Framing Health
Explanations of disadvantages in Taiwanese indigenous health from the perspectives of the government, the media and the experts

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This thesis examines the health framing strategies of the three stakeholders: the government, the media and the experts, with regard to how their assumptions and presuppositions of the notion of Taiwanese disadvantaged indigenous health overlap or diverge from each other. Taiwan is a democratic country situated in the East Asia. The ethnocultural diversity became in urgent need to be accommodated ever since the martial law was lifted in 1987. However for two decades, Taiwanese indigenous peoples have experienced health gap with the non-indigenous population in almost all health indicators. In order to complement the current literature, which has been developed with the biomedical paradigm, the health framing strategies of the three stakeholders are analysed to explore the implied factors that account for indigenous health disadvantages.

The notion of health framing is utilised to refer to identifying the discourses which have been supported by institutions and influenced by cultures, produced particular understandings of the issue of Taiwanese disadvantaged indigenous health. Qualitative content analysis (QCA) is applied in all parts of the analysis. First, the government’s health framing is examined through analysing the Annual Report on Public Health from 2001 to 2012 and the health framing embedded in the media representation is examined through analysing 98 pieces of news reports on both regional and national level from 2000 to 2012. Second, the analysis of semi-structured interviews with the Taiwanese indigenous health experts offer insights into the health framing strategies in and beyond the dimensions of the coding frame. Lastly, three levels of indigenous determinants of health are introduced to structure and to highlight the hierarchy of the framing factors.

The results from the analysis of the government and the media indicate that both stakeholders treat Taiwanese disadvantaged indigenous health as a structural problem of insufficiencies in medical and health resources. In addition, the media representation shows emphasis also on behavioural risk factors as explanatory factors. The health framing strategies from both stakeholders echo closely to the previous research that relied on the biomedical paradigm. Two implications are observed from the interview analysis. First, the implied problems to disadvantaged indigenous health are extended to the political, cultural, and genetic dimensions. Second, the factors that are inadequately addressed are not arbitrary and capricious, but being omitted systemically. The experts provide four explanations on the intermediate level and three explanations on the distal levels that are not addressed. For the former, they are (i) absence of access to the healthcare system, (ii) the presence in an educational system that systemically exclude their opportunities to continue education, (ii) poor access to basic infrastructure and resources to prevent economic marginalisation and (iv) the negligence of the importance of cultural continuity, especially the continuity of indigenous languages. For the latter, the implied problems are (i) the negligence of social change that were closely related to nation-building model which resulted in disassembled and deranged indigenous peoples, (ii) the role of power in the design of health institutions which manifested in the absence of cultural sensitivity and (iii) the ongoing impact of doctrine of discovery in Taiwan.
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Preface

I grew up in Wulai, an ethically diverse village in Taiwan where villagers spoke more than three languages on daily basis. Wulai was probably one of the most touristic indigenous villages of Taiwan because of its hot springs,\(^1\) nature and geographical proximity to Taipei.\(^2\) Atayal language was one of the three languages that I used to hear often, but learning Atayal was never a priority because of the overt discrimination atmosphere against indigenous peoples at that time. As an Atayal, my grandmother understood how difficult life I would have if I were raised as an Atayal.

In hope of a better future, I was raised up in the values and wishes of my grandfather. He grew up and taught in a high school in Guangzhou before the World War II, but after the war broke out he joined KMT and later on retreated with the KMT army in 1948. I was given name in Mandarin Chinese, Gao I-An, and was raised as a Chinese person. Therefore, I do not quiet know what it means to be an Atayal, I am not sure either how it feels like to be Atayal. I don’t speak the Atayal language, I am not familiar with the tradition, nor any tribal life style of my ancestors. I learned Atayal history from museums and libraries, from the perspectives of non-Atayal. My grandfather has taught me to study hard so I can survive in the future, so I strived to meet his standards. He was right about studying hard promised better opportunities in life, however I realised I was no longer familiar with my Atayal identity. As I worked hard and went through the best high school and the university deemed by the mainstream society, all of a sudden I realised I was carried further away from my Atayal roots: the tradition, the language, culture. It was in this almost non-Atayal position that I encountered the health problems faced by indigenous peoples.

I encountered challenges faced by Atayal as an outsider when I lived in Wulai. I was perplexed by the negative social attitudes against the Atayal people, and the fact that my Atayal friends tended to drop out from schools and had hard time finding decent jobs. What struck me the most was the health challenges faced by the Atayal people around me. Regardless of the good natural environment, Atayal people tended to suffer from diseases and die in young age. Atayal girls tended to give birth while they were still in school age which resulting in dropping out from school. Atayal people were

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\(^1\) ‘Wulai’ is derived from ‘boiling hot water’ in Atayal language.

\(^2\) It is only 20 km to Taipei city, the capital of Taiwan.
more likely to be exposed to drug and alcohol abuse than non-Atayal people, even among children and adolescents. After I moved into Taipei city in pursuit of my education, I heard similar stories that happened in many indigenous villages in Taiwan. People around me had their own theories about how Atayal—or indigenous peoples as a whole—ended up in such vulnerable health positions. Some of them were more eloquent and vivid, while others did not appropriately solve my perplexities on this health puzzle. It was under this proposition that this thesis embarked.
1. Introduction

The initial research motivation of this thesis started from the social inequalities between indigenous peoples and non-indigenous peoples in Taiwan. Taiwanese indigenous peoples are known as Austronesian speaking peoples who are ethnically, culturally and linguistically different from the majority inhabitants in Taiwan. There are officially 14 tribes being recognised, consisting 522 000 persons which is 2.2 per cent of Taiwanese population. This official recognition of ‘indigenous peoples’ is employed in the analysis throughout this thesis. The goal is to bring in explanations that focus on political, social, cultural and historical aspects as a way to enrich the debate of indigenous health inequality in Taiwan. The term framing health is employed to refer to the problem-forming process that interprets, justifies and explains and thereby gives diagnosis and prognosis to the disadvantaged Taiwanese indigenous health.

Indigenous peoples in Taiwan are left behind in virtually every social indicators (Fetzer and Soper, 2011). Among which, indigenous families earned NT$ 509 712 (around 12 838 euros) while the average Taiwanese families earned NT$ 1 099 739 (around 27 699 euros); Only 14.3 per cent of indigenous peoples acquire tertiary level of education while the average was 32.3 per cent; the density of medical doctors per 10 000 population was 6.13 persons for indigenous townships, but 15 persons for the average. Accidents, chronic hepatitis and cirrhosis, tuberculosis and gout kill indigenous peoples 3, 4, 4.3 and 8 times the rate of death in the non indigenous population. All of which are supposedly factors which contribute to standardised mortality rate 1.9 times the national average, thereby reducing life expectancy. Indigenous peoples’ life expectancy at birth is 9.41 years shorter than the non-indigenous people (Gao 2009: 528). Among the social inequalities, health inequality is the focus of this thesis. In particular, the initial goal was to explore the reasons explaining for the existence of life expectancy gap between Taiwanese indigenous and non-indigenous--- since health disparity was not so much an issue for the Sámi in the Northern Europe/Circumpolar area. It is decided to take the inquiry in a different light because the reasons resulting in life expectancy gap is complex. Exhausting the contributing factors of the gap among

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3 Originally I wanted to compare the Sámi and the Taiwanese indigenous peoples. The reason I wanted to compare was that the well-being (for example, life expectancy) gap did not exist in Norway, Sweden nor Finland between the Sámi and non-Sámi. Since it was too big to be a MA thesis, I decided to leave that to doctoral thesis and focus instead on Taiwanese indigenous peoples.
indigenous peoples may result in a cursory analysis. For this reason, the focus shifts to inquire how the issue of closing the life expectancy gap becomes a problem that various policies claimed to fix. While claiming to fix the problem, government is active in the creation of the policy problem. That is, the government gives shape to the problem without explicitly addressing it. In brief, instead of inquiring into the life expectancy gap, which has been created and shaped as a problem, the priority has been placed on examining the pillars that constructed the problem. In this regard, the assumptions and justifications to explain for disadvantaged health of indigenous peoples in Taiwan.

Many analyses have been made to tackle this issue. The predominant models to explain such Taiwanese indigenous health inequality, as Kuo stated (in Ru 2012: 150), have been based on unequal distributed medical resource as well as genetic and behavioural factors. Such phenomenon can be explained by the majority of the policies of indigenous disadvantaged health have been directly adopted from the pathological and epidemiological disciplines. The importance of this approach that is inspired by the biomedical studies cannot be overlooked. In particular, the significant contributions of acute treatments have been endorsed and the accurate observations of physical health have been accepted. As skeptics have pointed out the limits of relying exclusively on the biomedical studies (Nigenda, Lockett, Manca and Mora 2001; Smith 1999; Narayan and Harding 2000), complimentary approaches to tackle the disadvantaged indigenous health is in urgent need. One of the alternative approaches is the political perspective.

The political system in Taiwan has significant impact on the indigenous health. From the indigenous perspective, their historical position and sovereignty have been gradually lost since the Dutch colonisation in 1624. Chinese Nationalists fled to Taiwan in 1948 when they lost civil war and soon they promulgated martial law. It was not until the lift of the martial law in 1987 that previously suppressed identities, including indigenous identities, to be present on the surface. Currently, the Legislative Yuan (LY) is the unicameral legislature of Taiwan, designating six indigenous MPs through single non-transferable vote in two three-member constituencies. However the fundamental divide in the Taiwanese democratic structure remains to be the unification-independence polarisation that posts limitations on indigenous rights articulation on the institutional level. In brief, it was not until 1980s that Taiwan underwent democratisation. The electorate, which did not exist before 1990s, is now a dynamic player and a platform where indigenous peoples fight for their rights. Judging from the post martial law
historical development, Taiwan can be considered to be a consolidated democracy. Like in most of the democracies, indigenous peoples are now claiming their rights on both the local and national level. The debates not only represented different interests, but the clash of world views as well as knowledge systems.

While referring to the Indian health, the observation of Boyer (2003) can be applied in a more general situation. He pointed out that the failure of indigenous health policies “resided in the false assumptions” that the indigenous peoples “… were biologically predetermined to vanish, were inherently unhealthy and inferior, and that their culture caused them to pursue harmful lifestyles.” (Boyer, 2003: 7) Indigenous health policies are in need of urgent scrutinisation in regard to their assumptions. To do so, this thesis aims to explore the explanations for disadvantaged health of Taiwanese Indigenous Peoples and thereby scrutinise the assumptions and justifications of these explanations.

1.1 The Problem

This thesis examines the health framing strategies of the government, the media and the experts with regard to their assumptions and presuppositions of the notion of Taiwanese disadvantaged indigenous health overlap or diverge from each other. These three stakeholders are chosen because they are actively giving shape and meaning to the notion of ‘indigenous health problem’. The government controls the funding and defines the level of the problem selecting appropriate budget; the media repeats and reinforce the official speech and produce its own realities of indigenous ‘problem’; the expertise is embedded in the creation and maintenance of constituency that at the same time intertwined with policy-making and (mis)interpreted by the media.

The health framing strategies of three stakeholders are examined under the context of Taiwan. As a democratic state since the lift of the martial law in 1987, the new challenges Taiwan has been facing is to accommodate the ethnocultural diversity of indigenous peoples. In this context, biomedical paradigm has been utilised as basis to many official research on indigenous peoples thus resulting in its predominant position in the indigenous disadvantaged health discourse (Ko, Liu and Hsieh 1994). To response to this predominant discourse, it is decided to explore the explanations of the indigenous

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4 According to Samuel Huntington’s definition, the two peaceful transfers of executive power from one party to another qualifies Taiwan to be considered as a consolidated democracy. See Blundell (2012)
health disadvantages from the standpoints of the mainstream via scrutinising the three stakeholders. It is aware that the three stakeholders may present predominantly the mainstream’s standpoint of indigenous disadvantaged health. Analysing their bias allows me as an indigenous scholar, as Harding stated, ‘seeing ourselves as others see us’ (2006: 31-49). The disadvantaged health discourses of these three stakeholders will be scrutinised as to explore how indigenous disadvantaged health becoming a problem. In other words, indigenous disadvantaged health will not be tackled as an unproblematic truth, but a phenomenon deserved closer scrutinisation. Through scrutinising the framing, it becomes clearer that indigenous peoples are not unproblematic ‘disadvantaged citizens’. As Calma observed, poverty and inequality that experienced by the indigenous peoples can be traced back to their unequal treatment as peoples. It was noted that their ongoing disadvantages and inequalities in health were linked to systemic discrimination (Calma 2007).

The dominant discourses on disadvantaged indigenous health are systematically examined, at the same time, the implied indigenous problems of these dominant discourses are critically analysed. That is, the existing discourses are reflected and the conceptual alternatives to complement the current practices to deal with the health crisis are presented. Ultimately this thesis encourages seeing the world of sciences with both eyes open, as noted by Harding, “one on contemporary Western sciences and their philosophies and the other on other cultures’ scientific practices and legacies” (2006: 50-65). Accordingly my main research question can be formulated as follows: What kind of problems have the Taiwanese disadvantaged indigenous health become among the discourses from the government, the media and the experts? Under what health framings strategies the assumptions and presuppositions of the notion of disadvantaged health developed? What are the implications of Taiwanese indigenous disadvantaged health represented in the explanations?

The arguments are structured in the following six parts. Firstly, an overview of concepts that are relevant to indigenous peoples and their health is introduced. Secondly, a brief historical analysis relating to Taiwanese indigenous health is provided. This analysis aims to prepare the audience the relevant knowledge and understanding of the Taiwanese context. After anchoring the relevant background concerning Taiwanese indigenous peoples and their health, the theoretical framework is introduced as the third part. It includes the expert knowledge, doctrine of discovery, policy analysis and the
health framing. Fourthly, research methods that have been employed as tools to gather and to analyse the data are presented. The process of the development of the coding frame that has been formulated with the my data is elucidated. Furthermore, ethical concerns and researcher’s position are explained in this section. Fifthly, the analysis of scrutinising the explanations of the government, the media and the experts are reported. By focusing six dimensions of health determinants from the coding frame, the different lines of arguing among stakeholders are highlighted. Twelve policy reports from 2001 to 2012 are elucidated for collecting the explanation from government, and 98 pieces of news are coded and segmented for collecting the perspectives in the media representation. Eleven qualitative interviews with the Taiwanese indigenous health experts which were conducted in June 2012 to February 2013 are analysed. The last chapter concludes and discusses a couple of ways to move forward as well as flashing out the crucial areas that need more research.

1.2 Central Concept

The health framing strategies of the three stakeholders encompass notions that are embedded in the Taiwanese context. For this reason, it is prudent to outline the concepts that are central to the analysis. The definitions of the indigenous peoples are presented with regard to how the international, regional and national level of definitions differ and reiterate each other. The section is followed by identifying Taiwan’s indigenous rights to health and its relation to human rights and group rights. Lastly, the notion of treating indigenous peoples’ health as a collective notion is introduced.

1.2.1 Definition of the Indigenous Peoples

The concept of indigenous peoples is summed up in three levels: the international level, the regional level and the national level. The international level includes the definition given by Cobo (1982), the United Nations Declaration of Rights of Indigenous Peoples (UNDRIP) and the International Labour Organisation (ILO). The regional level entails a brief overview of indigenous peoples in Asia and the national level includes the definition of indigenous peoples under Taiwanese context. Taiwan’s definition of indigenous peoples is inextricably tied to its local circumstances, the regional ambiance and international trend. In this regard, the definitions of these three levels are of great relevance to introduce.
The international level of the definition of the indigenous peoples comes from the United Nations. Of all the relevant definitions from other mechanisms and agencies, such as the ones from International Labor Organisation (ILO), United Nations Permanent Forum on Indigenous Issues (UNPFII) and World Bank, the observation from Cobo is the most widely accepted definition. José Martínez Cobo, the special Rapporteur of the United Nations, defined the indigenous peoples as follows:

“In Indigenous communities, peoples, and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or part of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal systems.” (Cobo 1982)

Cobo (1982) emphasised that indigenous peoples are those who had established their own societies before invasion or colonisers arrived. Second, indigenous peoples are not dominant, which means beyond numeric sense, but also referring to power (Frichner 2010). Third, they have their own distinct languages, culture, social, legal and political institutions different from the mainstream society. In terms of recognising indigenous peoples, it is not only on the individual basis (self-identification), but also group acceptance (Cobo 1982).

