall) 'to be on [his] guard against this infection especially in half-breeds, persons of foreign extraction and orientals'[14] and where the Provincial Health Officer agreed that 'cases should be treated in the face of Whites being affected'[15]. By 1933 there were reports of 'two instances known in

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[14]Letter to Dr. H. E. Young from J. J. Wall MD, dated 8th December 1932. PABC GR 2586 Box 3 File 8.

[15]Letter to Dr. F. P. McNamee from H. E. Young, PHO, dated 23rd January 1933. PABC GR 2586 Box 3 File 8.

which the disease has spread from Indians to the white population' [an interesting statistic, considering the DIA estimated some 8000 cases of trachoma in the Indian population from Montreal to the Pacific Coast] and a year later questions were being asked such as 'to what degree the white population will be infected from the Indians before the disease is eradicated' even though it 'came in with immigrants from south-Eastern Europe and the Orient...' (Department of Indian Affairs Annual Report 1934: 11). From oral testimonies it seems that this disease may have been much less serious than the DIA thought, although there is no conclusive evidence for this. It is, however, remarkable that none of the people who I worked with on this project could remember any eye-problems at all, especially in view of the fact that they were living in the highest at risk area for trachoma in Canada.

3:3.d. Tuberculosis.

One of the most enduring stereotypical 'Indian diseases' must be tuberculosis. To be sure, this was a major problem for both native and white people alike in the early half of this century, but its seems that it is often remembered more as a native problem rather than a problem for all. Most of those I talked to could remember stories and experiences of tuberculosis. Sarah knew 'older people that had it you know. They'd say it's - they called it consumption or - they'd call it that 'cough that hangs on and on'. Amelia's mother died of TB, as did many of her siblings. She remembers:

> my uncle - all his children - they all died and then that's when we found out that er, she had tuberculosis. From there we turned round and looked at my mother. She must have had it. Coz everyone that nursed they never went older than two - one or two years old. Just I and my sister were the ones that survived. But my sister finally gave up and she got sick not long after mother died. And my sister was always in bed! I wondered why - that she never played with me anymore. But she was sick. I remember I went out after I had had lunch, and my sister wouldn't talk

to me. She was just laying there with her eyes closed. I shook her, I talked to her, I yelled at her - she wouldn't talk to me and I started screaming my head off. And then later on when my uncle started losing his children from his wife - and they said that she had tuberculosis but there was no such thing as a hospital for natives at that time - you just simply stayed home and that was it. And that's how - I surmised it myself that Mother must have had tuberculosis. Coz how could we get all this you know, and we all pass on this - I had one brother and the rest all sisters - there was six or seven of us and I'm the only one that survived.

Harry Graham, Indian Agent for Lytton, reported in 1917 that, 'there [were] no contagious diseases of any description outside of consumption which is prevalent among all these Indians'. Images of TB loom large in some of the stories told to me. Charlie, for instance, remembers:

Tuberculosis was pretty bad in this country. They had to build a hospital at Chilliwack, for that you know, and shipped all the peoples down there. Coqualeetza. Some of them died in there. The doctors were pretty well keeping an eye on everybody. If anybody gets anything, they don't tell you. You might get tuberculosis, you go to hospital, but the doctor wouldn't tell you. I had a girlfriend with it - well, she died of it. She got thin. She got so thin that she can't eat anymore. She passed away. I know, that is sad. And yet there is medicine around there for it you know, but nobody - was kind enough to do anything.

The association of TB with the native population meant that measures had to be taken specifically for that population. The fear that native people with TB could infect the white population was the main impulse behind the BC government's decision to set up a survey to monitor the situation in 1926. Indeed, in that year the DIA was arguing that:

expenditure [on tuberculosis] is undertaken as much for the protection of the white people as for the benefit of the Indian...The white population has a vital interest in the expenditure for the prevention of tuberculosis and the for treatment of venereal diseases...As health conditions among the Indians affect the welfare of the contiguous white population, the health question as a whole is one of extreme importance...[16]

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[16]DIA AR 1926: 18.

There were, according to the DIA, 'two fairly distinct classes of Indians, from the standpoint of tuberculosis [those] living in a white environment...and the more remote Indians [who were] comparatively and in many instances positively , under-nourished, ill-housed and uninstructed'. Those who lived in a 'white environment' were considerably better off in terms of resistance to the disease or so the DIA argued, whereas the 'more remote' Indians were not showing any 'satisfactory tendency towards increased resistance to tuberculosis'[17].

These fears were still present in 1933 when the DIA Annual Report voiced concerns that, 'The tuberculosis death rate among Indians is many times that among the white population and every generation of Indians has more intimate contact with white people than the proceeding one'.

With the results of the survey, and in an effort to get the problem under control in what was thought the most efficient way at the time, Coqualeetza sanatorium was built at Sardis, near Chilliwack in the mid-1920s. The hospital was also a residential school was for native children. Mae remembers that she

> ...worked in Coqualeetza sanatorium at 17 or 18 years of age. A friend died during that time - I didn't realize she was ill until I looked at her - she was all yellow and her lips were all blue and swollen. She said to me "You'd better not sit on the bed - look at me". And then I knew how sick she was. And she died two days later. Two days. She was real sick. I was send to work by Indian Agent to Coqualeetza Hospital - because I was *healthy*.

Rebecca remembers that:

> ...[m]aybe it was around before, because my grandfather used to call it 'dried up of the flesh' dried of the flesh - and that's what you people call consumption. Maybe that or it was amongst us already - I don't know - but they get real pretty they say at first, and then afterwards their lungs go - that was er, what I guess it was - what you

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[17]DIA AR 1931: 9.

would call consumption. Drying of the flesh. And the TB was over - oh! Every family! Had maybe two or three with it, sick of TB. That was the worst one that we got. TB. Coz I got it. So from there I went to the sanitarium at Sardis. I went there and er, I oh! I seen a whole bunch of people - men and women that had the same sickness as I had. And some of them died - maybe every week or so - that somebody had died of it - of TB. And er, I was pretty sick myself there. That TB was the worst killer of all around here, at that time.

The toll of the 'white plague' as tuberculosis was commonly known was undoubtedly high in native populations across Canada. But it's possible that some of its higher mortality rate in the native population may have been as much due to inadequate living conditions as a possible genetic susceptibility to the disease. Whilst certainly not denying the latter as a cause for relatively high levels of TB in the native population (particularly when the disease was first introduced), the effects of a thoroughly demoralized and despondent population cannot be discounted, particularly when they were organized into residential schools, reserves and other close contact situations. Ironically, this was recognized as early as 1907 when P. H. Bryce, MD to the Department of Indian Affairs published a report on his inspections of thirty five residential schools in Alberta, Saskatchewan and Manitoba. It was reported that 24% of all pupils who had been in the schools were known to be dead, and that these deaths were largely due to tuberculosis. Although the report was published, the recommendations never were and when Bryce published a pamphlet airing his grievances in 1922, he was retired off (and very much against his will[18]) by the Department of Indian Affairs.

It seems that the Department of Indian Affairs acknowledged the problems of TB in the native population - but once again mainly because of the risk to the

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[18]Bryce, P. H., *The Story of a National Crime: Being an Appeal for Justice to the Indians of Canada.* James Hope and Sons Ltd., Ottawa, 1922.

contiguous white population. Efforts to control the spread of this disease and even to assist native people were limited to the provision of a hospital at Coqualeetza and sporadic flare ups of interest in terms of surveys and health propaganda programmes. Ultimately the impression given by the DIA Annual Reports is that TB in the native population was an inevitable problem and one that was not going to go away in the near future. Whether tuberculosis was a native problem or a white problem it was going to remain a fact of life for quite some time. The costs of dealing with TB successfully were so high in terms of money and work input[19], that for the DIA the problem would remain until the introduction of antibiotics in the 1950s.

3:3.e. Measles.

I didn't get the measles! But er, some of the children - they got the measles - the one that er, stays, you know for quite a while, they'd take them away from us. But I never got the measles. Some did die from measles - especially when they opened this school, down here[20].

...the measles was the one that was awful. First the measles would come out - you know if you get measles now, you get better! [T]hey come on your face you know and it would go inside and you would get um - I dunno - my we was ill. We had the measles when I was - I don't know how old I was. We all had it. Yep. It was terrible that measles[21].