In addition to the definition provided by Cobo, the emergence of UNDRIP marked the new trend of legal definition of indigenous peoples on the global level. International law has encountered a turn from being instruments used by settler states to justify their colonisation on indigenous lands, to recognising the rights of ‘indigenous peoples’ as a collective to have control over their own land (Mona 2008: 84). The rights of indigenous peoples have been written into the UNDRIP and an annual conference is organised in the United Nations in order to exchange indigenous issues. In addition to the UN, International Labor Organisation (ILO) is also an important tool for advance
indigenous rights on the international level (ibid: 88). ILO Convention no.169 was made after no.107 had been argued to be based on assimilative ground. On the regional level, the definition of indigenous peoples represents a more diverse picture than the international one. Such diverse picture is predictable because among the 370 million indigenous peoples worldwide, around 100 million people reside in Asian countries. Although they share characteristics in line with the international definition, they are referred differently from country to country (Stavenhagen 2007: 4). For example, they are the Ainu and Okinawans in Japan, ethnic minorities in China, Austronesian speaking indigenous peoples in Taiwan, Igorot and Lumad from the Philippines, komunitas adat terpencil in Indonesia, Orang Asal in Malaysia, the indigenous peoples in Thailand, Kinh and the ethnic minorities in Vietnam, ethnic nationalities in Burma, Jummas in Bangladesh, Adivasi Janajati in Nepal, Scheduled Tribes (Adivasis) in India and the Nagas-- the transnational indigenous peoples across the borders of north-east India and north-west Burma (Mikkelsen 2013: 222-320).

In terms of accommodating indigenous rights in Asia, the process is limited. Asian countries tend to be reluctant to give indigenous peoples any political or legal status, which lead to serious human rights violation (Stavenhagen 2007: 22). The patterns of human rights violation of indigenous peoples in Asia are similar to the indigenous peoples in the world. However, there is big human rights implementation gap as a result of the weaker human rights protecting and monitoring mechanisms in Asia. Some of the most serious forms of human rights violation experienced by Asian indigenous peoples are related to the rapid loss of indigenous lands (Stavenhagen 2007: 6). Some commentators suggested that the land loss may be related to the homogeneity nation-building plan of states. During the nation-building period, a number of policies were made to facilitate the assimilative process during the states’ invasion and colonisation, such as encroaching indigenous land, restricting cultural and religious practices, prohibiting indigenous languages, and undermining their institutions of self-government (Kymlicka 2007: 66).

The absence of the accommodation of indigenous rights implementation has negative impact on indigenous health. When describing the disadvantaged human rights situations of Asian indigenous peoples, they not only in general “score low on the

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3 Some Asian countries, such as India, Malaysia, Philippines and Cambodia, give constitutional recognition to indigenous peoples (Stavenhagen 2007: 4-5)
indicators in relation to their enjoyment of basic rights such as education and health, they are impoverished as a result of the loss of their traditional lands, territories and lifestyles” (Stavenhagen 2007: 3), but are also exposed to possible health risks by national development projects (ibid: 12) and being excluded to health care and services (ibid: 16).

On the national level, the status of Taiwanese indigenous peoples is defined based on the Status Act For Indigenous Peoples which passed in 2001. The Act specified the definition of ‘indigenous peoples’, which includes both the mountain and plain-land regions, and the criteria for them respectively. For the mountain indigenous peoples, they need to be permanent residents of the mountain administrative zone before the recovery of Taiwan. They have to prove with census registration records that themselves or their immediate kin are of indigenous peoples descent. On the other hand, the criteria of being plain-land indigenous peoples is similar as the mountain indigenous peoples: they have to be permanent residents of the plain-land zones before the recovery of Taiwan and prove their indigenous heritage in the census registration records. Additionally, the plain-land indigenous peoples need to fulfil one more criteria: they have to register themselves as plain-land indigenous peoples to the local authorities of their villages (towns, cities, districts).

1.2.2 Taiwan’s Indigenous Rights to Health

There are three theoretical pillars that have constructed Taiwan’s indigenous rights to health, the one that built on human rights, the other based on group rights, and still the other that lied in the middle between human rights and group rights.

The commentators from the first theoretical pillar conceptualised indigenous rights as the third generation of human rights. Such strand is most popularly argued by Karel Vasak (see Shih 2011). In line with Vasak, Shih (ibid) claimed that indigenous rights can be seen as part of the third generation human rights. He divided the indigenous rights into (i) survival rights (ii) equality rights in accordance with the UNDRIP. Under equality rights, he further distinguished (ii-1) civic rights (ii-2) group rights. Finally he identified five different rights under group rights: identity rights, self-
government rights, cultural rights, property/land rights and compensate rights. Others view individual rights and collective rights both as umbrella concepts under universal human rights. The former relates to the guarantee of basic survival rights that does not discriminate race, ethnic groups, gender and age. The latter emphasises the collective language, religious, economic and political rights, which is indispensable to ensure the individual rights (Scheinin 2003:495; Kymlicka 2001:70-72).

Inspired by the notion of differentiated citizenship, the advocates of the second theoretical pillar regard that indigenous peoples are able to be incorporated into the political community not only as individuals, but also through the group, and their rights would depend partially on their group membership. Affirming group difference is indispensable for genuine equality (Young 1989: 257-259; Kymlicka and Norman 1994: 370-371). Indigenous peoples’ group rights under the framework of multicultural citizenship is self-government rights. This is not a temporary measure, nor is it a response to a form of oppression. With such rights, indigenous peoples are entitled to govern themselves in certain key matters (Kymlicka and Norman 1994: 372). Self-government rights are the most complete case of differentiated citizenship. Though countries might be tempted to ignore the claim for differentiated citizenship for the sake of state stability, very few democratic multination states could follow the strict ‘common citizenship’ strategy because it would increase the possibility to secession even more (Taylor 1992: 64; Kymlicka and Norman 1994: 375-376). In the political reality, Taiwanese indigenous peoples’ claim for self-government rights had been largely ignored by the mainstream media and academics. Some regard the self-government rights are unrealistic, others deem it as a threat against the Taiwan’s territorial integrity as well as the majority’s rights (Shih 2011).

Indigenous rights to health is also understood as a combination of basic human rights and group rights. These two rights are complementary because indigenous peoples, just as the ethnocultural minorities, are vulnerable to injustice in the hand of the state even though their individual human rights are respected (Kymlicka 2001: 69-70). Supplementing human rights with group rights is especially crucial to accommodate indigenous health, both as direct determinants and indirect determinants. For indirect determinants of health, Kymlicka’s examples of aspects that could not be accommodated by relying solely on universal human rights— forced migration, administrative divide and language (Kymlicka 2001: 73-82)— can be observed in the
Taiwanese context. It remains a challenge for Taiwan to reconcile the human rights and group rights in achieving the right to health of indigenous peoples. The implications of group rights in health are further explained as a collective notion.

1.2.3 The Taiwanese indigenous peoples’ health as a collective notion

The right to health originates from the individual perspective that links to basic human rights. In the trend of supplementing human rights with group rights, the notion of right to health has undergone a wave of recognising it as a semi collective notion. An international understanding of right to health is introduced as a way to establish the context for Taiwanese indigenous peoples’ right to health. The solution proposed by Calma (2007) to reconcile the general understanding of right to health and the indigenous right to health is presented, followed by the right to health in the Taiwanese context.

On the international level, the right to health is an inalienable right to every human being, no matter one’s age, gender, socio-economic or ethnic background. The right to health is also an inclusive right that extends further than building hospitals. It entails safe drinking water, adequate sanitation, safe food, adequate nutrition, quality housing, healthy working and environmental conditions, health-related education and information and gender equality, known as “underlying determinants of health” (Office of the United Nations High Commissioner for Human Rights 2008: 1). By definition, the right to health is “the enjoyment of the highest attainable standard of physical and mental health” and “the enjoyment of a variety of goods, facilities, services and conditions necessary for its realisation” (Office of the United Nations High Commissioner for Human Rights 2008: 1-5). The universal right to health on the international level, as presented above, may not be sufficient to secure the right for all groups of peoples. Indigenous peoples are one of them.

Indigenous peoples’ right to health can be still vulnerable to injustice because certain aspects of their health are inextricably linked to the group. In particular, the principle of non-discrimination should be taken into account when accommodating indigenous right to health as a group. Indigenous peoples are more vulnerable to ill health resulting from the marginalisation, exclusion and discrimination against them in

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8 I use it to be interchangeable to well-being, quality of life or even functioning, depending on the context. It’s also difficult to translate this concept in Mandarin Chinese. In Chinese, ‘health’ is closer to good functioning, but distant to both ‘well-being’ and ‘quality of life’.
the society that nullifies their recognition, enjoyment and human rights. “The principle of non-discrimination and equality are fundamental human rights principles and critical components of the right to health” (Office of the United Nations High Commissioner for Human Rights 2008: 7). Indigenous peoples are facing hurdles in relation to the right to health, especially difficulties resulting from socio-economic factors, discrimination and stigma. As urged in the report, positive measures should be adopted by state to ensure that indigenous peoples, as specific groups, are not discriminated against (Office of the United Nations High Commissioner for Human Rights 2008: 11).

Similar message that urges the special group recognition for indigenous peoples can be observed in Taiwan. Lee (2008) scrutinised social welfare system for indigenous peoples by analysing UN Declaration on Rights of Indigenous Peoples (UNDRIP). From his research, it was affirmed that ‘free from discrimination’ could be deemed as the fundamental components of the Declaration, along with ‘social security’ and ‘rights of collective development’. In order to achieve the goal of ‘free from discrimination’, three rights are prerequisite. First, rights of citizens, i.e. indigenous peoples as individuals should be treated as equal citizens. Second, individual rights for indigenous persons from their indigenous status. Third, inseparable collective rights to be possessed by indigenous peoples as a collective. One of the solutions proposed to tackle this inequality is to recognise the collectiveness of indigenous health by adapting the framework of rights based approach to health.

A rights-based approach to health, as Calma (2007) suggested, can solve the dilemma. The human rights based approach to health is a set of operational methods adopted in the United Nations to urge states to realise their legal obligation of closing the socio-economic outcomes among different sectors. It highlights governments’ responsibilities to guarantee that the right to health will be exercised without discrimination and to work in partnership with indigenous peoples (Calma 2007). In this context, social determinants of indigenous health should be considered and confronted as a matter of policy priority to close the gap. In Australia, Calma (2007) has illustrated several determinants and their linkage to health with evidences, including the linkage between health status and socio-economic status/ poverty, linkage between perception of control and chronic stress, evidences of the health impact of indigenous community control of health services, traditional ownership of land and health status, social determinants as a contemporary reflection of historical treatment.
The right to health as a collective notion is instrumental to Taiwan. It is because they are vulnerable to the health risks not as individuals, but as a group. It is especially significant given the historical stigmatisation against indigenous peoples. Under the trend of modernisation, a general concept of health in Taiwan that focuses on public health aspect through school education has been popular. Under the political ambiance before Taiwan democratised in 1980s, indigenous traditional concept of health, knowledge and healing was suppressed, labelled as backward, and therefore became forbidden. There has been no formal process of reconciliation taken place between the government and the indigenous peoples, that is, no official apology has been taken place and no official reparation of historical wrong-doings were stated (Shih 2011). The Basic Law, a comprehensive legislation passed by the parliament in 2005 to stipulate the basic rights of indigenous peoples, omits the concept of discrimination (Lee 2008). In fact, although the constitutional change in 1994 specified the status of indigenous peoples, the government still links indigenous peoples to ‘national minority at the peripheries’ (See He, Kymlicka et al. 2011). Taiwanese indigenous peoples acquire rights not under the framework of their distinct status (sui generis), but because they located in the peripheries (Shih 2007: 11-12). The shortages in substantial recognition can further expose indigenous peoples under the risk of injustice.

Genetic research scandals have been one of the undesirable results from the misrecognition of indigenous peoples. In Taiwan, Indigenous peoples have been subjected to numerous genetic research to identify that they are susceptible to certain diseases, such as gout, intoxicating effects of alcohol and mental disease. Similar experiences can be seen among indigenous peoples all over the world. For example, Indians in the United States had to fight the myth that was being refuted by research, that “Indians are generally more susceptible to the intoxicating effects of alcohol than are non-Indians”, and “Indians metabolise alcohol differently or more slowly than do people of other ethnic groups” The alleged ‘genetic weakness’ among Indians for alcohol had not been clinically identified. Media coverage reinforces the ‘binge pattern’ consumption problem among Indians, though they are mostly make-believes without basis,(Utter 2001: 100-101, 302-303). In sum, the universal right to health on the individual level can not easily accommodate the right to indigenous health. The rights-based approach presented by Calma took indigenous health as a collective concept and proposed insights in solving the health challenges of indigenous peoples. The absence
of recognition of collective indigenous health may have profound health consequences on Taiwanese indigenous peoples.

1.3 Scientific Background

The literature about Taiwanese indigenous peoples is limited, the analysis on Taiwanese indigenous health is even so. The existing analysis on Taiwanese indigenous health has been focused on certain aspects within the bio-medical paradigm. It is under this context that the analysis starts. Health gradient and historical impact on health are introduced, followed by two explanations of Taiwanese indigenous disadvantaged health. Lastly, a global context of indigenous health is presented.

It was not until two decades ago that the Taiwanese government started to pay attention to indigenous peoples. Bigger scale of Indigenous peoples’ policy evaluation has not been updated since 1992 (Gao 2009: 495-496). It is not until recently that the Taiwanese government began to contemplate the mechanisms and pathways that give rise to the health gradient. The gradient can be defined as follows:

“A gradient, which can be graphed as a slope that depicts this relationship: having more social goods or a more advantaged social position (horizontal axis) is associated with having better health (vertical axis)\(^9\), at least at the population level” (Kenting 2009)

Research shows the impact of income, wealth, education, occupation, and social status on health outcome. These findings have often been captured in the notion of a gradient. The same trend has been observed across the population: having more of any of these social ‘goods’ is associated with better health outcomes (ibid). In the context of this thesis, the aim is to scrutinise how do stakeholders understand the health gradient of Taiwanese indigenous peoples. It has been observed that when it comes to health gradient of Taiwanese indigenous peoples, the pathways that have given rise to this gradient mostly limited in malfunction medical resource distribution, risk factors embedded in indigenous culture, customs and behaviours (Ru 2012: 150). Such result can be traced back to the majority of discourses about disadvantaged Taiwanese indigenous health have been produced through disciplines such as psychology.

\(^9\) See figure 1.1 of Keating (2009).
physiology, epidemiology, pathology, molecular biology, genetics and behavioural sciences (Chen 2011). The mainstream discourses on indigenous health gradient have been built on the hypotheses that individuals with indigenous background tend to suffer more from insufficient knowledge on healthier way of life, inadequate diet, lack of physical activity, harmful behaviours that result in high risk factors; the mechanisms regarding the politics, economics, social status, ethnicity and gender (Ru 2012: 151) that may play a role to the gradient are not included.

Historical impact on indigenous health is one of the mechanisms that turns out to be ignored (Chen 2007; Ru 2012: 150-151). Neglecting the ongoing impact of history makes indigenous peoples vulnerable to injustice in two ways. First, omitting the historical factor makes the power dimension seemingly irrelevant in the determinants of indigenous health. Second, the suppression in the past may have ongoing and direct impact on indigenous health, especially during the state-building period. In this regard, this thesis aims to complement these two aspects via examining the discourses on disadvantaged indigenous health in Taiwan among the government, the media and the experts. This close scrutiny of these stakeholders aims to put the Taiwanese disadvantaged indigenous health in a different light, inter alia, the dimension of power. That is to say, the power variable, which the state’s actions of securing indigenous peoples’ compliance to domination, will be examined. This thesis employs the definition given by Lukes, who understood ‘power as domination’ as equivalent to, “suggest the imposition of some significant constraint upon an agent or agents’ desires, purposes or interests, which it frustrates, prevents from fulfilment or even from being formulated.”(2005: 113). In this context, the disadvantaged indigenous health may be the result of the history of domination. States need to secure indigenous peoples during of its nation-building period, as proposed by Kymlicka (2007), because it emphasises the unity and ‘peoplehood’ that would either exclude or assimilate the non-dominant group. In the case of Taiwan, the indigenous peoples were subjected to ‘national’ education, language and literature in the past-- first Japanese, then the Chinese. They were the target of the policies of assimilation. Their land and natural resources have been taken in order to make the state “prosperous”, especially in Taiwan’s industrialisation period (1960s). The assimilative policies, or the policies of colonisation, have negative impact on the mental and physical indigenous health (Calma 2007). Racial harassment and discrimination have impact on health (Nazroo and
Williams 2011: 256-257). The historical discrimination against Taiwanese indigenous peoples makes them systematically disadvantaged and vulnerable. The explanations of Taiwanese indigenous disadvantaged health can be largely divided by the one that inspired by the biomedical paradigm and the other that emphasised on the social and historical factors.

The commentators from the first paradigm favour scientific evidence in the paradigm of pathology, the other emphasises the importance to consider humanities and social sciences. The proponents of the first paradigm focus on fast, direct and precise solutions for one or more particular disease(s). In analysing excessive alcohol consumption and its related problems, they tend to apply universal theories to indigenous peoples in order to explain indigenous peoples’ disadvantaged health (Ko, Liu and Hsieh 1994). As a result, the scope of analysis of indigenous health focuses in harmful lifestyle, bad adaptation to the society, learning incapability that leads to a disadvantaged position on education, socio economic status and the “sense of health” (Chang 2004: 103-107). This paradigm appears to be easier to apply in policy initiatives because it is able to quantify outcome of health promotion and evaluation.

The first paradigm can be seen as the biomedical paradigm which largely inspired by the modern science (Narayan and Harding 2000). They study the conditions or habits that raise the risk of diseases thereby developing the treatments as well as preventions. Certain challenges could be observed. The ‘scientific evidence’ of the first paradigm has been often used to prove that indigenous peoples being blamed individually for their alcoholism (Chang 2004: 116). The second paradigm is proposed to response to this challenge. At least three challenges can be identified in relying on the first paradigm. First, first paradigm encourages us to see the indigenous health gradient as a combination of problem resulting from individual risk and incomplete medical system (Tsai 2005). However eliminating risk factors in programs such as anti-excessive drinking program, anti-smoking program, health behaviour promotion program in indigenous peoples do not solve the problems effectively. Second, first paradigm easily overlooks the importances of cultural sensitivity. Commentators argued that cultural sensitivity is central in health delivery to indigenous peoples, especially in the long term care policies (Wang 2013). Third, the policies which applied first paradigm easily reduce the meaning of healthcare for indigenous peoples. Not only the meaning of healthcare becomes residual subsidies compensating for insufficient national health
delivery, but also in the affirmative actions. The healthcare for indigenous peoples, as one of the four affirmative actions the Taiwanese government implemented in the social policy, has been limited to the subsidies of National Health Insurance and transportation subsidies of seeking medical treatment (Liu and Ho 2009: 125). The subsidies, which concern health delivery, can hardly respond effectively to the disadvantaged health of indigenous peoples (Cheng and Lee 2007). It is under these challenges that the second paradigm emerged.

The advocates of the second paradigm argue for the determinants of health on a more radical level that reflect the complexity and sensitivity on a macro history, in particular taking into account the impact of socio-political change (Chen 2007: 31). The advocates of the second paradigm disagree with the mainstream academia’s explanation that attribute the negative lifestyle and diet of indigenous peoples as the major contributing factor of the disadvantaged indigenous health. Nor do they agree with “the economic situation and the limitation of social structure” (Chang 2004: 120). Instead, the proponents of the second paradigm argue that a macro level analysis that looks beyond the behavioural risk factors helps us better identify ‘the cause of the cause’. For example, the prevalence of alcoholism leap from 0.11% in the 1950s, to 44.2-55.5% in the 1980s can hardly be satisfactorily explained by the genetic, individual nor environmental factors (Chen 2007: 2). Studies shown that though the prevalence of alcoholism differs from tribe to tribe, the percentage of alcoholism prevalence in the targeted tribes has dramatic increase\(^\text{10}\) in 30 years’ time (Chen 2007: 167-168). This finding shown that concluding the reason of indigenous peoples’ alcoholism prevalence on the abnormalities in the genome, which has been a very wide-spread approach, may not be accurate. In response to the first paradigm rooted in the modern science, the proponents of the second paradigm argue that although modern biomedicine is powerful and valuable for many purposes, it is easy to neglect or misunderstand other alternatives (Narayan and Harding 2000:250).

Indigenous health in crisis is not unique in Taiwan, but an international phenomenon. Indigenous peoples worldwide have worse health compared to the

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\(^{10}\) According to Chen (2007), during 1949 to 1953, the highest prevalence of alcoholism was tracked in the Amis tribe, in which every 1.6 out of 1000 suffered from alcoholism. Another studies tracked the prevalence in the late 1980s, revealing the prevalence of alcoholism were 44.2 per cent for the Amis, 47 per cent for Paiwan, 51.7 per cent for the Atayal and the 55.5 per cent for the Bunun. That is, if we take Paiwan people for example, the alcoholism prevalence was less than 1 per cent around 1949 to 1953, whereas the alcoholism prevalence increased to 47 per cent.
majority society. The gap in life expectancy between indigenous and non-indigenous people, for example, is 6 years in Mexico, 7 years in Canada, 10 years in Panama, 11 years in New Zealand, 13 years in Guatemala, 20 years in Nepal and in Australia (Cunningham 2009: 158). The only exception might be the Sámi people in the Nordic countries. The Sámi, like other indigenous peoples, experienced policies of assimilation. Such policies still have negative consequences on the health of the Sámi in the present (Näyhä, 2009; Hansen, 2011a: 26). However, the life expectancy of the Sámi today who live in Norway, Sweden and Finland are rather similar compared with the general population (Young & Bjerregaard, 2008). Hansen (2011b: 157-58) attributed such uniquely positive situation regarding health to Nordic societies which are pluralistic and offer equal access to health care services. Sjölander (2011) studied the health and living condition of the Swedish Sámi and confirmed that the Sámi have exceptionally good health, in terms of “no evidences of low-life expectancy, of significantly elevated incidences of common diseases, or of increased prevalence of alcohol and substance abuse that are serious health problems among other indigenous populations”. The positive picture has been revealed not as easy as it seems, because finding relevant data to study the health situation of the Sámi is extremely challenging due to the data protection laws that prohibit collecting ethnic data. Sjölander (2011) acknowledged the fact that the available knowledge of the health condition of the Sámi is still quiet poor and it is important for Sweden to build a national health policy for the Sámi people. There are more data collected and research done on the Norwegian side, such as the SAMINOR study\textsuperscript{11}, whereas there is only little studies done on the Finnish Sámi health\textsuperscript{12}. All in all, though the available information about the Sámi health is still limited, they nevertheless appear to have better health status. Unfortunately, it is not the case for other indigenous peoples.

To summarise, the mechanisms and pathways that give rise to the Taiwanese indigenous health gradients under the Taiwanese context has been largely inspired by the biomedical paradigm which rooted in the modern science. Other impacts to

\textsuperscript{11} A population based study of health and living conditions in areas with both Sami and Norwegian inhabitants in Norway. The aim of the study was to study health and diseases in relation to living conditions among the Sámi population and to compare these with the Norwegian population in the same area. The data was collected between 2002 and 2004. 61.3\% (n=16 640) participants among the age interval 36-79 replied. (Lund et al, 2007)

\textsuperscript{12} Question to Irja-Seurujärvi in the 5th Polar Law Symposium. September 2012, the Arctic Center, Rovaniemi. The priority on the Finnish side seem to be land issue (such as ratifying the ILO no.169), protecting Sámi culture and language.
complement the current debate of indigenous health gradient have been highlighted via introducing the second paradigm that reflects the complexity and sensitivity on the macro history. In the context of this study, indigenous disadvantaged health in Taiwan is placed under scrutiny as a case study of the international indigenous disadvantaged health phenomenon. The health gradient of Taiwanese indigenous peoples is examined through exploring the health framing of the stakeholders.
2. Disadvantaged Indigenous Health: the Taiwanese Case

Taiwanese indigenous peoples\(^{13}\) are part of the Austronesian speaking peoples, the most widely dispersed ethnolinguistic population in the pre-Columbian world. Today, there are around 270 million speakers of related languages spread throughout Taiwan, the Philippines, Indonesia, Malaysia, in part of southern Vietnam, Madagascar, and all the Pacific islands (see map 1.1) (Bellwood 2009: 336). Accommodating the ethnocultural diversity has been an urgent issue in Taiwan, a newly established liberal democratic government since the lift of martial law in 1987.

2.1 General Background

Taiwan, a 35 800 sq. kilometres country with the average population density of 644.21 per square kilometres (Ministry of the Interior 2013), used to be known as ‘Formosa’.\(^{14}\) Due to its geostrategically important location, Taiwan has been occupied by several regimes. Such as the Westerners (the Spanish 1626-1642, the Dutch 1624-1661), the imperial Chinese (1662-1894), the Japanese (1895-1945), and the Chinese Nationalist (known as Kuomingtang, KMT). These occupations, as the following chapters unravel, have profound impact on Taiwanese indigenous peoples.

Ethnic group in Taiwan can be distinguished as Austronesian indigenous peoples and Han Chinese peoples.\(^{15}\) Taiwanese indigenous peoples are well-documented by their ethnic markers in national population census (Fetzer and Soper, 2011). Taiwan has officially recognised 14 tribes as indigenous peoples.\(^{16}\) The number of Taiwan’s indigenous peoples is 527 250, which is about two per cent of the entire population of Taiwan in 2012 (Ministry of the Interior 2013). They have distinct ancestral territories and struggle to maintain distinct social, economic, and political institutions within their territories. One of the most distinct feature is that they are the Austronesian speakers.

\(^{13}\) also known as Austronesian-speaking peoples of Taiwan, Formosan Aboriginal Peoples (Blundell 2009)

\(^{14}\) It is called ‘formosa’ because legend has it a Dutch navigator on a Portuguese shop in 1590 called it Ilha Formosa. Taiwan continued to be known as Formosa in Western countries until after the mid-20th century (Blundell 2009)

\(^{15}\) The Han Chinese includes Hoklo, Hakka and Mainlanders, consisting 70 %, 15 % and 13 % of the population. Hoklo and Hakka migrated from China to Taiwan before the World War II, whereas the Mainlanders migrated after the World War II, hence they are given different categories (Shih 2004: 1-2).

\(^{16}\) Amis, Paiwan, Atayal, Bunun, Rukai, Puyuma, Tsou, Saysiyat, Tao, Thao, Kavalan, Truku, Sakizaya and Seediq.
Although no written system has been found in the Austronesian languages in Taiwan, studies pointed out that there had been more than 20 Austronesian languages being spoken in Taiwan (Li, 2010) (see map 1.2). They are one of the earliest speakers of Austronesian languages, making Taiwan “Austronesian homeland” (Li 2010: 18) i.e., the Austronesian languages were spread from Taiwan. Though the number of Austronesian languages spoken in Taiwan was unclear (Tsuchida 2009: 71), what could be sure was that nearly half of the Taiwanese indigenous languages have become extinct in the past two centuries and the rest on the brink of extinction (Li 2009: 47). The Taiwanese indigenous language speakers have been dropping on an alarming rate. There is no official research providing reliable statistics about the indigenous language speaking population. Pinpu languages are the most endangered because of the larger extent of acculturation with Han Chinese immigrations (Blundell 2009: 8).

Today, most Taiwanese indigenous peoples adopt an ordinary Han peoples’ way of living. About half of the Indigenous Peoples inhabit in the urban area. It is challenging to continue their traditional way of living because although they are entitled to the land rights on their traditional territory in principle, they are mostly denied to use their land in practice (Lin 2002). Indigenous peoples are left behind on virtually every social indicators (Fetzer and Soper 2011: 101-102), such high unemployment rates, low educational attainment, low per capita income, lack of access to health care and low life expectancy. Nearly 60 per cent of indigenous household with minimal monthly living expenditure per person fall below poverty line and the disposable household income is half of all households (Council of Indigenous Peoples 2011).

For the past 400 years, Taiwanese indigenous peoples have experienced economic competition and military conflict with a series of settlers (Fetzer and Soper 2013: 27). Settler governments implemented different forms of assimilative measures and

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17 The written system of Austronesian languages, such as Siraya and Favorlang, were not established until the Dutch missionaries came in the 17th century (Li, 2010: 225).

18 For an overview of the research finding of Taiwan as Austronesian Homeland, see Li (2010), Li (2009)

19 Li (2010:55-56) describes the language loss in the Rukai tribe.

20 I inquired this information directly from the Council of Indigenous Peoples via internet on May 31 2013.

21 Austronesian speaking plains people, it was written ฎᆏ (pinpu) in Chinese language.

22 which is defined by “Amendment Draft of Certain Provisions for Social Assistance Act” in the Legislative Yuan 2010.
practiced doctrine of discovery on indigenous peoples (Afo 2000; Munsterhjelm 2004; Shih 2004). The lift of the martial law (1949-1987) was a landmark event in the period of Taiwan’s rapid democratisation in the mid 1980s (Tien and Shiau 1992: 59). In light of democratisation which began in the 1980s, indigenous peoples’ self perception had better chance to be articulated and discussed (Blundell 2012). The politics of recognition began in 1997 on the constitutional level. Such constitutional change marked the emerging subjectivity of indigenous peoples in the Taiwanese citizenry.\textsuperscript{23} It also ignited the subsequent collective indigenous rights claims, including autonomy rights, land rights and political rights (Chi and Yang 2007: 463). Until now, it is the Council of Indigenous Peoples, a cabinet level government sector established in 2005, being in charge of indigenous peoples’ recognition. In the process of democratisation, the indigenous recognition law was amended in 2001 from a patrilineal approach to a more flexible identification that relies on the indigenous family name (Chang 2009). Indigenous Basic Law, which passed in 2005, marks a different era of indigenous rights recognition in Taiwan. The Basic Law affirms the principles of ILO no.169, especially concerning the rights of ownership and possession in Article 14 (Mona 2009: 185-186; Luvaniyaw, Ruan et al. 2013).\textsuperscript{24} In accommodating Taiwanese indigenous health, their rights to medical and health service were stipulated by many laws, in particular the Amendment article 10 of the Constitution in 1994 and article 24, 28 of the Basic Law in 2005 (Ru, 2012: 150-154).

2.2 Classification of Taiwanese Indigenous Peoples

Taiwanese indigenous health policy is intertwined with a series of classifications, which are constructed by authorities in forming assimilative policy to control and rule. Long history of colonial authority and governments have impact on Taiwan’s indigenous peoples via socio-political and administrative policies (Blundell 2002: 40). Just as indigenous peoples around the world, Taiwan’s indigenous peoples encountered a series of colonial rulers due to Taiwan’s geographical location.\textsuperscript{25} Although there are different ways of dividing the historical sections, the common ground was that the most influential ruling groups were the Japanese (1895-1945) and the Han Chinese (1945

\textsuperscript{24} For other relevant comments, see Shih (2007).
\textsuperscript{25} See Shih (2009).
This thesis will first present the current classification of indigenous health policy and illustrate the historical reasons explaining for such classification.

The construction of classification system, underlying the social context of exclusion and assimilation, is a key to unravel Taiwanese indigenous peoples’ history. Three means of classification may be instrumental as starting point to consider the meaning of classifications of Taiwan’s indigenous peoples: “the individual or ethnic groups’ self perception; the government’s perception; and those perceptions made by academics (which may be split between various fields, for example linguists and ethnologists)” (See Zeitoun in Blundell 2002: 9). The clashes between different perceptions might lead to psychological stress and accumulate into serious health problems. For the purpose of implementing lawful control over the indigenous peoples, the government’s perception may disregard, if not denounce or destroy, individual’s or groups’ self perception. The government’s perception does not necessarily scientific, in fact, the classification made from the government’s perceptions was made mainly for purpose of control and rule.