We got measles. Everybody got measles. All the children - I say all, but a lot of them got measles. My first cousin, his name was Forrest Nilah, he must have been six, seven, eight, something like that - offhand I don't know. He got measles. It was a funny thing. Any time my aunt's children got measles they *never* got over it. All her children - she lost three or four at one time - they all got measles. Forrest my cousin got measles. He groaned night and day. They took him to downstairs below the girls

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[19]DIA AR 1926: 18.

[20]Amelia, 11.8.93.

[21]Dot, 12.8.93.

dormitory, on the next floor there was an empty room there. And they took him down there and we could hear him groaning. He died[22].

We had measles...used to keep them upstairs in the dark, all the time...they say that if you have measles you gotta have the room dark all the time. There's one woman across the river - her eyes are like this. And that's what they say - that was measles she got and they didn't have a room in the dark[23].

Of all the information uncovered throughout this project, none startled me as much as memories of measles. Some of the stories were tragic, some horrific, and the havoc wrecked by this one disease seems to be firmly implanted in people's minds as one of the worst experiences of all - as the stories above testify. I don't know why this disease was so serious in Lytton in the 1920s, but the Department of Indian Affairs was also worried about it. In the Annual report for 1918 the Deputy Superintendent General of Indian Affairs Duncan C. Scott reported that:

Measles was prevalent throughout almost the entire province. It took the form of a severe epidemic among the Indians engaged in the hop fields at Agassiz [in the Fraser Valley]...[and] there were a number of deaths, especially among children, in spite of the energetic and efficient efforts of the department's medical officers.

After a lull of a decade or so, epidemics started to return. The 1933 Report stated that, 'Measles and whooping cough have been very prevalent, and have caused a good many deaths among young children. The death rate from these diseases, and their complications, in any section of the population, is higher than is usually realized'. And once again, in 1935, '...measles and whooping cough were widely prevalent, causing some loss of life among small children,' but the big measles epidemic that Amelia, Dot, Delores and Lucy remember was in 1937, when they

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[22]Delores, 18.10.93.

[23]Lucy, 25.8.93.

were at school. The Indian Affairs Annual Report explained that '...measles of a virulent type appeared among the Indians...in British Columbia', but did little to elaborate on the extent of loss of life from this one episode. It was, by all accounts severe and well remembered because of the ensuing infections that followed. Sarah told me the story of being sick in the measles epidemic - that then turned into an influenza and whooping cough epidemic:

> Oh yes. That was a major - like everyone was sick - everyone...the entire school you know, got sick and er, there was measles and chicken pox and flu and em, whooping cough. And three of them they sent home coz they couldn't do anything for them and that was Rebecca, Evelyn and one more - that I can't remember. Anyway, they were sent home because there was no hope they say. But they got better.

Rebecca remembers it too:

> I went to school - it was 1937, there was an epidemic. It was a real bad one. And it was a mixture. There was whooping cough, there's German measles, measles, er and what else was there - flu. That was all together. It wasn't just one epidemic - it was an epidemic of many, many sicknesses at that time it was 1937 - '36 or '37. Coz I just about died. There was three or four of us that were sent home. Sent home to die. I was so sick. [F]inally, I got better. But that was the first sickness the German measles - you know you can't breathe.

Measles, coupled with other infectious diseases had quite an effect on the lives of people at Lytton at certain times. Because of the intensity and infrequency of the epidemics, it may be that people tend to remember these episodes more clearly than, say, a more insidious type of infection that was less acute such as tuberculosis or trachoma. These less virulent types of infection may have been more or less endemic in the community, in which case they may have been less noteworthy than the infections that only visited on occasion.

3:3.f. Whooping Cough.

It's interesting to note that many conversations linked certain diseases together, as can be seen with the measles experience of 1937. Measles arrived first but was quickly followed by influenza and whooping cough by which time so many people in Lytton were sick, that it was no longer possible to tell which infection had come first. Not only was the residential school shut down during this time, but the town suffered greatly too. As Rebecca recalls:

> And then it spread - spread all around us - even the people got sick. And that was the whooping cough which was the worst thing that ever hit this valley...it was *very* bad sickness that flu. But then you see - the epidemics at St. George's School was mostly whooping cough. That was what killed there. And German measles - measles all together.

According to Sarah:

> I think the whooping cough caused nearly all the deaths. There was a lot of children that died. I was sick! I had measles chicken pox and er, the whooping cough. Not all at once, no! I'd get over one disease and then next one and the next one, but I didn't get the flu like the other kids did. But the whooping cough was really bad - *really bad* you know - you coughed till you can't breathe anymore, and there's nothing that anyone can do. Cough away. There's a galvanized bucket. You have to spit what comes up. And sometimes nothing comes up and that *really* hurts your chest. That's what I remember of 1937.

For all its seriousness, whooping cough did not get a mention in the Indian Agent's report that year. Instead, the emphasis was on the acquisition of new buildings, medical personnel and the general progress of the Department. Issues of infectious diseases, the recording of morbidity and mortality rates and indeed, what was actually done about them did not feature.

3:3.g. Influenza.

During the period 1910-1940 there were two major outbreaks of influenza in Lytton that I was told about. The first one was the more severe, part of the world-wide pandemic influenza of 1918/19. The area suffered at least as much as other areas in BC for several reasons. Lytton was a railway town with two transcontinental lines stopping there, thus there was a constant turnover of travelers passing through. The residential school where there would be many opportunities for infectious disease to take hold, may be just two of the reasons for the extent of influenza at this time, although doubtless there were many more reasons as well. Many of the stories told about the 1918 influenza involve experiences at the residential school. Unsurprisingly, this place was a haven for any infectious disease that thrived on crowds and was spread rapidly by droplets in the air. Amelia explains:

It was usually flu. Flu epidemics they had when the whole school would go down. You get two or three kids running around to look after the rest of the children. I used to be the first one down. Practically every year. Every winter - towards spring sometimes was when it seemed to attack us. We'd spend about a month out of school altogether. We had a flu epidemic there and I was down for six weeks with the flu, but I didn't get the measles! All I ever had was the flu - I got the flu all the time.

Dot remembers:

...Oh yes, they had um, er, they all was laying down - and we all was sick - what was that now? Was that flu or something else? Oh, yes, and we all - I says I'm not going to be sick! And er, I was wrong there - I was washing the dorm - no, the what do you call it - where we eat, you know - and er, and there I was wiping the table there and down I went - I melted down! I never thought I was gonna get sick. But I did! And I had to go and lay down - they carried me up you know to the dormitory and then there I was sick - but the other girls there - there were others sick there - they were all sick. Oh! Lots of us were sick in the beds. I don't know how many months we was in bed. And that was the real flu - the influenza. My feet went down and - it was awful that flu.

Although most of the quarterly reports for the school are missing, there is a brief reference to the fact that in 1920, "...an epidemic of influenza in February rendered the closing of the school for two weeks", highlighting one of the dangers of having so many people in an enclosed space. Outside of school, the community at large was also affected. Delores recalls that:

My great grandmother died of flu...she just lie there and died. I don't know that - if any of them were taken to the hospital - if there was any room coz the white people would have the preference. They didn't know what to do with it - it was something new and they just died wholesale.

And Mabel, '...lost a sister with that. She's the only one got sick and died. The people...from Shulus, Merritt used to go through here in a buggy you know - wagon and horses and that's where they died. It hit them - going home - died on the road going home'. Charlie painted a picture of not only influenza at Lytton but also of the surrounding area:

Oh, the influenza - I was awfully small but I remember when people were dying here, there and everywhere. Some villages were wiped right off - that influenza. Died - they all died in some villages. That happened all over - from here to Merritt, the Okanagan, up the river. Everybody was sad, coz there were so many deaths, you know and cold - you can't dig a grave when its cold. You know all the bodies are just piled outside...thousands of them all over the place. Plenty of them died but what they were told to do they do, that's why they didn't all die, you know. Anything they drink - it had to be boiled - it's got to be hot before they could drink it. Every time [my brother] goes to town, he sees boxes piled up, way up high. And he wonders what's in them - he didn't know they were bodies in there! You know, there were so many of them.

Rebecca remembers a story at that time:

I tell you, my dear, those were - they thought the flu - the flu that they got around here - which killed hundreds and hundreds of people some of the families - they were wiped out from the flu. Which is something that before was never known here. But that kind of sickness that came upon us - that was truly something that, er, we never really knew about. The flu was the first one. [My dad] was helping a person over here and he looked back [and the nurse] was down on the floor dead. That was the flu. And you know, the flu - he said that was the worst thing that ever happened. You see, you know how a person - when you bury a person, there's just one person in

the ground, four or five people are buried in there, one after another - no more coffins - everybody's too sick to make the coffins, so they just wrapped them up like that, in a blanket to put them in there - that's up at Merritt. There were families that were just wiped out. Coz that was the flu. The terrible flu.

Because the influenza epidemic struck in the winter, the ground was too frozen to bury bodies, moreover, there were few well enough to build coffins - and the sight of all the dead must have been appalling. As the Department of Indian Affairs Annual Report noted:

> The most serious setback to the health of the Indians of British Columbia during the year was the outbreak of Spanish influenza which was particularly severe in the...Lytton band, having a death-roll of over 100 in the months of October and November. ...[I]t interfered with the saving of the root crops...because so many were sick that there were none left who were well enough to dig them.

With no reliable records for the area, it is impossible to tell the mortality or morbidity rates of the epidemic, but it would seem that given the vivid recollections of those asked, the influenza epidemic of 1918 certainly wreaked havoc in the area, not only through sickness and death, but also through the ensuing problems of malnutrition.

The other influenza epidemic to strike the community was in 1937 and the only mention of it in official reports is, 'Throughout the winter of 1937 influenza was prevalent among the Indians, ...[and] was virulent in a few places...[24]. According to Mae, '...thirteen children died in the school'; as already mentioned, Rebecca was sent home to die. The problem with trying to unravel the story of the 1937 epidemic at the school is complicated because measles and whooping cough were also present and it becomes very difficult for people to distinguish the effects of these different diseases.

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[24]Department of Indian Affairs Annual Report, 1937: 191.

Notwithstanding this, I think it safe to say that in view of the fact that the 1937 epidemic of influenza was bad enough to be remembered by more than a handful of people it must have had a serious impact on the everyday lives of these people at that time.

3:4. Conclusions.

The dynamic between place, the racial discourse that contributed to the meaning of being Indian, and institutional practice in the making of this racial category can be seen through the stories of specific infectious diseases, where Lytton and the residential school were the localities through which these notions and experiences were reconstituted and lived. The dynamics of racial discourse and institutional practice helped organize local social action and political practices, where natives, being relatively powerless found these processes hard to resist as illness became ever more defined by the hegemonic (European) culture. Indians constituted a 'medical Other' that needed particular sorts of attention. These were couched within institutional practices such as the school and the law.

From a critical position we need to understand health in relation to the specific materialist conditions existing in specific localities, that is we need to examine the unique geography of particular places and times. This chapter has attempted to set the scene and context of some of the health issues at Lytton BC, in the first half of this century. By this time, Europeans had introduced a whole new disease environment that had perhaps an even greater effect on native health than the European constructions mentioned above. Material linkages between social, political and economic relations and health were closely intertwined at Lytton as evidenced in

the oral histories, moreover similar linkages are reflected in the hegemonic and discursive constructions of health in the official histories, although perhaps to a lesser degree. By this I mean that social relations had a direct bearing on the health of natives, where for example a racial hierarchy governing access to water meant that natives could only use the most polluted water with all the dangers that entailed. Moreover, from a political standpoint, many native people were powerless to have much influence in changing the situation. The social, political and economic realities of that time and place meant that most native people were faced with few viable choices about their own lives - including their own health, and many of their options depended on pre-defined hegemonic definitions of health. This can be seen by the changing emphasis on treating different conditions over the years, where for example, once smallpox was relatively under control, attention was paid to tuberculosis and following that, trachoma became the pressing concern of the day. Shifting priorities and definitions of health problems served to further entrench hegemonic definitions of health and ill-health, as the European population defined the health problems of the day. Native society was increasingly rendered unable to define its own choices and decisions, and became increasingly thwarted by the red tape and bureaucracy of the Indian Act.

The *dis-ease* environment of the area showed Lytton to be a relatively marginal place in modernizing BC, where a relatively powerful European population set the rules and standards for a native population that often could do little to react. The drive towards civilizing native people was pursued most enthusiastically through the provision of a church and a school, where basic household and farming skills were taught by missionaries and the Indian Agent both of whom wielded much influence

and power in the local community. From the official records, it seems that health and ill-health were merely incidental to the bigger project of 'civilizing' Indians. Disease events tended to be recorded only when their severity was enough to either disrupt the 'civilization' process, or,.when they posed a threat to the European population. It may be that, ultimately, relationships between whites and First Nation's peoples were not uniformly or even intentionally cruel, witness for example the attempts of John Smith to try and get the Cook's Ferry Band a clean supply of water. In the end, though, because Europeans were there, life for First Nations people changed for the worse as the majority of Europeans were busy maximizing their quality of life, often at the expense of the native population.

In these decades, several disease events and processes had lasting impacts on the community. The influenza epidemic of 1918 took a heavy toll on the population of Lytton where there were not enough well people to build coffins and bury the bodies of those who had died. The government's drive in the 1920s attempted to get tuberculosis under control - with limited success, and there was a sustained effort throughout the 1930s to beat trachoma in the Indian population, albeit mainly because of its risks to the white population. The simultaneous outbreak of several diseases at St. George's Residential School in 1937 is also remembered by those I asked. By looking at official records and listening to oral testament, I am confronted with both a state of *dis-ease* in the community and a disease picture of events at Lytton - a provisional and tentative account of the kinds of social and biological processes that were going on at that time and place. Ultimately, I would argue that infectious diseases were social problems as much as biological ones, in that diseases had social effects. To some, these events may seem unimportant and marginal. But I

would argue that because they make up part of the history (and geography) of the community, and because they play such an large part in the formation of the lives of those I talked with, they are not marginal at all. The fact that these narratives are still important enough to be told in the 1990s shows that to some, they remain precious, and they surely contribute something to our knowledge of the connections between the past and the present.

In the next chapter, I look at some experiences of one particular example of the *dis-ease* environment at Lytton, that is the Residential School. The aim of the chapter is to recall some of the social relations in the earlier half of this century, when those who collaborated on this project were pupils at the school. The chapter explores some particular school experiences in an effort to provide some concrete examples and effects of the social relations that were experienced there.

Chapter 4. Landscapes of Social Control and the Disciplining of Disease.

4:1. Introduction.

"This was.....a crime of power".[1]

A history of colonialism is also a history of power, where the imposition of new ways of life onto others cannot fail to take into account power relationships between those who imposed the new regime and those who were imposed upon. Classical theoretical models see power as invested in a sovereign or monarch - as a 'top-down' model (Clegg 1989). Conversely, Foucault (1976, 1977; 1980) has argued that power is diffused throughout all levels and strata of society. Thus the manner in which power operates is not as a visible, terrifying relationship (which he argues it was until the eighteenth century), but that it functions through discrete mechanisms that penetrate our everyday activities and existence (Foucault 1977). An example of this type of power includes surveillance strategies where there is no overt use or manipulation of power, but power relationships are there none the less. In this sense, power is not something that can be 'acquired, seized or shared' (Foucault 1979: 94), rather it is a 'shorthand for describing a certain "strategic relation" in a given society' (Armstrong 1983: 4). As a strategy of power, surveillance includes mechanisms such as 'supervision, close observation, invigilation, especially of suspected person'[2]. Thus 'deviant' bodies can be controlled.

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[1]Quoted in York 1989: 29.

[2]*Concise Oxford English Dictionary* 1982, Oxford University Press, p.1075.

There is, of course, no doubt that colonized peoples and other minority groups have been subject to close surveillance throughout the nineteenth and twentieth centuries, indeed surveillance continues today in its myriad forms (see for example Davis 1990). Mitchell (1988) has shown in the Egyptian context how strategies of surveillance were introduced as an attempt by colonizers to regulate the daily life of native peoples through for example, schooling, the introduction of public health controls and redesigning the street layouts. The effectiveness of these strategies of power were measured not in terms of their extent or weight but in terms of their 'localized ability to infiltrate, rearrange and colonize' (ibid: ix). Foucault (1977) shows how systems of surveillance, inspection and punishment (which are termed 'disciplinary methods') became principal tools for ordering society (or certain parts thereof) and rendering it docile, by disciplining the body and regulating the mind. For Foucault there were two main thrusts to these systems of surveillance - disciplinary power and bio-power (Clegg 1989). Disciplinary power as a mechanism of surveillance became widely disseminated through schools and asylums and was aimed at particular individuals or groups of individuals. Bio-power filtered through the medical system whereby the 'medical gaze' concentrated on the 'subjugation of bodies and control of populations in general' (Clegg, 1989: 155). In this way, 'deviant' bodies could be detected and treated.