There is no single responsible agency that can be held accountable for the health of Taiwanese indigenous peoples. The mandate to promote indigenous health had been scattered across different sections within the government (You 2009). Two of the most symbolic agencies with mandate to indigenous health are the Third Section within the Bureau of Nursing and Healthcare under the Department of Health and the Department of Health and Welfare within Council of Indigenous Peoples. Though both Council of Indigenous Peoples and the Department of Health have been given the mandate to be responsible of indigenous health policies, it has been the case that the Department of Health takes the central role while Council of Indigenous Peoples in the periphery of the power relations (Ru 2012: 162). For this reason, the classification in the Department of Health will be the centre of scrutiny.

26 Before the Japanese, there were Spanish controlled the Taipei basin (1626-1642), the Dutch East Indian Company (1624-1661), Ming Dynasty loyalist Koxinga (1662-1683) and the Qing Dynasty or Manchu (1683-1895). After World War II, the Chinese Nationalist’s martial law period (1949-1996) and the current independent or Democratic period (1996-present) (Blundell 2002; Munsterhjelm 2002).

27 “Bureau of Nursing and Healthcare” was changed into “Department of Nursing and Healthcare” in July 2013.
Taiwanese indigenous health policies have been the mandate area of the *Third Section* within the *Bureau of Nursing and Healthcare*\(^{28}\) under the *Department of Health* since 1998. The third section is referring to the geographical zone of mountain, offshore and remote areas. This geographical zone entails 30 mountain administrative zones, 25 plain-land administrative zones, 18 offshore islands and 65 remote areas as its mandate area (You 2009:8).\(^{29}\) Five administrative zones out of all 55 indigenous zones— that is, the mountain plus plain-land administrative zones— are not included in the remote areas category.\(^{30}\) That is to say, 50 indigenous zones are included in the category of remote areas. Indigenous peoples have been migrating from indigenous zones into the cities due to impact of urbanisation. By 2011, 31.65 per cent of indigenous peoples dwelled in the mountain zones and 25.72 per cent in the plain-land zones, while the rest — 42.63 per cent— lived in the cities (Council of Indigenous Peoples, 2013). The fluidity of the population flow creates a challenge for the Department of Health to accommodate indigenous health policy especially under their current framework that recognises the geographic marker.

The Department of Health manages and executes indigenous health policies under the framework of ‘mountain, offshore and remote areas’ on the national level (Ru, 2012: 155-156). The national indigenous health policies were developed and executed under such framework that ended up devoting budget and attention to the geographical area, but not the peoples. This mismatch has profound implication on indigenous health. Under this framework, not only indigenous peoples’ right to health is difficult to be accommodated, but the negative health consequences of indigenous migration to the urban area have been obscured because they became invisible in the indigenous health policies when they leave the mountain and plain-land zones. Such division is the direct result from the colonial classification design from the 17th century.

The distinction between mountain indigenous peoples and plain-land indigenous peoples were made in 17th century from the Qing dynasty. Mountain indigenous peoples was referred as “untamed barbarians” (or raw savages, *sheng-fan*) and plain-

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\(^{28}\) “Bureau of Nursing and Healthcare” was changed into “Department of Nursing and Healthcare” in July 2013.

\(^{29}\) The mountain administrative zones and plain-land administrative zones were combined into indigenous zone in 2002.

\(^{30}\) According to the Ministry of Interior, remote areas are referring to those administrative zones with population density lower than 1/5 of the national average population density; and the offshore islands that are further than 7.5 kilometres from the municipalities’ administrative office.
land indigenous peoples was referred as “tamed barbarians” (or ripe savages, *shou-fan*), i.e. sinicized peoples. Between “untamed barbarians” (sheng-fan) and “tamed barbarians” (shou-fan), there used to be “converted untamed barbarians” (*guihua sheng-fan*) (Ferrell 1969; Faure 2009: 110; Tsuchida 2009: 71).

“Since the 17th century, the aboriginal Formosan groups have been distinguished according to degree of adoption of Chinese culture, by such terms as ‘raw savages’ (Mandarin *sheng fan*) and ‘ripe savages’ (shou fan). (...) replaced by ‘high-mountain tribes’ (kaoshan tsu) and ‘plain tribes’ (p’ingp’u tsu), the latter terms used for the Sinicized groups and the former for groups still identifiable as aboriginal whether actually in the mountains.” (Ferrell, 1969:23-24).

The administrative distinction made between the ‘raw savages’ and the ‘ripe savages’ not only illustrate the extent of acculturation (Ferrell 1969: 23), but also a matter of tax status in practical sense as well as a degree of unruly “barbarian-ness”, which reflected the contradictions of the frontier situation (Faure 2009: 110, 115-117). In operational level, the classifications were made on three basis: family registration, taxation and military service (Xu 2009). In sum, the classification of Taiwanese indigenous peoples began in the Qing Dynasty in terms of level of sinicisation and the tax category. In the subsequent Japanese colonisation period, this categorisation was taken a step further in the political sphere.

The Japanese initiated the systematic ethnographic study of the societies and cultures of Austronesian-speaking peoples in Taiwan for the need of administering new colony (Ferrell 1969: 24; Shimizu 2009: 183). As a report to the Governor General of Taiwan for a basic native administration policy, the first well-known categorisation were established: *The Conditions of Aborigines of Taiwan* in 1900 (Wu 2012). In

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31 If one fulfilled the military service (應差), family registration (編籍) and paid taxes (納糧), one is categorised as a ‘ripe savage’. If one has fulfilled none of the above, s/he will be categorised as a ‘raw savage’.

32 Governor General of Taiwan, known as 總督府, represented the Japanese rule between 1895 and Japan’s unconditional surrender in 1945. The building has been utilised as the office of the president from 1950.

33 It was written by the Japanese anthropologists Ino Kanori (伊能嘉矩) and Awano Denmojou (栗野傳之丞). See Shimizu (2009:184).
continuation to their work, Torii Ryuzo\textsuperscript{34} completed the investigation of Taiwanese indigenous peoples which became the basis of the indigenous categorisation in the Japanese ruling period (Mabuchi 2012: 9).

The untamed barbarians, in Japanese empire’s eyes, were a failure in biological evolution. They were barely human on a sociological sense, therefore, they were not considered to be citizens (Xu 2009). On the other hand, tamed barbarians were perceived as having better chance to evolve. They were, therefore, excluded from the Japanese government’s politically adopted classification of nine tribes because the Japanese “did not feel any necessity of counting them for government control” (Tsuchida 2009: 72). In the post World War II period, Chinese Nationalist government remained reluctant to recognise indigenous peoples, specifically the pinpu (Shih 2004: 7). This reluctance increases the health risk of pinpu as chapter 2.4 will explain.

2.3 Health of Taiwanese indigenous peoples

Taiwanese indigenous peoples’ health has been left behind the national average in many health indicators, \emph{inter alia}, life expectancy, rate of death and prevalence of infection. Many commentators proposed possible reasons to explain for such phenomenon. In the end, common explanations supported by certain health framings in the Taiwanese context will be examined briefly.

Many of the public health indicators of Taiwan’s indigenous peoples are lacking behind the Taiwanese average level. Indigenous peoples die approximately a decade\textsuperscript{3} younger than other Taiwanese (National Health Research Institutes 2008; Council of Indigenous Peoples 2011). Chronic hepatitis and cirrhosis, accidents, and hypertension kill Taiwan’s indigenous peoples at 4, 2.9 and 2.7\textsuperscript{36} times the rate of death in the non-indigenous population (Council of Indigenous Peoples 2011: 85). Other evidence of the health crisis can be seen also in the increasing rate of malignant neoplasm, heart disease, drinking-related health problem, suicide and mental health disorders\textsuperscript{37} (National

\textsuperscript{34} Known as 鳥居龍藏 (とりい りゅうぞう).

\textsuperscript{35} The life expectancy gap was 10.1 years for male and 7.8 for female in the 2010 census.

\textsuperscript{36} These rates are standardised mortality rate. The crude mortality rate would be 3.2, 2.5 and 1.5 respectively.

\textsuperscript{37} The diseases prevalence differ from tribe to tribe. For example, Tsai (2010) pointed out that Tao people suffered mental disorder five times higher than the general population. The original
There have been improvements on some measures of indigenous health status, indigenous peoples continue to experience certain diseases many times higher than the general population (Cheng and Lee 2007: 226). In terms of standardised death rate of major death causes, indigenous peoples experience higher risks compared to the general population on all indicators (Council of Indigenous Peoples 2012: 84).

Chart 1. Life expectancy of Taiwanese indigenous peoples and the general Taiwanese population from 2001 to 2010 (Council of Indigenous Peoples, 2011)

One of the examples of inequality gap between indigenous peoples and the general population is life expectancy (see chart 1). The chart illustrates the gap of life expectancy among 512,878 indigenous persons and the total population (indigenous peoples included) in the end of 2010. Group/tribe-specific data on population growth rate, mortality rate and numbers of death were available while data on life expectancy was not available. In 2010, the life expectancy at birth among indigenous peoples was 70.3 years, which was 8.9 years lower than the national average life expectancy at birth was 66 years for indigenous men and 74.8 for indigenous women, which were 10.1 years and 7.8 years lower respectively than the national average. See Council of Indigenous Peoples (2012: 25-28)
The average death age for indigenous peoples were 59.8 years old, which was 10.7 years lower than non-indigenous population.\textsuperscript{39}

Various attempts were made by commentators to show the logical development or causal relations of this health disparity. The first attempt focuses on the profound impact of homogenisation policies of the old nation building model as argued by Kymlicka (2007). Under this model, indigenous peoples used to be regarded as backward and inferior (Kymlicka 2007: 64-65) thus became the target of national homogenisation. In the case of Taiwan, most of the policies before 1980s were made under the premise to upgrade the lives of barbaric mountain people by assimilative strategies (Cheng and Lee 2007: 200). The ‘homogeneous nation-state’ model and the policies of assimilation have been increasingly contested in the 1980s. The proponents argued that the national homogenisation has profound impacts on indigenous peoples, because the health policy was made in the context where state was defined as the expression of its nationhood and the construction of national homogeneity (Kymlicka 2007: 61-62).

The national homogenisation policies as manifested in the Martial law period, have impeded the development of recognising the right to health of Taiwanese indigenous peoples. The end of martial law marked an opportunity for the promotion of non-dominate groups’ rights, including indigenous rights to health. It is important to note that the Taiwanese national social welfare system emerged in Taiwan around the same time as the lift of the martial law. It was not until 1986 that the government published a proposal of national social welfare system (Jiang 2010: 24). The indigenous welfare/health policies could not have been made earlier because conditions of indigenous welfare needs, employment, health status remained ambiguous to the central government (Cheng and Lee 2007: 184-185). The central government was not interested in indigenous welfare/health related issues. It is not difficult to imagine a social welfare/health policies for indigenous peoples are still incomplete. The systematic health and social welfare policy for Taiwanese indigenous peoples existed for the first time in 1996 as the Council of Indigenous Peoples established. That is to say, it was not until then Taiwan’s indigenous peoples had channel to express their opinions about policies. Thus far, the nation-state building model explained how such mindset crippled the

\textsuperscript{39} The average death age was 56.2 years old for men and 64.7 years old for women. They were respectively 12.4 years and 8.9 years lower than the national average of death age. See Council of Indigenous Peoples (2012: 162-163)
development of Taiwanese indigenous health policy especially during the martial law period. The progress after 1987, however, faced several fundamental challenges.

The first challenge was the absence of an universal healthcare system for indigenous peoples. Although the National Health Insurance (NHI) — a compulsory program that was implemented since 1995 — aimed to create more equal access to healthcare for Taiwanese citizens across socioeconomic classes (Hsiao and Lu 2003) The total number within the NHI system had achieved 23,198,664 persons by the end of 2011, which is 99 per cent of the Taiwanese population (Bureau of Health Promotion, 2012). Indigenous peoples had difficulties to be in the system because of their economic difficulties. As a solution, Integrated Delivery System (IDS) which was implemented in 1999 as a major NHI project to increase the accessibility of medical resource for indigenous peoples. However it was to be noted that IDS was designed to promote the accessibility of medical service to inhabitants of ‘offshore and mountain area’. With annual budget of NT$ 334 million (around 8.395 million euros), more than 400,000 inhabitants of ‘offshore and mountainous area’ utilise IDS service every year (Wang, 2011). Under the current administrative design, indigenous peoples were subsumed under the ‘offshore and mountain areas’. This subsumption has created problems to detect the real needs of indigenous peoples, in the end the policy aim to improve indigenous peoples’ accessibility to medical service would not be fulfilled. Commentators argued that the current ‘offshore and mountain areas’ seriously hampered the efficiency of indigenous health delivery (You 2009: 11).

The second challenge was that the Council of Indigenous Peoples did not have the position to promote indigenous health, other than closing the loopholes of the average welfare and health system with residual measures (Cheng and Lee 2007: 208). These residual measures had limited fulfilment on the goals that the welfare and health policies designed to accomplish.

Taiwanese Indigenous peoples do not enjoy equal access to national health insurance (Lin 2001; Kulas 2004). The lack of doctors on the indigenous zones is one of the biggest challenge. As indicated below, indigenous peoples living in the tribal area needs to share one doctor among 1630 people; whereas the average of Taiwan is one doctor per 667 people. For every ten thousand indigenous peoples in the tribal area, 6.13 doctors are available, whereas the average number of doctors per ten thousand
Taiwanese people is 14.95. The inaccessibility to universal health care post negative impact on Taiwanese indigenous health.

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of people</th>
<th>Current number of doctors</th>
<th>One doctor per population</th>
<th>Number of doctors per 10000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taiwan (main island)</td>
<td>22626772</td>
<td>33909</td>
<td>667</td>
<td>14.95</td>
</tr>
<tr>
<td>Mountain areas</td>
<td>193947</td>
<td>119</td>
<td>1630</td>
<td>6.13</td>
</tr>
<tr>
<td>Offshore islands (Liuqui, green island, Penghu)</td>
<td>108156</td>
<td>80</td>
<td>1352</td>
<td>7.4</td>
</tr>
<tr>
<td>Kinmen area</td>
<td>65282</td>
<td>31</td>
<td>2106</td>
<td>4.75</td>
</tr>
<tr>
<td>Matsu area</td>
<td>9573</td>
<td>10</td>
<td>957</td>
<td>10.45</td>
</tr>
<tr>
<td>Mountain areas and offshore islands</td>
<td>376958</td>
<td>240</td>
<td>1571</td>
<td>6.37</td>
</tr>
</tbody>
</table>

Table 1. General population and numbers of medical doctor at Mountainous areas and offshore islands (Tsai, 2005)

The third challenge was that the indigenous health issues have been treated as a medical issue (Ru 2009) on the central level, other relevant determinants of health seemed to be downplayed. For example, the urban indigenous peoples’ health needs have been neglected.