The work of Foucault illustrates a conceptualization of power where the mechanisms of power are seen as a 'capillary form of existence, the point where power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives' (Gordon 1980: 39). As such, power is not something that is 'plonked

down' from above, but is rather a strategy that is an integral part of our daily lives, of social production and reproduction and thus is diffused throughout society and space, forming patterns and landscapes of social control. Although Foucault's work has concentrated on European experiences, the links between his analysis of power and the subject of this study are apparent. Within the context of this study, the main agents of disciplinary power were the Indian Agent, the Anglican Church and the residential school; bio-power in the form of medical surveillance was entrusted mainly to the school. In this way a link was formed between systems of medical and educational surveillance, as the school carried out its moral and educational concerns. Although this study's focus is on the experiences of infectious diseases, I think it is important to include some reference to issues of power and surveillance, because in a very real way, they form part of the setting in which societal *dis-ease* occurred at Lytton at that time.

4:2. Disciplinary Agent: Indian Agents.

As an important source of disciplinary power, the Indian Agent had a conspicuous role within the local community, where potentially he had enormous power and enjoyed from some native and white people, a certain amount of respect (Smith 1993). The Indian Agent oversaw the day to day running of activities in the area, although with Agencies as large as they were, it was impossible to know everything that was going on. This was reflected in the amount of interaction some people had with the Indian Agent in comparison to others. Those who lived nearer Indian Agent headquarters were more influenced by his presence than those living further away. Although often regarded as a second rate and marginal post within the federal government, in their own localities Agents could exert a great deal of

influence on the daily lives of community members. To a certain extent, the lives of the native community were in the hands of the Indian Agent, who could make decisions that would affect whole bands in one way or another, such as the dishing out of crop seed and farm implements and machinery, thus fixing the potential for some (favoured) people to receive help. They also submitted formal annual reports to the Department of Indian Affairs and corresponded frequently with officials at both provincial and federal levels.

It was the Indian Agent's duty to ensure that the Indian Act was adhered to. The Indian Act itself was constantly changing, being modified to deal with new 'problems' as they emerged. Under the Act, provinces were divided into Agencies, each one of which was under the control of an Indian Agent. The boundaries of the Agencies did not necessarily reflect the boundaries of native nations the result of which was that nations were often split between Agencies. Lytton and Spences Bridge were in the Kamloops-Okanagan Agency until 1910, when Lytton became an Agency in its own right, and Spences Bridge was put into the new Kamloops Agency, along with the Shuswap Nation. The Agent for Lytton was Harry Graham and John Smith was the Agent for Kamloops. Both men stayed in their posts for long periods of time, and are well remembered by those I talked to.

The Indian Agent in general was viewed by native people as part of a European bureaucracy that they had little, if any, need for, and he often was disliked simply for what he stood for. The Indian Agent in Lytton was generally disliked, as Sam's comments suggest:

He was more like an English people. Aloof. He doesn't mix with the Indians. The way I see it he had you spotted or he didn't like you - he'd tell the police straight

away and sit in his house and let the police do the working for him. That's the way I see it.

Charlie would agree with Sam's assessment of the Agent:

No, he wasn't a nice man. He was a man who needed a rope around his neck! He's been bad since he was born. He was an outlaw in London. Robbed banks. They shipped him to where there was a prison - on one of those islands. And when he was in England, he told him that there was some missionary work and they shipped him to Canada and he became Indian Agent over here...[a] guy came from London and he asked us how we liked him and we told him "We don't like him". And he told us the story that he's no good. "He's a thief, he's an ex-convict". The pattern just came right out you know. You could see he was a thief. He robbed this tribe - hundreds and thousands of dollars - he got out of this tribe. We'd ask him for something you know, and he had a lot of excuses "We can't get that and you can't have this". He's a skinny man too you know, he doesn't look like a human being. He was thin - tall and thin. He had an Englishman's accent. He's an ex-convict - he's no good!

In summary, the Indian Agent played an important role in natives' lives at Lytton. He controlled access to farming supplies, was in charge of rounding children up to go to school, and ran the other day-to-day affairs of the area. Harry Graham seems to have been an unpopular man - whether this was his personality, or what he stood for symbolically needs further enquiry.

4:3. Disciplinary Agent: The Anglican Church.

Prominent in the process of disciplining was religion. A regular feature of everyday life, at school, there were prayers, scripture lessons and of course church attendance. Some of the local people feel that the effect of this religious component of their everyday lives left them generally acquiescent and not questioning what was happening to them. For instance, Delores told me that:

[At] the residential school they'd teach us the bible right away you know...the bible. That's what they - that's what they teach you so you won't er get even with them when they hit you and treat you like dogs. These were sisters - supposedly - supposedly kind and so on - they hit you and they punished you for speaking your

own language - I had to go without supper and be beat on your seat by sisters because I was speaking my own language. And that's no lie. I wasn't the only one.

According to Sam:

'We had a hard time at St. George's. Really hard time. You had to fight your way from the day you got in till the day you got out. And the religion was the worst part of it'.

'Philanthropic Christianity' (Dyck 1991: 29) was directly aimed at civilizing 'unruly' Indians, but also reflected the political and material concerns of European Canadians (ibid.: 35), where the belief remained that Indians should be assimilated into a European Canadian way of life. The irony of spatially segregating them onto reserves and residential school should not go unnoticed. At Lytton, the native population had to use a different church building from the European population, so just how successful the policy of integration was is highly questionable. Moreover, in terms of sickness, priests, according to Sam, were selective in who they visited:

...at Lytton, the priests there would take the doctor round and bypass the Indian doctor's house. Go to the next house. So on the - the church followers were well treated - the others were bypassed.

Closely linked with the church was the residential school, which was set up originally by the Society for the Propagation of the Gospel in 1901. The senior staff of the school were clerics, and the connections between church and school are more than apparent in the comments above. In the next section, I shall briefly look at the school as an agent of discipline.

4:4. Disciplinary Agent: Indian Residential Schools.

I didn't go. I was lucky I guess. I learned my culture. But if I had gone to school I would have learned nothing about my culture. How to live from the earth - the mother earth[3].

In this study, and indeed across Canada, one of the most enduring legacies of British colonialism and one example of the inherent power relationships this produced are the effects of Indian Residential Schools. Like the government, both the Roman Catholic and Anglican churches originally saw native peoples as barbaric savages who needed 'civilizing' through education and religion (Haig Brown 1988). Convinced that there was little if any hope of succeeding in making adults conform to these ideas, church and government both agreed that certain standards should be taught to those most easy to manipulate. Schools were set up and used as weapons by the missionaries and federal government in a systematic attempt to destroy native ways of life. In many ways, they succeeded. As a mechanism of social control, the schools, via Canadian legal system and the construction of 'Indian', functioned to legitimate the reality of the dominant society. Convinced that the adult population was beyond hope in terms of civilizing, efforts would have to be concentrated onto children who spent ten months of the year in residential school.

To this end, two schools were set up in the area, one for boys and one for girls. All Hallows was the girls school at Yale, about sixty miles south of Lytton and St. George's School was set up for boys by the Society for the Propagation of the Gospel in 1901 (Wickenden nd.). Two and a half miles north of Lytton, St. George's was

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[3]Mabel, 10.8.93.

designed as an industrial school that could initially house a total of sixty native boys, plus staff. The then prevailing half day system was in use there, and the boys were instructed in general farming, gardening, carpentry, blacksmithing and boot repair. A huge imposing brick building, it was three stories high and must have seemed an extremely forbidding place, completely out of context with the environment in which is was situated. This heterotopia (Foucault, 1986) was to structure and alter lives and events in Lytton for at least the rest of the twentieth century. The school was Anglican, run by priests, and its pupils came from the major Anglican enclaves in the British Columbia interior, namely around Lytton and the Nass and Skeena River areas further north. By 1916, the girl's school at Yale, All Hallows, had closed, the girls were transferred to St. George's at Lytton, and in 1927 the school was formally handed over to the Department of Indian Affairs.

If, as Foucault (1977) argues, the influence of power is best seen on a micro-scale, a residential school may be a good place to try and make sense of these strategies. Power for Foucault is expressed through the day to day workings of society rather than by a monarch or sovereign, and is conceived as a technique which achieves its effects through its disciplinary character (Foucault 1977). 'Privileged spaces' such as the classroom (Foucault 1984: 46) were to be the sites of the exercise of such power, and this was manifested through the implementation of hitherto unknown time and space disciplines as well as a teaching of a discipline of the body. Both these aspects will be considered more thoroughly.