As a result of rapid urban migration of indigenous peoples, over half of the Taiwanese indigenous peoples are not residing in their own indigenous counties.\(^{40}\) The vast migration to the cities has implications in health because urban indigenous peoples were exposed to risks derived from lower social economic status and excluded from social security system. Large groups of Taiwan’s indigenous peoples migrated into the cities and the most common explanation are the perspective from push-pull hypothesis:

\(^{40}\) Indigenous peoples in the indigenous counties (territory) were around 60% in 2007 and the common destination were the biggest cities in Taiwan (Chang, Lin et al. 2007: 61, 64) The urbanisation for indigenous peoples started in early 1960s (Su 2007: 4). The percentage of indigenous migration has always been increasing. It was 3.5 per cent in 1969, 8.5 per cent in 1978, 16.9 per cent in 1985 (Chang, Lin et al. 2007: 116) and it was 44.83 per cent in June 2013 according to the national census (Council of Indigenous Peoples 2013). Nevertheless 30 per cent of the population registered in the indigenous counties do not actually reside there (Chang, Lin et al. 2007: 72).
lack of employment in their territories as the major pushing factor and the tempting
prosperous industrialised city life, needs for labor and relatively better conditions of life
are the pulling factors (Chang, Lin et al. 2007: 51). It was, as the proponents of political
economy argued, not the entire story. It should also be examined from the nation-
building policies (Kymlicka 2007: 62-63) in the Taiwanese context. That is, to privilege
the dominant group’s political agenda, indigenous lands and natural resources were
seized by the state and corporates (under the permission of state in the name of
benefiting the nation) to assist Taiwan’s industrialisation in the 1950s (Chen 2007:
60-61). The vast migration was the direct result of the commercialisation and
industrialisation of mountain economy, implemented by the central government (Chen

The fourth challenge was that indigenous peoples were left behind the public
health indicators because of many interconnected social factors (Calma 2007). These
interrelated factors causing the indigenous peoples occupying an unequal opportunity to
be as healthy as majority Taiwanese population. In this regard, the socioeconomic
disadvantages could be a primary factor that place indigenous peoples at a greater risk
of exposure to behavioural and environmental health risk (Chen 2007: 63). Secondly,
indigenous peoples do not have equal education opportunities as the majority. While the
non-indigenous population achieved higher education as majority, indigenous peoples
were allocated systemically at the vocational training at the high school level (Chang,
Lin et al. 2007: 86). Thirdly, Taiwanese indigenous peoples do not enjoy the same level
of infrastructure as the majority. For example, the tap water availability percentage of
indigenous population served was 67.7 per cent in 2008 (Council of Indigenous Peoples
2009: 2-3).

Additionally, the findings presented by Cheng and Lee (2007) illustrated the
disadvantaged position of indigenous peoples in examining indigenous income,
eco...
services. Fifty per cent of the indigenous respondents utilise health service— health check-ups and NHI subsidies in particular— provided by the government. Furthermore, 75 per cent of indigenous respondents had never utilised governmental housing service because they were not informed (Cheng and Lee 2007: 250-251).

2.4 Taiwanese Indigenous Peoples without Status

The status-less Taiwanese indigenous peoples are Taiwan’s Austronesian speaking peoples who do not have official recognition because they did not fulfil the criteria required by the Status Act For Indigenous Peoples. They are even more vulnerable than their recognised counterparts— the mountain indigenous peoples and the plain-land indigenous peoples— in terms of health because they do not acquire Taiwan’s official recognition. For this reason, they are not entitled to various benefits and protection. On one hand, they are not entitled to the social welfare and health related benefits provided by the state. For example, they are not given rights to the National Health Insurance subsidies. On the other hand, many legislations that secure indigenous peoples’ right to health cannot be applied to them.41

Most of the discussion about indigenous peoples without status were referred to the struggle for recognition of the pinpu (Hsieh 2006; Duan 2012). The pinpu were once called “tamed barbarians” (or ripe savages, shou-fan) who had been assimilated over the rules of Qing Dynasty, the Japanese Empire and after the World War II (Shih 2012: 2-3). They are consist of twelve peoples (Chen 2009; Li 2009: 51), who used to reside mostly on the island’s western plains and prairie area (Hsieh 2006: 4; Blundell 2009: 8). Over the years, they had been largely acculturated by the settlers but they are still struggling with preserving their identities, language and religion (Blundell 2009; Chen 2009). Pinpu identity was suppressed and they were not visible to the public before the democratisation of Taiwan until the 1980s (Shih 2004). It was not until then that it became clear some of the pinpu were wrongly categorised into the existing officially recognised 14 tribes, other are left unrecognised (Cheng 2009: 119). Kavalan was the first pinpu group to recover their indigenous status from the existing Amis people under

41 In this regard, the legal source of indigenous rights to health from the Constitution as well as the Basic Law cannot be applied to them.
the government led by the Democratic Progressive Party (known as DPP, the opposition party to the Chinese Nationalist’s party KMT) in 2002 (Shih 2004: 10-11).42

One of the common reasons that contribute to the slow recognition process of these peoples without status was linked to the interest redistribution of indigenous peoples (Yan and Xie 2012). Opponents argue that many ‘unauthentic pinpu’ may appear only for the financial interest thus make recognising pinpu expensive for the government (Gao 2009: 521-522). Another reason is that the positions of Council of Indigenous Peoples are held by the indigenous peoples who had indigenous status already. They remained skeptical against the highly sinicised pinpu (Shih 2004: 11-12).

2.5 Taiwan’s isolated international status and its impact

Taiwan lost its permanent representation in the United Nations and had been absent in most of the international activities ever since 1971. This isolation has significant implications on the accommodation of indigenous peoples’ right to health both on the positive side as well as the negative side.

Speaking of the positive effect of Taiwan’s isolated international status, this isolation fortifies Taiwan’s determination to uphold the Western values, including human rights values, so Taiwan would gain more political leverage against the People of Republic of China (PRC). In this regard, positive impact on indigenous rights could be observed as Taiwan strives to promote its democratic image as well as ideology that in line with the United States. The legal protection on human rights of Indigenous Peoples have been actively developed in Taiwan.

The “basic structure” (Rawls 1993: 257-289) of Taiwan has been largely improved in the past three decades in three aspects. First, Taiwan made the recognition on the constitutional level to accommodate indigenous peoples. In 1994, Indigenous peoples made constitutional change to right their name from mountain people, with negative connotation, to indigenous people. In 1997, Additional Article 10-9, 10-10 were added into the Constitution which stipulate that indigenous peoples have rights to be assisted in promoting their languages and cultures, political participation, education, health, economy, land and social welfare.43 Second, Council of Indigenous Peoples was

42 See Shih (2004:13) for the illustration on the multi-layer recognition of the Kavalan.

43 See the Constitution of the Republic of China (Taiwan) at the Office of the President http://english.president.gov.tw/Default.aspx?tabid=1037#10
established to further accommodate the needs of indigenous peoples. It was the first cabinet level council that in charge with indigenous issues and was founded in 1996. Third, Taiwan took a step further to response to the claims of indigenous group rights by promulgating Basic Law in 2005. It is said that Indigenous Basic Law passed in the parliament for promoting survivals of indigenous peoples (Mona 2009). The Basic Law was a comprehensive law in response to the claims of indigenous group rights, especially self-government rights and autonomy in key matters, such as education, finance, land use, and so on. These legal protection to safeguard the principles of justice in Taiwan for indigenous peoples had direct impact on the Human Rights Reports.

The Human Rights Reports (HRR) affirms that the Taiwanese Indigenous Peoples’ civil and political rights have been protected from the record started in 1996. It recognises the laws in Taiwan ‘protects the civil and political rights of these indigenous persons’ in self-governance, policy formulation, rights protection and the development of their language and culture (The U.S. Department of State 2010). It is not the case in most of the Asian countries. According to Stavenhagen (2007), indigenous land loss caused human rights violation most severely in Asia through the form of “development projects, plantation leases, logging concessions, and the establishment of protected areas” which lead to “massive displacement of indigenous peoples from their traditional territories, the degradation of their traditional environment, and rising poverty and migration” (Stavenhagen 2007: 6). The very fact that Taiwan was excluded in the report on human rights in Asia which Stavenhagen submitted to the Human Rights Council can be regarded as one of the most significant negative impact of its isolated status.

Taiwan’s isolated international status entails the absence of international monitoring mechanism, which in turn hampers the implementation of legal promises on the domestic level. It might lead to the gap between the legal promises and actual executing realities. The sluggish progress to implement the laws might be the result of the imbalanced power relations between the state of Taiwan and the indigenous peoples (Afo n.d.). In the light of this isolated status, the power relation between the state of Taiwan and the Taiwanese indigenous peoples has not change much from the earlier colonial relationship. The Pangcah (Amis) indigenous activist, Isak Afo (2000), argues

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that the negative settler attitudes, possessed by the state and reinforced by the mass media, perpetuate the unjust inequalities and imbalanced power relations.

It was under the context of isolated international status that Taiwanese indigenous health was situated. During the last decade, Taiwan had shown its devotion to protect the human rights. Though still without official representation in United Nations, two conventions were passed in the Taiwanese parliament in 2009. Further more, the Initial State Reports on ICCPR and ICESCR were published in 2012 and Independent Experts’ Review in 2013.


46 Taipei Times 2013/03/02 by Rich Chang, available at http://www.taipeitimes.com/News/front/archives/2013/03/02/2003556053/1
3. Theoretical background

Four theoretical strands that this thesis utilises to explain Taiwanese indigenous disadvantaged health will be introduced. To start with, *expertise and power/knowledge* will supplement to the inquiries in this thesis, as three sets of data—the government, the media and the experts—are captured as forms of knowledge. In particular, this thesis regarded that news reports and policies constitute a form of knowledge mediated by text (Smith 1990: 61). These three forms of knowledge enable the inquiry of Taiwanese indigenous disadvantaged health, at the same time they enclose the scope and direction of this thesis’ inquiry. The confinement in scope and direction may hamper the validity of this analysis. In hope of avoiding such possible danger, theories that critically examined power/knowledge and expertise will be highlighted. In scrutinising Taiwanese indigenous peoples’ disadvantaged health circumstances, the *Doctrine of Discovery* will be acquainted because it plays a crucial role in realising justice for indigenous peoples as well as reconciliation. The Doctrine of Discovery links the inquiry between the present and the past, while upholding the justice and equity of indigenous peoples. Since there is unlikely to reach substantial reconciliation and sensitivity of the importance of anti-discrimination, the doctrine of discovery plays an instrumental role in the conscious-making process. Third, *critical policy analysis* provides the point of departure for the health discourse analysis from the governmental perspective. As the health issues of indigenous peoples were framed into policy objectives, the objectives were at the same time constructing the indigenous health issues. Last but not least, *other health-framing theories* that are relevant to this thesis will be introduced. Such as the analysis of discourse, theoretical paradigms within health policy and the media representation.

3.1 Expertise and Power/Knowledge

The theories of Michal Foucault will enable the critical scrutiny of the government, media and expert data. These three sets of data are treated as forms of knowledge where their limits, opportunities and possible danger that may generate will be examined. The power and knowledge were the identified ‘central concerns’ of Foucault (Townlwy 1993: 519). He understood expertise in a radically different framework than the ordinary usage which identifies experts as ‘who are particularly competent as authorities on a certain matter of facts’ (Flick 2009: 165). Instead, it was
suggested that Foucault had an ‘ultra-radical view’ on expertise (Lukes 2005: 88). Two strands of Foucault’s radical understanding of expertise will be explained in the following section.

First, Foucault understood the notion of expertise not as competent individuals telling facts. Instead, he argued that the notion of expertise was very complex because its entanglement to power/knowledge. For Foucault, experts or intellectuals, are ‘not the “bearer of universal values”’ but they are the people occupying “specific positions”. In such positions, their specificity were linked to ‘the general functioning of apparatus of truth’ (Rabinow 1984: 73). They are struggling with threefold specificity, namely, that of his class position; that of his conditions of life and work, linked to his condition as an intellectual; and the specificity of the politics of truth in our societies (Rabinow 1984: 73). As Foucault puts it:

“In other words, the intellectual has a threefold specificity: that of his class position (whether as petty-bourgeois in the service of capitalism or ‘organic’ intellectual of the proletariat); that of his conditions of life and work, linked to his condition as an intellectual (his field of research, his place in a laboratory, the political and economic demands to which his submits or against which he rebels, in the university, the hospital, etc.); lastly, the specificity of the politics of truth in our societies.” (Foucault 2001: 127-128)

It was on the last specificity of the intellectuals that their ‘position can take on a general significance’ because it was where intellectuals operate and struggle with the regime of truth (Rabinow 1984: 73). Our society is precisely embedded in the intellectuals’ struggle with regimes of truth. The battle should be understood as ‘the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true’, rather than ‘the ensemble of truths which are to be discovered and accepted’ (Rabinow 1984: 74). The term ‘expertise’, thus far, is proposed to be conceptualized from the standpoint that questions the universality of truth and power/knowledge. As Foucault put it, “a new way will be envisioned”, if we “...think of the political problems of intellectuals not in terms of ‘science and ‘ideology,’ but in terms of ‘truth’ and ‘power’. ” (Rabinow 1984: 74).
Second, expertise can be seen as a medium to be in control of certain knowledge, or having a battle “for truth” (Rabinow 1984: 74). In this way, experts have control over discourses that shape perception of a given phenomenon. Such knowledge formation is by no means a neutral concept (Townlwy 1993: 521).

“The exercise of power itself creates and causes to emerge new objects of knowledge and accumulates new bodies of information... the exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power... It is not possible for power to be exercised without knowledge. It is impossible for knowledge not to engender power” (Foucault 1980: 52)

To illustrate, the way Foucault perceived power/knowledge does not based on any traditional understanding, which can be referred as ‘knowledge may lead to power, or power may be enhanced by the acquisition of knowledge’ (Townlwy 1993). For Foucault, knowledge does not exist independently to power, but a constituent of power. Regular effects of power were induced by truth, which is ‘centred on the form of scientific discourse and the institutions which produce it’ (Rabinow 1984: 73). The scientific discourse and the institutions are part of the knowledge that should be questioned (Knights 1992 as in Townlwy 1993) As Townlwy (1993:521) explained what Faucault had observed, ‘Knowledge is the operation of discipline. It delineates an analytical space and in constituting an arena of knowledge, provides the basis for action and intervention--- the operation of power’.

In brief, Foucault argued that power and knowledge imply to one another. As Rabinow (1984: 175) explained, “there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations”. In addition, it is to be noted that knowledge as a constituent of power is the operation of discipline. As Townlwy clarified, “The focus, therefore, is how disciplinary practices operate to create order, knowledge, and ultimately power effects.” (Townlwy 1993: 523). In the scope of this thesis, explanations from the government, the media and the experts are understood to be deeply implanted in the power/knowledge relations explained above. It may be called ‘truth’, if it were to be understood as ‘a system of ordered procedures for the
production, regulation, distribution, circulation, and operation of statements.’; such ‘truth’ is embedded in a circular relation with systems of power, which produce and sustain it (Rabinow 1984: 74).

3.2 Doctrine of Discovery

Doctrine of discovery has no universal definition. However, ten elements that had been identified to recognise the presence of doctrine of discovery could be served as the departure of our inquiry (Miller, Ruru et al. 2010: 7-8). The ten elements includes (in italics): firstly, colonisers’ claim of first discovery to indigenous land which initiated the actual occupancy and possession; secondly, the colonisers took preemption to declare European title to substitute the original indigenous/native title, which led to Indigenous nations’ limited sovereign and commercial rights. Thirdly, the colonisers used the principle of contiguity to expand their control of lands as well as declared indigenous peoples do not have right to land due to terra nullius. Fourthly, the principle of christianity was employed so indigenous peoples as pagans do not have right to land. Fifthly, indigenous peoples were not suitable for owning land because they are backward in the level of civilisation. Last but not least, indigenous peoples’ land and rights were automatically transferred to the colonisers because of the principle of conquest (Miller, Ruru et al. 2010: 7-8). These elements can be used as a reference to identify the manifestation of the doctrine.

The enduring oppressive treatments in the contemporary indigenous peoples’ lives can be traced back to the doctrine of discovery. The doctrine has been employed to justify erasing indigenous peoples’ lives and identities, or creating nonrecognition or misconception that imprisons them in false, distorted, and reduced mode of beings (Taylor 1994: 25). The doctrine of discovery can be regarded as the international legal principle that has colonised the indigenous peoples for the past five hundred years (Frichner 2010; Miller, Ruru et al. 2010). Originating from the advocacy of racial, religious, ethnic and cultural superiority, it was adopted by the colonisers to justify legally and politically for “the dispossession of indigenous peoples from their lands, their disenfranchisement and the abrogation of their rights” (Economic and Social Council 2012: 2). Doctrine of discovery was used to dehumanised indigenous peoples into constructs such as ‘savages’, ‘barbarians’, ‘backward’ and ‘inferior and uncivilised’ by the colonisers so they could dominate and exploit indigenous peoples and their lands,
territories and resources (Frichner 2010; Economic and Social Council 2012). Though the colonisation and dehumanisation were common among all indigenous peoples, the manifestation of the doctrine had its localised characteristics.