New conceptions of time and space were integral components of a changed lifestyle for the children, where adherence to schedules and boundaries became part of their training. Spatially segregated at school, children were socialized into new

norms of what was and was not acceptable behaviour. Before it closed down, All Hallows was a school for both white girls and daughters of 'respectable Indians'. The school was literally divided down the middle, with native girls on one side and white girls on the other. Separation even went as far as school uniform with white girls wearing navy blue and native girls red. Only Amelia, Delores and Dot are old enough to have experienced school life at Yale. According to Delores:

> The girl's school All Hallows, Yale, BC, was for white girls who had their own.....where they lived, their own school, dormitories and where they went to school. They had different teachers. The buildings were joined together but partitioned off, and we had, - the Indian girls had their own apartment where they lived...it was the white girls who was on one side of the building and we lived on the other side. The only thing we shared was the church chapel. Indian girls did not have a playground. They just had the one room at Yale BC one big room, where they had their lockers, where they played, and where their dining - where they dined, where they ate. And there was just another room where we went to classes. We only went to classes - half of the girls went to school in the morning and then the afternoon, they had to clean the school, the dormitory where we slept in and our playroom where we played, and the other half of the Indian girls went to school in the afternoon, we did not go all day long, not one person.

In this way there was a racial hierarchy attached to the use of space, moreover, this spatial segregation continued when the two schools amalgamated in 1917, as both boys and girls were housed and taught in separate buildings. Officially they did not come into contact much at all, but children often found ways to disobey the rules as Sarah told me:

> We were well separated!...the doors on the other side where the boys are? All the kids - they used to tie the sheets. And they go down to the ground and they run away to town. Yep. They really got punished though. They'd get the strap. It was a strap made of a - a - like a piece of a tire you know - that black stuff? Oh, you'd really get punished!

Children at the residential schools were under constant supervision, not only in the classrooms, but in the dormitories as well. Through this strategy of supervision

children could be monitored and observed, manipulated and transformed. Close scrutinization of everyday life according to Sarah meant that:

> ...you can't go anywhere, you can't leave the front door you can go through the back door, but there's a fence around the place - you can't go over that fence, or crawl under. They say that's out of bounds. If you're caught out of the front door, like - you're in trouble!

It was originally intended that the schools were to be filled by voluntary attendance, but by 1920, amendments to the Indian Act had given the Indian Agent sweeping powers to force children into residential schools. Rebecca said that she:

> ...remembered him talking a lot to the people about school and things like that. It seems to me he was, he was er, the push to get the kids to school. Yet he missed some! Some of them never went to school. I think they hid up in the hills! They had the Provincials [Police] all over the place, collecting kids. You see, a lot of us didn't want to go to school. Parents didn't want their children to go to school - to stay away for what ten to twelve years. I know my dad put up a scrap but then - then they told him "We're gonna put you in jail". We had to come.

The disciplining of time and space at school was accompanied by the teaching of a discipline of the body, which was implemented by introducing the language and techniques of health, hygiene and good house keeping into the schools (see also Mitchell 1988: Ch. 4). According to Rebecca:

> St. George's School - it wasn't all that bad in my time. I mean I was sick but I had an education - which is good. I learned how to count my money anyway! I learned how to keep a house clean and to do cookin', and er, sewing, things like that I was taught there.

The disciplining of bodies extended as far as regular (as well as ad hoc) inspections for sick children and in this way the body was seen, described, analyzed, recorded and constructed in what Foucault (1977) refers to as a 'political anatomy'. Cataloguing the health of children meant that they were no longer in a social place as individuals but in a rank which stressed relations of positions. Bodies were inspected

to judge their (health) status, and this inspection ensured that the children were the objects of a detailed analysis. Through this notion of bio-power (Foucault 1976), the monthly and quarterly returns of the school were able to make assessments of the children's overall health (see Appendix 1, pp.124-126). These records to some extent involved a double mapping of localities and of relationships, where disease was pin-pointed within the school community in order to make possible interpretations and observations of where it started and how it progressed. In addition to this was the screening and observation of individual children, whereby a network of social relationships was plotted within the school in order to ascertain disease patterns[4]. This type of surveillance established what Armstrong (1983: 11) terms the 'reality of the social,' by identifying diseases of social spaces, of contacts and of relationships. In this way, questions of infectious disease at St. George's School became questions that dealt not so much with the environment or sanitation, but with social relationships. Moreover, the child in general became an object for the medical gaze - not just in Lytton, but throughout the western world through the rise of an evermore specialized aspect of biomedicine - paediatrics. At the same time, moral and educational concerns ensured that compulsory education would likewise scrutinize children, thus developed a hierarchy of observation in the forms of the Provincial Officer of Health, the local Doctor and various school personnel.

Medical inspection by these personnel was concerned particularly with individual bodies, particularly when they posed a threat to others, as in the case of infectious diseases. The body was to be treated as a physical machine and disease as

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[4]St. George's School Quarterly Returns,1926, 1936, Diocese of the Cariboo Archives, Lytton Box 7.

a mechanical process of cause and effect (Mitchell 1989: 99) and in this way, a moral order was established. Schooling was intended to discipline the body and instill morals into children's minds so that they would adhere to the new order of hygiene and personal grooming.

Foucault constructs his notions of bio-power and the medical gaze in terms of conditions that are non-infectious, such as psychiatric conditions, which are continually being redefined by the medical profession through perceptions of the level of their 'deviance' from the norm. As a result, their social constructions are readily apparent. In the case of this project though (indeed for any infectious diseases) I would argue that not only are social constructions harder to see and unpack, but also that this type of surveillance may not have been completely undesirable - childhood diseases were a potential problem for the school and regular inspections and monitoring would have been an important way of watching for any signs of an outbreak. Moreover, I would argue that surveillance and spatial segregation in the form of isolation and quarantine would have been necessary if infectious diseases were to be curbed early on. In this way I would suggest that it wasn't so much the notion of a 'medical gaze' that was defining what was normal or deviant in terms of disease, as much as simply attempting to stop or at least reduce the impact of infectious disease in the school and elsewhere. The problems of an epidemic in the school were obvious - not only would the school on occasion have to be closed down, but there was also the problem of deaths of children to deal with, especially difficult when the children were from far away. Moreover, the school apparently had a reputation to uphold, '...R. H. Cairns, Inspector of Indian Schools of B. C. gave out in an interview in the Vancouver "World" that St. George's had the

best record in the matter of health and attention to physical culture of all Indian schools in B. C. ...'[5] , although Rebecca would disagree, 'If they tell you that er, that er, there was no sickness here - the whole school! About six hundred of them were sick!'

An analysis of what school records are available suggests that school was not the healthy place argued to be so by the Nass River Indian Agent. Appendix 1 (pp. 124-126), for example, shows the remaining school records for illnesses at various times, and it can be seen from these records (which are incomplete) that the school had its fair share of childhood ailments as well as adult complaints. Mumps, measles, influenza, whooping cough and chickenpox were not uncommon, although certain outbreaks are remembered as being really bad. According to Rebecca:

...there was an epidemic. There was whooping cough, there's German measles, measles, er and what else was there - flu. That was all together. And then it spread - spread all around us - even the people got sick. But then you see - the epidemics at St. George's School was mostly whooping cough. That was what killed there. That was the most I ever was sick was in St. George's. You see I spent ten years there - in my teens and when I was a child and my teens...I tell you I was sick!

Sarah remembers the same episode:

...that was a major - like everyone was sick - *everyone*. Just maybe a couple of students weren't, but the entire school you know, got sick and er, there was measles and chickenpox and flu and em, whooping cough...there was a lot of children that died and three of them they sent home coz they couldn't do anything for them. Anyway, they were sent home because there was no hope they say.

Dot, who was at school twenty years before this remembers it being as bad, although the main problem in her day was measles not whooping cough:

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[5]Letter from W. E. Collinson, Indian Agent, Nass River Agency, 21st June, 1920. Diocese of the Cariboo Archives Lytton Box 7.

'In school...that's where I was when we got sick. The measles was the one that was awful. First the measles would come out - you know if you get measles now, you get better!'

Not only were there regular outbreaks of the usual childhood diseases, but as already mentioned, on occasion quite serious epidemics of influenza at the school. On at least two occasions epidemic diseases closed the school down as there were no well children to teach, let alone a healthy teacher. In 1920 the Quarterly Report stated that 'an epidemic of influenza in February rendered the closing of the Classrooms necessary for two weeks'; both Dot and Amelia remember this distressing time:

Oh yes, they had um, er, they all was laying down - and we all was sick - what was that now? Oh, yes, and we all - I says I'm not going to be sick! [T]hey were all sick. Oh! Lots of us were sick in the beds. I don't know how many months we was in bed. And that was the real flu - the influenza...it was awful that flu.

Mae remembers classes being disrupted during the later influenza epidemic that the school encountered in 1937:

[In] 1937 - flu hit the S.G.S. Thirteen died...although we don't go to town. Maybe a teacher or staff. My brothers and I were sen[t] home and was healthy all winter. - got hit in Feb. Started around Feb...thirteen children died. We don't even go out often. Maybe from a teacher or staff, they always go to town and go places. My brothers and I were sent home and we was healthy all winter. We didn't get sick.

The construction and management of space within the school ensured that children were spatially segregated when they were sick as well as when they were well. As well as having an infirmary, dormitories were also often used for sick children, who were often looked after by other well and/or older pupils. Particular rooms were set aside for particular diseases, the children being moved around from room to room as they came down with a different condition. As a mechanism of health and ill-health surveillance, it seems that St. George's School functioned

relatively efficiently. Children were supervised at all times under regulations that imposed surveillance and organization in a continuous, meticulous and uniform manner, which Mitchell (1988: 44) refers to as 'enframing' and in this way, were children fixed in their place. An example of the official correspondence issued at this time follows and from it can be seen the attempts that were made to curb the spread of infectious diseases.

> ...On the 17th, inst., I examined two boys at St. George's School. One had a well developed Scarlet fever with the Usual attendant constitutional disturbances. The other boy had a rash on his legs much resembling Scarlet fever, but he had apparently not been sick. This latter one was only discovered on the *daily inspection* which I instituted since the outbreak of the smallpox. I have quarantined them in a building apart from the school and hope that no further cases develop[6].

The overarching and enduring memories of school life have had very real consequences for many people in the Lytton area, although many of the stories I have gathered are not pertinent to the main point of this thesis. Suffice it to say that the pain and grief this institution has caused has been monumental, and the effects it has had on the population in terms of quality of life and life-chances cannot be underestimated. Although many of the children made it through school without dying of an infectious disease, the exact extent to which the school could be implicated in the high rates of suicide, accidental death and alcoholism in the area will never be known, and it is in terms of these conditions that the school continues to be a focal part of everyday life in Lytton.

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[6]Letter from P. M. Wilson, MD to Dr. H. E. Young, Provincial Health Officer, dated 23rd March, 1926. PABC GR 2586 Box 2 File 1 (My italics).

4: 5. Conclusions: Social Control and the Racialization of Disease.

Social relations in Lytton affected patterns of infectious disease because of the interactive social networks that existed between people. Moreover, power relations impacted on these networks to a large extent, determining who might mix with whom and under what circumstances. The material linkages between social, political and economic relations and health as evidenced in oral histories cannot be denied, nor can the hegemonic discursive construction and reconstruction of health in official histories be ignored. The consequences of this discursive construction were to stereotype native people as dirty and diseased, thus adding to already unsavoury images of a barbaric and uncivilized people. This process occurred often through the media, particularly the leading newspapers of the day. Headlines such as 'Are Indians Human?'[7], 'Indians are a Health Problem'[8], and 'Tubercular Indians'[9] served to deepen racial stereotypes.

Forms of social deviation are often considered an illness, where the blame is placed on those who become ill and they are therefore made to feel they deserve it. Disease - or any form of social deviation - therefore develops because of personal failures - in this case, being an 'Indian', - or at least this was a common understanding of the way of things in Lytton at this time. The metaphors that became attached particularly to tuberculosis and 'Indians' implied living processes of a particularly

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[7] *The Province*, March 2nd, 1935, p.5. Magazine section.

[8] *The Times*, February 6th, 1939, p.5.

[9] *The Times*, September 18th, 1924, p.4.

resonant and horrid kind for the reason that tuberculosis was imagined as a disease of poverty and deprivation (Sontag 1978: 9), a mythology that persisted well until the middle of the twentieth century. The notion that Indians were unhealthy and/or diseased further justified surveillance and monitoring of everyday life for the native population, and further embedded racial discourse into the institutional practice of medicine. Moreover, the language and metaphors that constituted diseased Indians kept Indians firmly and literally in their place:

> ...the house where the disease started is supposed to be quarantined. An Indian from there left quarantine today and came to town to take No. 4 to Kamloops. I would not allow him in the station and after learning who he was, informed the Justice of the Peace and he was sent back. It is over two weeks since the first case but no Officer has been sent *to keep the Indians where they belong and apparently they are doing as they please*[10].

> Dr. Proctor of the CPR called me up last night on the long distance and said that a case of an Indian woman with Smallpox had got on the No. 3. train going to Kamloops....*We do not wish to have an epidemic start and the best way to start one is to allow these people to travel indiscriminately and move around from place to place*. If necessary, appeal for help to the Provincial Police, and insist upon Helmsing taking precautions to enforce quarantine[11].

As Peroff (1990: 289) points out, metaphors are powerful carriers that convey our known things to the unknown, influencing the ways in which we think (thought) and talk(ed) about Indians and Indian policy. In terms of this project, one of the most prominent metaphors bedeviling native people was the stereotypical image of them being diseased and dirty, and thus by extension having no morals or discipline or decency. Ultimately, these metaphors played no small part in molding contemporary

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10 Letter from T. W. Shaw, CPR Agent, to C. S. Maharg Esq., Supt. Vancouver, BC, dated 29th November, 1926. PABC GR 2586 Box 2 File 2 (My italics).

11 Letter from Dr. H. E. Young, Provincial Health Officer, to Dr. Archibald dated 1st December, 1926. PABC 2586 Box 2 File 2 (My italics).

thinking about alternative prospects for the future of Indians in British Columbia in particular, and Canada in general - not only in terms of health, but in almost every aspect of their lives. This was the process by which ideas about health were connected with Indians in white discourse, where Indians became negative people, diseased, immoral and undisciplined.

Chapter 5: Conclusions.

5:1. Introduction.

In drawing this project to a conclusion, I want to finish by summarizing my main observations and findings and attempt to explain why I think these findings are significant - not only for the Nlaka'pamux Nation or for medical geography, but also in terms of critical reflections of my own experiences and development throughout the research process. I also would like to make a few suggestions for others who might go on with such work in relation to the discussions introduced in Chapter 1, including methodological and theoretical considerations, and following on from this, exploring, future directions and specific research questions that perhaps need attention.

5:2. Observations.

The thesis involved a geographic investigation of what it was like to be a sick native at Lytton BC, mainly in the first half of the century. The research stemmed from the need to analyze how health is much more than simply the absence of disease, and, the need to produce contextualized studies within medical geography. The thesis therefore looked towards other influences that may have contributed to the disease environment, by drawing on several areas of current theoretical geographic investigation. These included constructions of 'race' and the effects of disciplinary powers.

Narrative from ten elders produced a descriptive and exploratory study. The stories I have been told have several reoccurring themes. The experiences of illness

in childhood are well remembered, and the residential school was focussed on much more than I had originally anticipated, showing some of the effects that institutionalized racism in Lytton produced. All Hallows used a racial hierarchy in its use of space, and at St. George's, diseases became identified in terms of social spaces, so that questions of disease became concerned with social relationships rather than the environment or sanitation. These relationships were recorded so as to ascertain the patterns and the spread of disease. The church, the Indian residential school, and the bureaucracy of the Department of Indian affairs all left legacies, some of which have been mentioned in previous chapters. As the stories attest, these legacies remain today, and until the effects of institutionalized racism are addressed, they cannot be successfully tackled. As the problem becomes better recognized - and increasingly it is - it may become more successfully dealt with. By addressing some of the historical nature of the processes involved, it is hoped that our understanding of the situation is deepened, thereby increasing our resources for effecting change.

Following Said's (1993: 15) suggestions, this project aimed not to separate, but to connect different nineteenth century colonial discourses and to connect the analysis with the actuality of lived experiences - in this case, in terms of disease. Examining how racialization of the disease process occurred leaves little doubt (in my mind at least) that overall, social relations at Lytton had a detrimental effect on the health of the native population. Systematic and spatial exclusion from society led to relative overcrowding in the school and on reserves, producing ideal circumstances for infectious disease to take hold. This spatial entrapment and lack of control over their own destinies had profound health effects for the native population, both in the long terms and the short.