Christendom’s principle is the most evident manifestation of the doctrine in the Western countries (Newcomb 1992: 18). Special Rapporteur of Permanent Forum of Indigenous Issues Tonya Frichner called it “the doctrine of Christian discovery” (Frichner 2010: 7). The Doctrine of Discovery has been built upon various theological and legal doctrines, during and after the Crusades that dehumanised the non-Christians. In the 15th century, the Pope gave privilege for Christian nations to enslave and conquer the pagans (Newcomb 1992).

“In the bull of 1452, Pope Nicholas directed King Alfonso to ‘capture, vanquish, and subdue the saracens, pagans, and other enemies of Christ,’ to ‘put them into perpetual slavery’ and ‘to take all their possessions and property.’ (Newcomb 1992, page in Davenport year 20-26)

Thus far, commentators argued that doctrine of discovery was created under the context of declaring war against all non-Christians throughout the world, specifically sanctioning and promoting the conquest, colonisation, and exploitation of non-Christian nations and their territories (Newcomb 1992). Under the context of the United States, the doctrine of discovery was first officially identified as ‘a principle’ as part of ‘the law of Christendom’ in 1835 by Judge John Catron after its first manifestation five centuries ago (Frichner 2010: 7). In 1823 the USA Supreme Court ruling Johnson v. M’Intosh 8 Wheat. 543 case also shows that ‘Discovery had become American law after already being English colonial law’. The Supreme Court held the position that ‘under this international law when a European, Christian nation discovered new lands it automatically gained sovereign and property rights over the non-Christian, non-European peoples even through Indigenous nations and peoples were already occupying and using the lands.’ (Miller, Ruru et al. 2010: 3).

While the Western interpretation dominated the discussion of the doctrine of discovery, it is to be noted that the manifestation of doctrine of discovery took its

47 See Frichner (2010: 17-21)
unique form in Asia and Africa. As Tauli-Corpus, the former chair of United Nations Permanent Forum on Indigenous Issues, noted in the 11th session, such doctrine has not been articulated to justify states’ domination in the context of Asia and Africa. She emphasised that the Asian countries continued to adopt the colonial laws, which result in indigenous slavery. It is crucial to be aware that such dominating doctrine may not necessarily take the form through Christianity expansion, especially under the context of Asia. The doctrine may take different forms and has been practiced through different concepts around the world upon indigenous peoples.

On the international level, the doctrine of discovery has emerged to be recognised to serve as one of the major roots of contemporary discrimination against indigenous peoples. In the eighth session of the UN Permanent Forum on Indigenous Issues (UNPFII) in 2009, Special Rapporteur Tonya Gonnella Frichner was appointed to conduct a preliminary study on the impact on indigenous peoples of the international legal construct known as the doctrine of discovery. Consequently, the doctrine of discovery was evaluated to be closely linked to contemporary ‘economic and social development, culture, the environment, education, health and human rights’— which was the theme of the eighth session of UNPFII— of the indigenous peoples. In 2012, UNPFII included doctrine of discovery as the special theme: ‘The Doctrine of Discovery: its enduring impact on indigenous peoples and the right to redress for past conquests (articles 28 and 37 of the United Nations Declaration on the Rights of Indigenous Peoples)’. It was argued that evidence of the doctrine of discovery can be found in the international definition of ‘indigenous peoples’ in the early 1970s, 1981 and 1995 (Frichner 2010: 13). In the Final Report Study of the Problem of Discrimination Against Indigenous Populations (1982), Cobo employed key concepts that identify and acknowledge dominance as the context of indigenous peoples, such as ‘pre-invasion’ and ‘pre-colonial’. Such terms demonstrated the invasion of indigenous peoples’ territories was more than an allusion and his consent that the patterns of colonialism and colonisation had taken place. In addition, the term ‘prevailing’ acknowledges the non-indigenous societies gained ascendancy and to have a ‘superior force or influence’. And ‘non-dominant’ illustrated the invading settler societies claim dominance over indigenous peoples while violating the individual and collective human rights of indigenous peoples (Frichner 2010: 16).
For centuries the doctrine of discovery has been employed by the states in their assertion of sovereignty over the indigenous peoples (Newcomb 1992). Its manifestation has influenced indigenous health immensely. For example, the state’s notion of law and legality are deeply affected by the doctrine of discovery because it has been firmly entrenched in State’s legal history. Many of the institutional design and execution targeting health promotion had been directly or indirectly acknowledge the presence of such principle. The institutional design and implementation to improve indigenous health, which based on these principles in question, may lead to opposite health outcomes.

3.3 Critical Policy Analysis

Building a healthy public policy is central to health promotion action, according to the Ottawa Charter for Health Promotion (1986). The Taiwanese health promotion policies, which were promulgated as a response to the Ottawa Charter, will be examined in the analysis. There are two forms of policy analysis will be highlighted: the conventional and the critical policy analysis. In the first part, the conventional policy analysis will be presented to give a context of how critical policy analysis formulated. In the subsequent part, the critical policy analysis will be explicated as the major policy analysis instrument of this thesis.

The conventional policy analysis places emphasis on ‘stages’ of policy making in order to create “solvable problems” (Wildavsky 1979: 17). Patton and Sawicki (1986: 46-53) identifies six steps of policy analysis for the purposes of ‘evaluating’, ‘cutting problems to manageable size’ and ‘reducing subjectivity’. The six steps are problem definition, determination of evaluation criteria, identification of alternatives, evaluation of alternatives, comparison of alternatives, and assessment of outcomes. Another classical case of conventional policy analysis is Jennings (1987), who distinguishes three models of policy analysis: the Science model, the Advocacy model and the Counsel model. First, policy analysis as science bases on strong objectivity and embedded in positivists’ (as well as empiricists’) philosophical presupposition. The analysts under this model of Science, consequently, search for brute facts that are ‘out there’ and carefully adopting the methods and stances of the natural sciences. Jennings (1987:138) reminds us that the policy analysts of Science model can be seen as
advocates only in a very specific sense: they are the loyal advocates of scientific rationality, neutrality and positivistic principles.

In addition to the policy analysis as science, the advocacy model holds the skeptical ground towards the science model. The proponents of the advocacy model claim that the positivistic science model is ‘an illusion masking the inherently value-laden character of any analytic method’. The reconcile point is the Counsel model, ‘a profession with a different normative content and a different epistemological self-understanding to guide his practice’ as Jennings puts it. The Counsel model entails the ‘post-positivistic objectivity’ and interpretive social science (Jennings 1987:143).

On the other hand, critical policy analysis rises from the critique of the conventional policy analysis’ deductive evaluation and monotonic problem identification. It was observed that many health promotion still focus on altering individual health behaviours rather than the social, cultural, environmental, structural and economic circumstances within which people live (Bastian 2011: 111). To examine beyond individual health behaviour, scrutinising ‘policy frame’, or in Bacchi’s wording ‘reflexive framing’— which starts from the premise that concepts are ‘essentially contested’ (Bacchi 2009)— offered a solution.

Here, Verloo’s definition of ‘policy frame’ has been utilised: ‘an organising principle that transforms fragmentary or incidental information into a structured and meaningful policy problem, in which a solution is implicitly or explicitly included.’ (Lombardo, Meier et al. 2009: 11). In this regard, critical policy analysis captures substantial aspects that this thesis aims to answer. It takes into account the political and contextual factors of the development and process through which the policy was conceived. As argues in the public health nutrition analysis by Bastian (2011), ‘Policies can represent problems in various ways through the types of solutions they offer’. In analysing nursing policy, Cheek (1997: 671) highlights the importance of policy development and implementation for they have impact on the shaping as well as understanding of the practices. The central notion of critical policy analysis is that there is no single absolute objective truth, but different ways of viewing or understanding. Policies, in this sense, ‘represent problems in various ways through the types of solutions they offer’ (Bastian 2011: 112).

48 See, for example, the critical analysis of gender processes in policy making by Jalusic (2012).
analysis, in consequence, ‘exposes the ideologies and values underlying policy issues and their proposed solutions, and the inclusiveness or the exclusiveness of the policy debate’ (Duncan and Reutter 2006: 244).

3.4 Framing Health

The notion of ‘framing’ is to identify and analyse the reasons that contribute to Taiwanese disadvantaged indigenous health via examining the range of ‘scripts’ that were reiterated in the policies, reproduced in the media, and consolidated among experts. The concept of ‘health’ is understood under the perspective that it was embedded in its own culture and distinctive knowledge system. Therefore, localised knowledge systems were produced by different cultures because their dissimilar nature and distinct interests in the surroundings and environment (Narayan and Harding 2000: 250). This section will discuss health and framing respectively and introduce health framing with examples of health framing. It will explicate media representation as media data was employed in the framing analysis.

To begin, health is an indeterminate goal and its meaning depends on time and place, and cultural norms (Bacchi 2009: 138). Health can be referred differently under different circumstances, depending on the distinctive locations where the speakers possess. Therefore, the notion of health and the approach to health change as it travels from one culture to another. In this regard, health is not a fixed idea or a measurable quantum, but a slippery concept (Bacchi 2009: 128). In fact, the concept of health has been often objectified into statistics form which is necessary to the ruling of contemporary societies (Smith 1990: 107). The focus here is not to examine the underlying institutional relations of power that goes hand in hand with the production and interpretation ‘facts’ as expressed in textual realities of the statistics. Rather, this thesis is interested in exploring the interpretations of disadvantaged indigenous health materialised in text, as in the policies, media reports and experts’ knowledge.

On the other hand, the notion of framing employed in this thesis can be viewed under the framework of ‘analysis of discourse’, which is a distinctive analytic tradition from “discourse analysis”. It derives from social psychology and aiming to construct texts through linguistic and rhetorical devices (Bacchi 2009). The goal of ‘analysis of discourse’ is to identify the discourses, which have been supported by institutions and influenced by cultures, produce particular understandings of issues and events (ibid:
22). Though the term discourse appears ambiguously in frame analysis for it serves as a rough synonym for a range of objects (ibid: 23), it is referring to the explanations of disadvantaged indigenous health in the policies, news and expert interviews from in the this thesis.

Goffman’s *Frame analysis: An essay on the organization of experience* marks initiating interest in human framing practices (Bacchi 2009). Framing can be defined as “connecting beliefs about social actors and beliefs about social relations into more or less coherent packages that define what kinds of actions are necessary, possible and effective for particular actors.”(Ferree 2009: 89) It is of special interest of this thesis to examine the ‘known world’ about indigenous health represented by the media reports, as well as the government and the experts.

It is base on this particular understanding that framing health matters. The explanations provided for indigenous disadvantaged health are the concrete realisations of the health framing process. By investigating the explanations of disadvantaged indigenous health, this paper wishes to unravel the patterns of assumptions-- that are not necessarily made explicit-- by exploring the discourses of health framing. The following part will give Bacchi (2009:128-129) as an example.

Bacchi (2009: 128-129) identified two theoretical paradigms within health policy: a biomedical paradigm and a social paradigm. These two paradigm are very distinct from each other for two reasons. First, the genesis of health rests on a narrower premise for one, but broader for the other. In the former, health is framed primarily on physical disease. Bodies are regarded as machines that can be repaired when malfunctions occur. Whereas for the latter, health is framed as synonyms of wellbeing that refers to a more holistic understanding, stretching beyond the biomedical sense of health. Second, each paradigm contextualises ill-health and its cause in their own way. The former framed health in terms of absence of disease, the proponents of this paradigm argued for the importance of biological risk factors to avoid ill-health. On the other hand, the advocates of the social paradigm of health put emphasis on the importance of social factors in determining health and illness. As signalled in Ottawa Charter that deems ‘fundamental conditions and resources for health’ as ‘peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity’ (Ottawa Charter for Health Promotion 1986 as in Bacchi 2009: 129). In addition, prevention is one of the key concepts that cut across the two paradigms. In asking “what kind of a
‘problem’ is ‘prevention’ represented to be?”, Bacchi (2009: 130) addresses that the core dispute lies in whether individuals should be held responsible for their (poor) health due to their active (poor) lifestyle choices, ‘The biomedical paradigm, while primarily curative in orientation … has … preventive dimension. (...) Immunisation and screening programs are examples of biomedical preventive programs.’ (Bacchi 2009: 130) In this way, individuals were easily held responsible from the biomedical preventive point-of-view because individuals were assumed to be able to actively change their harmful behaviours to avoid diseases.

The tendency that echoes with the preventive dimension of biomedical paradigm has been observed in explaining Taiwanese indigenous disadvantaged health. The preventive dimension of biomedical paradigm has manifested in overly relying on the behavioural factors as the cause of disease (Bacchi 2009: 130). In response to the biomedical paradigm, social epidemiology and social determinants of health (SDH) were proposed (Bacchi 2009: 132). Bacchi (2009) reminded that examining through the social paradigm does not necessarily guarantee we automatically stop understanding the problem in terms of risk factors, which tend to blame individuals. She suggested to focus on the social determinants of health inequalities (or health inequities), because this way of inquiring enables us to examine social and environmental influences harm some groups more than other groups (Bacchi 2009: 141)

The health framing will be examined through media representation. This thesis examines mass media reports as one of the explanatory sources of health disadvantages in Taiwanese indigenous peoples. Mass media and its representation are embedded in their particular context that participates in the power function of public opinion shaping and the particular power distribution in the certain social context (Kuu 2010: 19-21). Thus, media does not passively reflect social reality, but actively intervene the production information. Media is not a mirror, but more closely associated with framing and knowledge-producing function. Wodak gives mass media as an example to illustrate how Discourse Analysis can be used in “disclosing the discursive nature of much contemporary social and cultural change” (Wodak 2004: 188). Mass media and its language is scrutinised as a site of power and as a tool of representation. Media representation is involved with knowledge reproduction that reinforces certain ideologies that support particular ways of distribution.
In this thesis, emphasis will be placed to examine the ‘framing health’ of the government, media and experts through their ways of arguing (frames) (Bacchi 2009: 27-29), which have direct effect on indigenous peoples’ self-perceptions, public discourses and policy decision-making. The topics of Indigenous peoples’ well-being and health have been treated as a medical issue (Ru 2012) or cultural issue. In Health Minister Chen’s words in 2001’s seminar of national medicine association, “Due to the cultural differences, indigenous peoples tend to have higher percentage of depression and suicide rate.” (Kolas 2003) Such framing often lead to the ‘culture-blaming’ problem, that state actors and institutions blamed problems on minorities’ cultures. This deterministic view is argued to portray certain cultures are portrayed as inherently harmful (Kantola 2010: 163). It is crucial and urgent to scrutinise the ‘framing’— the meaning and concepts— of indigenous health, which were reproduced and perpetuated in the discursive politics (Lombardo, Meier et al. 2009: 10).
4. Framework for Methods

This thesis offers an overview of the method framework of conducting the research that examines the explanations of Taiwanese indigenous peoples’ disadvantaged health. To begin with, the Data Collection Method gives a concise report on the rationale and approach of data collection from the government, the media and the experts. Secondly, Data Analysis introduces Qualitative Content Analysis (QCA) as the major analytical tool employed in this thesis. Thirdly, Coding Frame Development reviews the framework built with both concept-driven and theory-driven techniques. To ensure the reliability of the coding frame, results of reliability checks will be reported in this section. Last but not least, Ethical Concerns and Researchers’ Position will be discussed.

4.1 Data Collection Method

Three sets of data were collected for the Taiwanese indigenous peoples’ disadvantaged health-framing analysis, including the Annual Reports from the governmental agency, the news reports from the media and the interviews with the experts. First, Annual Reports for Public Health have been used as targets of governmental policy analysis for the reports contains consistent and concise information about Taiwanese government’s health policies. Second, media reports were collected via news database from various news agencies. Lastly, experts’ opinions had been collected through semi-structural interviews with snowball sampling. This thesis will explain more in details the methods of data collection and analysis in each specific field below.

4.1.1 Government Data Collection

For the data from the government, nation-wide Annual Report on Public Health (ARPH) published by the Department of Health\(^49\) were selected as a way to explore the explanations of the indigenous peoples’ disadvantaged health. ARPH is an inter-agency collaboration between all sectors within the Department of Health. Due to the fact that

\(^49\)“Department of Health”（衛生署） was changed to “Ministry of Health and Welfare”（MOHW, 衛生福利部） in July 2013.
healthcare policies related of indigenous peoples have been absent in the annual reports from the agencies, ARPH is the best available choice for the data analysis.

This thesis collected the ARPH from the year 2001, the earliest available annual report, to the year 2012. Most, if not all, important health projects concerning indigenous peoples can be found in the APRH. Such as Tribal Health Promotion Plan, Integrated Delivery System (IDS) and Alcohol-control Program (ACP). The length of the annual reports are as follows (without appendix): 124 pages in 2001, 102 pages in 2002, 98 pages in 2003, 98 pages in 2004, 102 pages in 2005, 106 pages in 2006, 115 pages in 2007, 115 pages in 2008, 111 pages in 2009, 97 pages in 2010, 105 pages in 2011, 108 pages in 2012. Of total 1281 pages of these twelve ARPH articles between 2001 and 2012, Taiwanese indigenous healthcare were mentioned in 18.5 pages.

The policy description dealing with indigenous health in the ARPH are illuminated with the feature of concision on one hand, but on the other hand repetition and ambiguity. The ambiguity caused challenge in developing the coding frame, in particular ensuring the face validity and content validity (Schreier 2012: 185-186). The coding frame was developed after acquiring the clarifications from the experts.

4.1.2 Expert Data Collection

This thesis takes the stand to be more interested in experts’ capacities for certain field of activity as representing a group (of specific experts) (Flick 2009: 165) That is, it is the capacities rather than the individuals that are in the central of the analysis. The experts’ knowledge, often known as authoritative knowledge, can and should be analysed, because the appeared mysterious or natural authority ‘establishes cannons of taste and value’ as well as produces truth (Said 1979: 19-20). This thesis connects experts’ specific positions (of their disciplines), their constituencies and their parameter of the health notion and thereby examines a fuller picture of the explanations of disadvantaged indigenous health.

In the scope of this thesis, expert interviews were conducted to collect the data for the health framing analysis because for one, the topic concerning health is a highly specialised knowledge. The specialised interviewing, therefore, is considered to be more suitable than mass interviewing in terms of validity and reliability. For another, 

50 Several agencies in Department of Health have their own annual reports, such as Annual Report by Bureau of Health Promotion, Annual Report by Centres of Disease Control (CDC), and so on.
literature and sufficient quantitative information is difficult to obtain due to the study of indigenous health framing is an emerging topic in Taiwan. Under such circumstances, expert interviews are more appropriate (Patton and Sawicki 1993: 97-98). For still another, experts’ opinions are intertwined in the context of health framing of indigenous peoples. They are referred in the news and consulted by the government. From time to time, people tend to assume their knowledge as truth and do not dare to question their legitimacy, regardless their opinions had been mistranslated to various degrees through the production in the media representation and the policies (Toivanen 2008: 207-208). For these reasons, examining experts’ opinions and bias via interviewing was chosen.

Concerning the format, the interviews are all acquired with semi-structured interviews because such not-standardised information are better sources for analysis of their discourses. The snowball sampling has been employed because the topic in question concerns specific knowledge that was only known to and could be articulated by certain people. The principle of representativeness is ensured in the sampling process. Informed consent and study design are presented and explained a prior to each interview.

The interviews were conducted in two field trips to Taiwan in the summer of 2012 and winter of 2013. The shortest time for the interview was 42 minutes and the longest was 1 hour and 37 minutes. In the eleven interviews, seven are conducted with recording and notes whereas the other four interviews are documented with detailed notes. All the interviews are conducted in Mandarin Chinese.

As a result, eleven interviews are conducted. Three of the informants have official positions in the central government. Eight of the informants are researchers who have professional training in their respective fields. Two of them are local doctors. Most of them have been involved with indigenous health improvement programs, ranging from grass level to national level (see table 2). Abbreviations are employed for the purpose of anonymity. In the following text, IS refers to Indigenous Scholar, NIS refers to non-indigenous scholar, ILD refers to Indigenous Local Doctors, and ICS refers to Indigenous Civil Servants.

Seven of the experts were indigenous peoples and the others were not of indigenous origin. Most of the interviewees are in their 40s or 50s. Two of the informants were conducted within one interview because of their limit of time and the nature of their research expertise shared high similarity. Two of the experts were
interviewed twice for further clarifications on the notes. The attitude principle of ‘flexible, objective, empathic, persuasive, a good listener’ had been taken into the interview process (Flick 2009: 195).

This thesis identified challenges during the expert interviewing process. It was less on identifying experts or finding appropriate informants, but more on difficulties on ‘excluding unproductive topics’ (Flick 2009: 167). Such as experts tries “to involve the interviewer in ongoing conflicts in the field and talk about internal matters” instead of talking about the topic of the interview; or the experts “changes the roles of expert and private person” but not directly relevant to the capacities; or the “rhetoric interview” occurred that the experts gives lectures on their knowledge instead of responding to the questions posted by the interviewer (ibid).

Table 2. List of interviewees and their information

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>interview date and time</th>
<th>Means of documentation</th>
<th>Profession of the interviewee</th>
<th>Gender</th>
<th>Indigenous background</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. IS1</td>
<td>7/2/12. 48:56</td>
<td>Recording and notes</td>
<td>Professor and the national health promotion responsible person</td>
<td>F</td>
<td>Yes</td>
</tr>
<tr>
<td>2. NIS1</td>
<td>(1st)7/17/12. 51.47</td>
<td>Recording and notes</td>
<td>Researcher</td>
<td>M</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>(2nd)2/13/13 42.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. NIS2</td>
<td>(1st)7/27/12. 1.22.30</td>
<td>Recording and notes</td>
<td>Professor</td>
<td>M</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>(2nd)2/20/13 1.22.45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. IS2</td>
<td>6/22/12. 50.47</td>
<td>Recording and notes</td>
<td>Professor and the national health promotion responsible person</td>
<td>M</td>
<td>Yes</td>
</tr>
<tr>
<td>5. NIS3 and</td>
<td>June 2012</td>
<td>Notes</td>
<td>PhD students</td>
<td>F</td>
<td>No, Yes.</td>
</tr>
<tr>
<td>IS3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. IS4</td>
<td>July 2012</td>
<td>Notes</td>
<td>Former MP</td>
<td>M</td>
<td>Yes</td>
</tr>
</tbody>
</table>
4.1.3 Media Data Collection

This thesis utilised 98 reports from Taiwanese media, including both the mainstream media and the non-mainstream media, in the representation of indigenous health framing analysis. Among the 98 reports, 17 reports were used for the first pilot study whereas 10 was used for the second pilot study. The media reports include a variety of sources, including the China Times and the Liberty Times, Focus Taiwan News Channel, Health News, K.S. News, Epoch Times, Lihpao, News Taiwan, Poja news, Public Television Service Taiwan (PTS Taiwan), Taiwan Indigenous TV and UHO news. Among these 98 reports from 12 media sources, the length varies from half the page to six pages. The earliest report can be dated back to year 2000, while the latest one is year 2012. Each report had been saved as primary document for the further analysis with Atlas.ti, a Computer-Assisted Qualitative Data Analysis (CAQDAS) software that facilitated the process of coding, creating categories and retrieval systems (Schreier 2012: 241-242). Both version six and seven of Atlas.ti were utilised. Employing Atlas.ti allowed more transparency in terms of how categories have been developed and analysed (Flick 2009: 370). It is to be noted that the researcher is aware of the software Atlas.ti is ‘only a tool for facilitating analysis and interpretation’ for it ‘needs to be guided by a method’ (Flick 2009: 371). The Atlas.ti program was employed in this thesis as a QCA complementary tool.

| 7. NIS4 | June 2012 | Notes | Former Minister of Health | M | No |
| 8. ILD1 | 2/12/13 1.02.53 | Recording and notes | Local doctor | M | Yes |
| 9. NIS5 | 2/14/13 1.37.35 | Recording and notes | Professor and the national health promotion responsible person | M | No |
| 10. ICS1 | 2/19/13 | Recording and notes | Civil servants at CIP | M | Yes |
| 11. ILD 2 | Feb 2013 | Notes | Local doctor | M | Yes |
Two pilot studies had been conducted to discover the shortages of the coding frame. The coding frame development from the media data reflects the dynamic inquiry process that involves re-evaluation and refinement of the research focus. The goal of the coding frame is to examine the existing explanations of disadvantaged indigenous health, as well as to scrutinise the explanations that were equally important but being left unaddressed in the media reporting. In this way, the coding frame addresses both the ones that play the major role and the others that are prone to be neglected in the media representation.

The possible limitation of my media data is that there has been limited Taiwanese news report on indigenous peoples as a whole. Looking for information for indigenous well-being and health is even more challenging. Consequently, the possible limitation of the data collection is that the media representation might be concentrated in the online Taiwanese media materials. Nevertheless it is a resource for the analysis to examine the biased reasoning in the news reproduction. It is meaningful to show what had been systematically ignored from the Taiwanese data, by leaving the category empty. The main purpose of this study is to make the best use of QCA’s systematic nature (Schreier 2012: 5-6).

In brief, the rationale and approach chosen in the data collection for the government, the media and the experts have been introduced respectively. The aim of collecting these data was to complement the currently biomedical orientated scope of indigenous disadvantaged health research under the Taiwanese context. The sampling for the media and government may not fulfil the principle of exhaustion and exclusiveness due to the limitation of time and funding. Nevertheless the available data is able to provide sufficient information for adequate analysis.

4.2 Data Analysis

Qualitative Content Analysis (QCA) is utilised to examine the patterns of disadvantaged health with a critical-interpretive attitude (Schreier 2012: 49). The patterns of explanation are not treated as unproblematic truth, but are comprehended in a way to question the similarities and dissimilarities between them. The construction of the coding frame enables the author to emphasise on the addressed reasons as well as those reasons that have been excluded, the said as well as the unsaid. Its case-oriented feature enables us to take a holistic stand of examining the health crisis. As Schreier
(2012: 25-26) put it, “the total is more than the sum of its parts: the case is more than any number of variables taken together to describe a case”. The rationale of applying qualitative approach to content analysis will be introduced, followed by the segmentation and coding of the collected data.

The first rationale of analysing the health framing data of Taiwanese indigenous peoples with QCA is because it shares and combines characteristics of both qualitative and quantitative research (Schreier 2012: 35). QCA has features from qualitative research, such as emphasising on interpretation, reflexivity, inductive coding frame building and validity (ibid). QCA has been used to unravel the functions of health framing which this paper aims to study because just as other qualitative methods, it took into account the complexity of content-dependent meaning. Additionally, qualitative methods consist of drawing attention to ‘plausible relationships proposed among concepts and sets of concepts’ (Anselm Strauss and Juliet Corbin 1994:278, as in Babbie 2007: 378) with the premise of dynamic interplay between data collection and theory. Therefore, choosing the qualitative approach of content analysis enables the textual materials being analysed in a way that does not easily overlook the complex, holistic, and context-dependent meaning (see Kracauer (1952), as in Schreier 2012: 13).

Both of the qualitative and quantitative characteristics will be utilised in the analysis to describe systematically the pattern of health framing strategies. Meanwhile the analysis will not stop at the frequency counts, because the higher the frequency does not necessarily correspond to the larger extent of importance (ibid). On the contrary, it may be the less-mentioned ones that carry greater significances. Seven of the qualitative dimensions will be highlighted to further illustrate the rationale that this analysis focuses to utilise both qualitative and quantitative features while remains conscious in developing beyond frequency counts. First, the focus of QCA is on latent meaning that are not obvious or immediately-seen. Second, it pays strong attention to local context instead of universality. Third, variable approaches of handling reliability. Fourth, validity checks just as important as reliability checks. Fifth, the coding frames are at least partly data-driven because it is not validating theories that is important, but capturing what is inside my materials that is more essential. Sixth, QCA is more likely to make inferences to context, author, and recipients. Such inference is built on the basis of validity. Finally, QCA is more flexibility in going through the steps, compared with quantitative content analysis that always follows a certain series of steps (Schreier 2012:
On the operational level, it is essential to emphasise the descriptive feature embedded in the seven characteristics. This leads to the section rationale of choosing QCA.

The second rationale of choosing QCA as the method is because it is highly descriptive that allow space for the discursive explanations naturally flowing out from various data source (Schreier 2012: 2-3; Flick 2009: 328), at the same time, QCA allows interpretation to flash out the long-ignored determinants of health within the coding frame development (Schreier 2012: 20-21). It is precisely because its subjective interpretation and systematic classification process of coding (Hsieh and Shannon 2005: 1278) that allows the space of describing what is there in the materials.

As far as materials is concerned, QCA is ideal to apply to health research because it is flexible to be applied to a variety of textual data. This is the third rationale of choosing this method. As Hsieh and Shannon observed, ‘it offers researchers a flexible, pragmatic method for developing and extending knowledge of the human experiences of health and illness’ (2005). QCA has been used extensively in health research and becoming increasingly common (Hsieh and Shannon 2005). Just as mentioned above that validity is as important as reliability, the other important features of QCA is the development of the coding frame. QCA can be categorised into different types according to the development of initial codes. Hsieh and Shannon (2005) distinguish three QCA approaches: the conventional content analysis, directed content analysis and summative content analysis. The key differences among the three approaches lie in the different strategies to develop codes (Hsieh and Shannon 2005: 1286). Examples were given for each approach from the area of end-of-life (EOL) research. Since the existing theories are limited, the directed content analysis is consider less relevant to this paper. Summative content analysis that starts with keywords is not applicable because this thesis is interested more on the disadvantaged health discourse, not just specific words. However it may be interesting nevertheless for the future research. Conventional content analysis may be the closest tradition for this paper to take reference from.

Lastly, the fourth rationale of making QCA the analytical method is because it provides solid basis for coding. It enables “the discovery of patterns among the data, patterns that point to theoretical understandings of social life”(Babbie 2007: 384). This feature is central to unravel the health framing because the analysis requires segment and code the three sets of data into the coding frame.
So far, four rationales of choosing QCA as the tool for analysis has been introduced. In the subsequent sections, this thesis gives brief descriptions of how QCA applied in the government, the media and the expert interviews. In the government analysis, each of the twelve ARPH articles will be a unit of analysis. The unit of coding was not identical to the unit of analysis, but smaller. That is to say, the unit of analysis contained several unit of coding. Formal criterion was employed because the inherent structure of the data was clear. The segmentation was utilised by ‘skipping the statements that overlap at the level of the generalisation’; Codes were marked ‘on the intended level of abstraction’ to ensure only the segments that were highly relevant to the research question remain (Flick 2009: 323-327). The findings from the Report give a fuller content to the coding frame (see below). The coding for the government data had been done manually.

In the media analysis, each piece of news was utilised as an unit of analysis. In most cases, the unit of analysis contained several unit of coding. However, in one article that dealt with smoking-free indigenous county, the unit of analysis and the unit of coding was identical. The code ‘excess tobacco consumption’ was given in the Atlas.ti for that particular article. Thematic criterion was used to the process of unit of coding. The themes that are central to the thesis were not present in the material, therefore an alternative conceptualised theme was introduced to ensure the themes were applicable to the coding frame (Schreier 2012: 136-138).

In the interview analysis of the experts, individual pieces of data with the key timing retrieval system was identified due to the large amount of data. That is to say, the timing and important terms in the interviews had been marked down, so to facilitate the researcher to retrieve certain terms used by the interviewee that was relevant to the categories from the coding frame. Mandarin Chinese was utilised when written the markings because it was the language which was spoken in the interviews. The thematic criterion was employed on the experts’ interviews. There are eleven units of analysis and each unit of analysis contains several units of coding.