Social relations doubtless affected patterns of illness at Lytton but in varying ways. Whether these effects were positive or negative can be very difficult to uncover from the information that I have at present. For example, the change over of housing from keekwillie to frame buildings does not provide any evidence either way of disease changes. This *may* be because social relations within the home stayed the same; without a further season of field work and some close questioning, these speculations for now must remain at exactly that level. As another example of social relations, patterns of work also affected the health of native peoples. In the narratives, much illness was blamed on the building of railways. The surplus of men meant that prostitution became a potential way of earning good money. Venereal disease was perceived by many of the collaborators to be the major population check in the post- smallpox period.

The extent to which surveillance by the colonial power was operating behind contemporary notions of health has proved difficult to elucidate as record keeping was notoriously poor and thus it could be argued that surveillance of deviant bodies in terms of ill-health was not considered important at that time. What was under constant surveillance and meticulously recorded was the effort involved to turn natives into farmers. The drive to 'fix' people in their place, by forcing them to take up agriculture, was seen as a measure of the degree of civilization attained by natives. It was also seen as a mark of the success of the Indian agent's regime in that area, and as a result these are the records that were kept most conscientiously. This forced lifestyle change may have contributed, in part, to adequate nourishment during the depression, as natives became self-sufficient in food production. Generally speaking, these people were well fed and also taught canning at school.

They were then instructed to go home and teach their mothers. The stories collected suggest that these native people did not go hungry during the depression because of these new skills as well as the salmon runs. However, water supplies remained problematic because of the racial hierarchy that governed access.

Space and time shape the character of places, and the peculiarities of a place may resist or set in motion social or spatial processes (Gregory 1994). The particularity of Lytton meant that the social spaces of class, gender and especially 'race', were inscribed in a particular way. In terms of physical space, the setting up of reserves and the effective denial of place for the Nlaka'pamux both produced and reflected particular social processes such as forms of legislation, long lasting attitudes and racial stereotyping of natives. This study has attempted to bring some of these issues together to try and get a feel for the multidimensionality, contingency and simulataneity of lived experience (including health) in time and space. Social life is dynamic, multi leveled and chaotic and it extremely difficult to tell any part of a story in any comprehensive manner, because words are necessarily not chaotic and simultaneous. In trying to piece together part of Lytton's story, I have learned that to tell a story is to leave most of it untold, that it is bigger than just the 'facts' alone. The limits of social, political and economic freedom in Canada, as in other places elsewhere, combine and interweave, ever changing as are social relations, serving as a reminder that a fight for life, dignity and self-esteem is not without value or cost.

5:3. Significance of the Study.

I would argue that even today the Nlaka'pamux Nation still remain one of the most marginalized First Nations within British Columbia. Their small numbers (see

Appendix 2, p. 127) means that it is difficult for them to organize politically with the success of others such as their neighbours, the Shuswap. Moreover, the area is still besieged with problematic historical remnants from the past, for example the difficulty of self-administering the many tiny reserves (see Map 3, p. xvii and Appendix 2, p. 127) and the land claims disputes that are not uncommon between natives and non-natives. In view of this marginalization, one of the reasons that this project could be seen as useful is that it takes Nlaka'pamux history, as they themselves see it, seriously. In so doing, perhaps the project contributes in a small way to the ever growing realization that the lives and experiences of these people are indeed important because they form the basis of shaping the community into what it is today. And what it is today matters not only for those who live there at present, but also for those who will live there in the future.

In Canada today, and perhaps especially in British Columbia, native history is more relevant to the present than any other type of history. Whilst a history of native-white relations is not native history *per se*, the study has at least attempted to give some native people the chance to tell their side of the story. Of necessity though, these stories have been abstracted from the 'total story' that I was told. In doing this, the excerpts become biased and limited. Even so, it maybe that this is a step in a process whereby the Nlaka'pamux will be better able to articulate their own histories. The telling of what has been a previously repressed history may become a component of focusing on strengthening community relations through the realization and expression of common experiences. However, in contrast to the oral tradition of the Nlaka'pamux, Western society has traditionally relied on the written word as more or less uncontested knowledge (witness the British Columbian land claims case

Delgamuukw v. the Queen as an example of written words being believed more than spoken ones). This can be seen as problematic as it may be that the Department of Indian Affairs may have recorded somewhat distorted and prevailing views of the day. The records may thus have been written in such a way that other realities were (intentionally?) suppressed. We should be mindful of these discontinuities and we should remember that there are other ways of knowing. Oral history as an example of this pushes at Western epistemology and authenticity and challenges the superiority of written words over spoken ones.

The project also serves as a reminder to medical geographers that things medical should be concerned with much more than just what sickness facilities are available and which diseases manifest where. Health and disease are intricately bound up with who we are and where we fit into society, and depending on where we are will profoundly affect our health because of our differing lifetime experiences. Thus I would argue that there is necessarily a certain amount of geographical contingency to our health status, not only in terms of certain diseases thriving in certain climates for instance, but also in terms of social relations and social processes that change and alter through both time and space.

The project has attempted to incorporate some issues currently being debated in contemporary human geography and contemporary social science, such as notions of insider/outsider and the construction of 'Others'; how best to represent these 'Others' (indeed, should we be attempting to represent them at all?) and the idea of a postmodern attitude with a concern for the context of the particular problem (Tyler 1986; Carter 1987; Mitchell 1988; Young 1990; Cloke 1991; Anderson 1992; Francis 1992; Jackson 1992; Sibley 1992). In trying to use these ideas, I have attempted

(admittedly with limited success) to contribute in a small way to medical geography as currently practiced, with the realization that as a medical geographer, I need to be interested in far more than medicine alone. This project has therefore looked at particular social relations and processes impacting on health in a specific time and place (while realizing that these relations and processes may or may not be mirrored elsewhere) and the effects of these relations on particular peoples' health.

Reflection on this research brings certain issues to the fore. Firstly, cross-cultural research can be a tricky process, but one, I feel that can be beneficial to all parties. The notion of 'cultural safety' (Dyck and Kearns 1994) must not be ignored, and this should be explored further in relation to First Nations peoples. The way I have presented data here is not the only way that it could have been presented, and were the research put together differently, doubtless other stories and issues would have become more prominent.

Although the work has drawn inspiration largely from Anderson (1987; 1988; 1991) it is important to remember that this research differs from her work. Anderson concentrates on the formulation of an 'Other' in terms of Chinese immigrants; this work, however concentrates on an indigenous native 'Other'. My sense is that the two were seen in different ways. The 'Chinese' were seen as potentially threatening to European people, and the threat took concrete forms through 'Chinatowns' and the vices that went on there. Native peoples on the other hand, were often seen more as a bureaucratic and administration issue; that with the exception of perhaps the potlatch, there were few threatening connotations associated with 'Indians'. Even so, I would still argue that a European construction of a (native) 'Other' was an ongoing and very

real process, although it may have manifested in ways different to that of the constructed 'Chinese'.

Having completing the research, I am left unsure as to how useful the construction of 'race' is when talking about illness. Although certainly not an entirely useless approach, 'because of the the data I have used, I am left uncertain whether 'racial discourse' is a very effective way of understanding place/people/sickness relations. With hindsight, it may have been prudent to concentrate on the illness event more and the social constructions less, particularly as this study was, from the outset, descriptive and exploratory only.

In terms of my own position, my previous experiences as an RN have probably influenced the development of the thesis; it certainly influenced my original interests and potential research questions. But I did not tell the collaborators that I was an RN, because I didn't want to influence their narrative. Also, at the time, I felt it would be inappropriate because I thought it would only serve to reinforce notions that I was a highly educated, privileged, 'white' person. The Tribal Council, however, knew my background, and I don't know if they told any of the collaborators.

Undertaking this project has been important for my own development - not only in terms of my getting to grips with health issues from a geographical perspective, but also because tackling theoretical issues and particularly putting theory into practice has never been a simple task for me, although I hope to become more proficient with practice and experience. In this case, theory has helped me interpret stories in different ways. I have encountered both successes and failures

throughout the research process, all of which (I hope) can only serve to reinforce and develop any research skills I might already have.

5:4. Suggestions for Future Work.

Although certain methodological frameworks may appear theoretically coherent, it should be remembered that once contextualized and applied in reality inconsistencies may appear. Thus any future research needs to be based on broad and flexible strategies or even entail an eclectic approach as has been used in this study, drawing from a range of theoretical sources. The analysis of discourse and power relations are important emerging themes in contemporary social science and future works in a similar vein to this one would do well to develop further these notions. Discourse and power are intimately linked because the interpretations of these discourses by a hegemonic society reflects contemporary social relations in terms of power and also the ensuing spatial contexts that arise from them. Moreover, these interpretations get caught up in the contradictions of society as political and popular acceptance of socialized theories and arguments rationalize economic and social (and by extension, health) problems.

In nineteenth century British Columbia, the emergence of new forms of (colonial) power and the exercise of it by one culture over another was a reflection at a different scale of the extension of power by the new nation state that was called Canada into BC itself. The medical landscape of Lytton was intricately linked with space and power and it may be that only by examining the contradictions of nineteenth century social formation will we be able to understand the diversity of relations of power that existed in early twentieth century British Columbia. Thus I

would suggest that future research in this field should be undertaken with specific reference to an earlier time period than I have covered, in order to make better sense of early twentieth century power relations than I have managed. It seems also that an examination of the complex nature of native exclusion could be useful, in terms not only of health care practices, but also more broadly speaking, of the experiences of social life in general for many different times and places. There are intricate links between the historical, the geographical and the social world and a further pointer for research could be a closer study of the conceptual spaces that served to produce and reproduce the category of Indian. Perhaps it was almost inevitable that this category was perpetuated, as racial stereotyping particularly in the newspapers became commonplace. The effects of the social construction of 'race' doubtless had more or less real impacts for native people, and it would be helpful to explore the processes that led to this construction. A study of this type could perhaps contribute to our understanding of the health/race/space nexus which is tortuous indeed.

The Department of Indian Affairs itself had an important, ongoing and discursive role to play in shaping British Columbian native-white relations. In constructing what an 'Indian' was, it's official reports may well have functioned to suppress an authentic native reality. In my view, though, it should be remembered that while some detrimental processes were set in motion by the DIA, not *all* processes and effects had bad outcomes, as the experience of farming, and the learning of housekeeping attest. It is possible that the effort to change housing was undertaken as much out of benevolence as the drive towards 'civilization'. Agricultural techniques may have helped survival rates in the thirties and at other times, and some of the collaborators believe that school taught useful skills such as

housekeeping, money counting, and in some cases, literacy. Although some Indian Agents were concerned about native health and welfare, it seems this was not the case at the Lytton.

It would take a lifetime to sift through the complete Black Series, which is where all the DIA information and correspondence is housed, moreover, in view of the questionability of some of those records, and in view of what is and (perhaps more importantly) what is not said, like any other source, they should not be used uncritically. However, they still remain the most valuable written source for information on the institution and some of the native people it purported to look after.

How to go about constructing the recent native past is affected by a researcher's own experiences as well as the issues being dealt with. Historians do not have a monopoly on the reconstruction of the past, and because the archaeology of the local heritage is perhaps more important to the Nlaka'pamux than to others, future research into Nlaka'pamux issues would perhaps best be undertaken by nation members themselves. There is, at present, some activity concerned with collecting and translating myths and legends, but we are still in an 'age of discovery' and it would be gratifying to see other projects being undertaken as well.

For all the hegemonic processes that occurred in Lytton, dominant ideologies never achieve a position of unquestioned authority - they are always contested (Gramsci 1971; Jackson 1987, 1989; Anderson 1987, 1988, 1991; Carstens 1991; Dyck 1991). In terms of native experiences, resistance has taken many forms such as running away from school, or continuing to use native herbal medicines. These

examples can be seen as both literal and metaphorical sites of struggle and it is through these sites, through these experienced spaces that we must begin to chart the geographies of resistance. To me, this is the most important direction of all for future research. Ways of going about this could be to explore the impacts and strategies of human agency, different coping strategies, and the continued use of traditional medicine. How did individuals react to and resist processes that occurred around them? How long did traditional medicine remain an integral part of native illness? Does it still to this day? Or is it becoming forgotten if native people are co-opted into the hegemonic biomedical model?

The present community of Lytton in some ways is trying to heal itself from the effects of the past. In July 1993, the second Community Healing Gathering was held at one of the Nation's most sacred sites at Pasulko Lake (see Map 2, p. xvi). This gathering was an event specifically designed to deal with the legacy of the residential school, and was open to all members - native and non-native of the community. It involved many different aspects of native life in Lytton today, from the sweat lodge at the side of the lake to herb walks, where one could learn which plants are good for certain ailments. There were also prevention of AIDS, suicide and alcoholism workshops which were very well attended and importantly a laughter workshop which was very successful. It was amazing to feel the optimism in the crowd following this three day event. As well as Lytton helping itself, as part of the British Columbian New Directions in Health programme, Lytton's hospital has been chosen as a pilot site for the integration of traditional healing practices with biomedical interventions. Whilst the success of this amalgamation is questioned locally (perhaps because biomedicine is the hegemonic paradigm at Lytton), it is encouraging to see

government bodies enabling native people to participate in defining their own health needs and requirements and it certainly gives them an opportunity to be heard. These contemporary issues serve as a timely reminder that what was and is on British Columbia's own doorstep should be analyzed carefully if we are all going to have the opportunity to make our own futures and name our own realities.

APPENDIX 1.

Sick Records. St. George's Indian Residential School.

YEAR ENDING MARCH 31/1926			
ILLNESS	BOYS	GIRLS	TOTAL
SYPHILITIC ULCERS	1	0	1
SMALLPOX	8	13	21
IMPETIGO	1	0	1
SMALLPOX & IMPETIGO	3	0	3
SMALLPOX & CHICKENPOX	1	0	1
SMALLPOX & SCARLET FEVER	2	0	2
TUBERCULOSIS	1	1	2
NEPHRITIS	0	1	1
TOTAL SICK	17	15	32
TOTAL CHILDREN	53	46	99
%AGE CHILDREN SICK	32.07	32.6	32.32

NB: It is important to note that the percentages above have been calculated on the existing records only. This means that the percentages are only applicable to the tables above, and not to the school population as a whole.

APPENDIX 1.

Sick Records. St. George's Indian Residential School.

YEAR ENDING MARCH 31/19 36			
ILLNESS	BOYS	GIRLS	TOTAL
MEASLES	8	8	16
CHICKENPOX	6	2	8
MEASLES & CHICKENPOX	4	10	14
UNSPECIFIED	25	50	75
TOTAL SICK	43	70	113
TOTAL CHILDREN	84	94	178
%AGE CHILDREN SICK	51.19	71.4	63.48

NB: It is important to note that the percentages above have been calculated on the existing records only. This means that the percentages are only applicable to the tables above, and not to the school population as a whole.

APPENDIX 1.

Sick Records, St. George's Indian Residential School.

YEAR ENDING MARCH 31/1937			
ILLNESS	BOYS	GIRLS	TOTAL
MEASLES	0	1	1
INFLUENZA	2	1	3
MEASLES & INFLUENZA	17	27	44
MEASLES & WHOOPING COUGH	5	4	9
UNSPECIFIED	26	21	47
TOTAL SICK	50	54	104
TOTAL CHILDREN	89	98	187
%AGE CHILDREN SICK	56.17	55.11	55.61
YEAR ENDING MARCH 31/38			
ILLNESS	BOYS	GIRLS	TOTAL
UNSPECIFIED	22	22	44
TOTAL SICK	22	22	44
TOTAL CHILDREN	83	60	
%AGE CHILDREN SICK	26.5	36.6	30.76

NB: It is important to note that the percentages above have been calculated on the existing records only. This means that the percentages are only applicable to the tables above, and not to the school population as a whole.

APPENDIX 2.

Nlaka'pamux Nation Members.

(See Map 2. p. xvi for Nation Member Locations.)

BAND	HECTARES	# OF RESERVES	
ASHCROFT	2018.0	4	
BOOTHROYD	2122.0	19	
BOSTON BAR	608.8	12	
COOK'S FERRY	4058.2	24	
LYTTON	5980.7	54	
OREGON JACK CREEK	822.8	6	
SISKA	319.6	11	

BAND	# ON RESERVE	# OFF RESERVE	TOTAL
ASHCROFT	132	43	175
BOOTHROYD	84	160	244
BOSTON BAR	64	118	182
COOK'S FERRY	75	192	267
LYTTON	714	766	1480
OREGON JACK CREEK	11	38	49
SISKA	78	153	231

(Source: Nlaka'pamux Nation Tribal Council, BC 1991.)

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