In conclusion, QCA was chosen to function as the analytical tool for its capacity to describe systematically the patterns of phenomenon. QCA is suitable for exploring the explanations across three data sources, in doing so, it flashes out the health framing of Taiwanese indigenous peoples. The coding frame, which was developed with QCA, raises the opportunity to problematise the existing explanations for the disadvantaged
indigenous health: they prone to be tied up with certain explanations, but not others. It is of scientific and social significance to take a closer look at the matter in question. In the following section, this thesis looks closer at the development of the coding frame for it is instrumental in the health framing analysis process.

4.3 Coding Frame Development

Coding frame building was the third step of the standard sequence of QCA (Schreier 2012: 5). A coding frame is defined as followed: ‘a way of structuring your material, a way of differentiating between different meanings vis-a-vis your research questions.’ (ibid: 61). In the scope of this thesis, the coding frame consisting of four dimensions and two levels were built to flash out the wide range of explanations across three stakeholders. The four dimension were publisher, health problem mentioned, reasons given for poor health and who is to blamed. As to concentrate in the research the question, dimension three ‘reasons given for poor health’ will be prioritised in the analysis.

In terms of the structure of the coding frame, the method to generate subcategories was the combination of concept-driven and data-driven (ibid: 84). Three theories were consulted to develop the coding frame where concept-driven played an essential role, including International Classification of Diseases (ICD), risk factors introduced by World Health Organisation, health inequality explanations (Bartley 2004). These theories had inspired and influenced in the development of the coding frame. In particular, the influence was shown in the application of the classification of diseases in dimension two as well as the sub-categories development for ‘behavioural risk factors’ in the dimension three from the WHO. Incorporating ICD, the top ten causes of death for indigenous peoples were revised into the final coding frame with all other aspects that described as ‘indigenous health problem’. On the other hand, five inter-related risk factors to health proposed by AIHW were identified and generated into the subcategories of the coding frame. In addition, the cultural-behavioural explanatory models for health inequalities by Barley (2004) had inspired the coding frame development.

In terms of data-driven strategy, initially 16 determinants of indigenous health were identified. The data used to generate the coding frame was from the media because it covered diverse viewpoints and strong linkages between itself and the policies as well
as the expertise. The data-driven determinants of health include lack of health behaviour and habits, lack of healthy diet, lack of healthy concepts, reside in remote area, lack of medical infrastructure, lack of health life style, poverty, unable to adapt to the modern society, bad water quality, bad living environment quality, inherit genetic determinism, workplace discrimination, sense of alienation, politics (such as polarised political dispute), not enough national health insurance support and changing role of local health centre. Although not all determinants above were included in the final coding frame, all of them were considered in the final analysis from the data of three stakeholders.

After explicating the coding frame was developed with data-driven strategy with inspiration from the theories. It is necessary to explain how to ensure the quality of the coding frame, which lies in objectivity, reliability and validity.

This thesis is aware of four principles of reliability checks in accomplishing a good coding frame. Namely, unidimensionality, mutual exclusiveness, exhaustiveness, and saturation (Schreier 2012: 71-78). In particular, internal reliability has been utilised to ensure the reliability in the process of preparing the main coding. The result of the internal reliability check was promising. The quality of the coding frame had improved and the results of the consistency check remained steady. There were, however, some minor improvements that needed to be made. The problem was solved by examining again the context of their statements, or putting them in the ‘other’ category. This thesis utilised experts’ advice as the third person opinions. Bringing in third person’s opinion was helpful for that person could point out alternative coding options for the segments easily due to the distance between the third person and the research topic in question.

4.4 Ethical Concerns and Researcher’s Position

Ethical concerns of this thesis were ensured under the general rules provided by Academica Sinica, the national research institute in Taiwan. The reviews, rules and procedures of conducting indigenous research were not possible to retrieve because Council of Indigenous Peoples was still in the consensus-making process of ethic committee. All interviews were conducted with free, prior and informed consent. The principles of the Declaration of Helsinki was enshrined in all interviewing process, especially the duty of researcher “to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information” (World Health
Organization 2001: 373-374). Codes of ethics (Flick 2009: 36-38) were adopted as the main guiding rules in the conduct of this paper, especially the principles of informed consent and voluntary participation. The research design and the consent form were sent forward to the interviewees prior to the interviewing venue. Before the interviews started, it was made clear that the interview participation are of complete voluntary basis. All recordings were made with the participants’ prior consent. It was also clarified that the informants have the right to leave whenever they wish so. Additionally, the recordings were securely saved and the anonymity of interviewees were protected, in order to reduce the risk to them.

My position as a researcher is to critically examine the health framing, as it affects how the research question is framed, how the knowledge is produced and what instruments have been chosen (Smith 1999:143). It is similar to the concept of **methodology** which Harding (1986) proposed.\(^{51}\) This thesis reflects on the feminist and the postcolonial science and technology studies and utilises their philosophies to locate the indigenous methodology (Harding, 2009). In this regard, indigenous methodology is recognised to be created as part of the social transformation that recognises the evolving rights of indigenous peoples.

This thesis committed itself in taking initial step endorsing indigenous methodology in the right to health inquiries that were originally contemplated as autonomous and value-free. It devoted itself in pursuing two main trajectories: (1) Recognise indigenous epistemologies, knowledge, methodologies and philosophies of science which are underlined by self-determination; (2) Initiate reconciliation by confronting the colonial past and the doctrine of discovery.\(^{52}\) On one hand, the axis of this thesis has been built on the problematisation of the mainstream epistemologies, methodologies, and the philosophies of science that produce and support the current practice that reckons indigenous peoples as irrelevant objects. On the other hand, this thesis employs doctrine of discovery, the legal and political justification for the dispossession of indigenous peoples from their lands, their disenfranchisement and the

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\(^{51}\) This paper distinguishes ‘method’ from ‘methodology’. According to Sandra Harding (1986: 2-3), methodology refers to a theory and analysis of how research does or proceed. Whereas method refers to a technique for (or way of proceeding in) gathering evidence.

abrogation of their rights (ECOSOC 2012), as the keystones for reconciliation. It has
been suggested that imperialism and colonialism are not the legacy of the past, instead,
they persist and their ongoing manifestations have severe impact on the daily lives of
indigenous peoples. Indigenous methodology is ‘an agenda for indigenous research’ that
situates in a decolonising context and focuses on the goal of self-determination of
indigenous peoples (Smith 1999: 115).

Commentators emphasise on the practices in academia is worthy of scrutinisation.
Kuokkanen remains skeptical towards the existing academic practices and discourses,
because the academy continues to exclude non-Western intellectual traditions, such as
indigenous epistemes (Kuokkanen 2004). Indigenous peoples distrust ‘scientific
research’ because it inextricably linked to European imperialism and colonialism (Smith
1999: 1). The ‘indigenous problem’ is the recurrent theme theme in all imperial and
colonial attempts to deal with indigenous peoples. In health programs, indigenous
peoples are not only blamed to be ungrateful natives for not accepting the terms of
colonisation embedded in these programs (Smith 1999:91), but also communicated to
them that they have no solutions to their own problems (Smith 1999:92).
5. Analysis of the Health Framing Strategies

The health framing strategies are scrutinised to unravel how disadvantaged indigenous health has become a problem via utilising both the structures of coding frame which is developed with QCA as well as the three levels of determinants of indigenous health. To begin with, the explanations from the government, the media and the experts are systematically reported. In doing so, a basic framework of explanations of disadvantaged Taiwanese indigenous health is established. Second, experts’ interviews are examined closely with the structure of the coding frame to supplement this basic framework. Coding frame highlights the aspects that have been reiterated as well as other aspects that have been dismissed. Third, the Canadian social determinants of aboriginal health research (Reading and Wien 2009) is presented for it proposed a relevant structure to the factors that have been addressed in the previous analysis. Structuring the factors with the hierarchy of proximal, intermediate and distal levels enables examining factors in a new light.

The analysis results from the governmental and media framing confirm the observation of previous research that biomedical paradigm are employed in explaining indigenous health as articulated by Kuo (in Ru 2012). The interview analysis highlights cultural, political and genetic factors as well as seven strands of determinants of health play a role in addition to the factors emphasised biomedical paradigm. Lastly, the three levels of indigenous health determinants are introduced to hierarchy the factors. The analysis indicates that factors that have been recapitulated in the governmental and media’s framing tend to be on proximal level which has direct impact on health, whereas the factors that these two stakeholders have been omitted tend to be on distal level which has indirect impact on health. Interview analysis fills in the gap of these omitted factors on the distal determinants of health.

5.1 Initial Explore

When analysing the explanations from the government and the media, the issues becomes that every suggested cause to the disadvantaged health implies a different factor. In the analysis of the government, the factor explaining for disadvantaged indigenous health has been identified to be insufficient health and medical resources.
for the media, the indigenous disadvantaged health has been framed primarily as a result of structural—mainly medical resource-related—and individual behavioural factors. The patterns of problems implied in explanations have been consistent with the previous research that have been relied on the biomedical paradigm (Ru 2012; Ko, Liu and Hsieh 1994).

The findings will be structured in the following sequence of presentation. The health framing strategies of the government and the media will be presented as the basic framework of explanations of the Taiwanese disadvantaged indigenous health. The health framing strategy is examined from elucidating the suggested factors embedded in the alluding cause. Lastly, the experts’ positions and their expertise will be connected and presented. Linking their specific positions and expertise is essential for the interview analysis in the following chapter.

5.1.1 Explanations from the Government

The health framing of disadvantaged indigenous health from the government has been examined through analysing the Annual Reports of Public Health (ARPH). According to the reports, the indigenous policies have been consistent in the recent twelve years (2001-2012). The common themes of the interventions for disadvantaged indigenous health underlined in the ARPH are coherent: improving the quality of medical facilities, improving health delivery and subsidising hospitalisation fees. However, it is also noted that the indigenous health policies have been under very limited update throughout twelve years on the national level. Small modifications are made on the policy schemes for solutions, but the logic of the health framing remains unchanged.

The results of the health framing from the government’s perspective concentrate in the first dimension (coded as 3.1 structural factors). In explaining indigenous health, 111 codes are reported for the reasons that indigenous peoples do not have sufficient health/medical resources, eight codes were reported in their insufficient economic resources (coded 3.1.2 lack of economic resource), five codes were reported in an aspect to contribute indigenous disadvantaged health in inadequate cultural sensitive support (coded 3.1.5 lack of cultural support). The health framing underlined by the number of codes can be find in the table form (see appendix 4.3). A visual chart with the
percentage of the codes to underline the government’s health framing can be examined below (see chart 2).

As chart 2 shows, the major part of the health framing from examining the ARPH are concentrated in the structural factors, which represent 82 per cent of the government’s explanations of disadvantaged indigenous health. Within these structural factors, 63 per cent are highlighted as contributing the reason of indigenous disadvantaged health to insufficient health and medical resources.

The percentage of insufficient health and medical resources, as highlights in chart 3, is disproportionately higher than other codes. In other words, the insufficient health and medical resource plays a major part among the government’s health framing strategy. In calculating the frequency of the codes, the analysis of the ARPH shows the percentage of the explanation ‘lack of health/medical resource’ (coded 3.1.1) has been in a dominating position throughout the years. Two structural characteristics are identified to explain the background of government’s health framing, which is shaped almost only by the insufficiency of health and medical resource.
The structural characteristics of indigenous health policy-making within the national healthcare policy can be observed as its categorisations are inextricably linked to two aspects by the ARPH: ‘health care for the disadvantaged groups’ and ‘mountain and offshore islands’. The first aspect entails the transition from general to more specific while the second aspect involves the static feature of indigenous health policy under the national healthcare system.

First, indigenous health is treated as a constituting part of healthcare system from 2001 to 2008, which highlights the organisational planning and executing of health delivery. Whereas from 2009 to 2012, the principle has been substituted by healthcare for the disadvantaged groups (Department of Health 2009). That is to say, the level of the problem marked by the categorisation of indigenous health policies from the ARPH shows that the transition is taken place which subsumes indigenous peoples from general health care system to disadvantaged groups. It was not until 2009 that indigenous peoples are recognised as ‘disadvantaged health group’. Disadvantaged
health group in the ARPH were comprised of disabled people, immigrants and ‘patients with special needs’ as well as low income families.

Second, the findings from ARPH confirm that indigenous healthcare has not been dealt as indigenous health care, but as a subgroup under a particular geographic location. Their structural location within the national healthcare system is defined by the national administrative area, not their distinct status. The policy plan for indigenous health, as described in the ARPH, is targeting indigenous peoples who reside in a certain geographical area, i.e. mountain, offshore islands and remote areas. That is to say, before 2009, indigenous peoples and their health has been labelled with the significance of geographical marker in ARPH. Since 2009, while not changing the geographical category, the term ‘indigenous people’ has been added in the report. In addition, language barrier is a central issue in immigrants’ health, while the possible negative impact on health due to inter-cultural communication barrier between indigenous peoples and non-indigenous peoples is not depicted in the ARPH. Until now Taiwan has not employed ‘indigenous peoples’ to recognise their collectiveness in the health care policies on the national level.

These two structural characteristics of indigenous health policy have impact on the policy agenda’s priorities. The priority of ARPH is reiterated in promoting sustainability for local doctors, remote/digital medical care and a variety of residual projects to improve the shortcomings of health care system for indigenous peoples in Taiwan, for example, Tribal Health Promotion Plan and Integrated Delivery System (IDS). The reports emphasise unanimously the importance of improving national and local medical facilities and the availability of health/medical support on the local level, suggesting the key to solve the indigenous health challenge lies in building a complete medical system (Ministry of Health 2002: 32). These priorities imply that indigenous health problem is due to “medical policy, lack of human resource and skill” (Ru 2012: 157). In other words, the government approaches the indigenous health primarily from the perspective which focuses on the scarcity of medical resource and presence of ‘convenience’ towards tangible resources (Department of Health 2008: 79) i.e.

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53 including leprosy patients, patients with rare disorders, human immunodeficiency virus infection (known as HIV/AIDS), elderly people who are disabled or suffer from dementia, Yusho or Yu Cheng disease (oil poisoning by PCBs), inmates in the correctional institutes.

54 See chapter 2.2 for more information on the classification of Taiwanese indigenous peoples.
accessibility and availability of medical resource. Therefore, indigenous health problem becomes an inevitable corollary to the incomplete medical system problem.

Thus far the government’s disadvantaged indigenous health framing has been introduced and the background for such phenomenon has been identified. In recognising indigenous health problem as a corollary to the imperfect medical system, two examples from the ARPH will be introduced. These two examples will served to illustrate government’s strategy to to remedy the incomplete medical system as a way to rescue the disadvantaged indigenous health.

The first example to improve indigenous health, under the government’s health framing, was to launch health promotion campaigns. The ARPH recorded a series of campaign to engage college students in the national health promotion plan for indigenous peoples since 2008 (Department of Health 2008: 81). In this campaign, the ARPH defined clearly the indigenous health problem into certain areas and the known world was thus being created (Ferree 2009: 89): domestic violence, sexual harassment, and the prevention of alcohol, tobacco and beetle nuts.55

“[The Department of Health] subsidised 15 health service camp projects (...) in order to facilitate college students making contribution to indigenous health in terms of domestic violence, sexual harassment, and the prevention of alcohol, tobacco and beetle nuts.” (Department of Health 2008: 81)

The second example was featured by initiating behaviour-correcting programs as a way to rescue indigenous health. Taiwanese indigenous health promotion has been featured with series of behaviour-correcting programs as an integrated part of accommodating indigenous health. In this case, series of head start programs engaging indigenous children to learn about healthy lifestyle has been implemented as a part of national indigenous health promotion scheme (Department of Health 2008: 81). In total, 548 indigenous children from primary schools has been recruited since the launch of the ‘Little Angel of Indigenous Health’ empowerment scheme in 2005 (Department of Health 2012).

55 Known world, according to Ferree (2009), referred to the concepts being given meaning. Such concepts were embedded in networks of other more or less widely shared and practically relevant meanings.
“... 60 ‘Little Angels of Health’ were invited to pay visit to National Health Commend Center (NHCC), Bureau of National Health Insurance, National Bureau of Controlled Drugs and Center for Verified Aerial Ambulance. By doing so, health concepts were taught ... encouraged to carry out healthy life style... ” (ibid 2008: 81)

In conclusion, the health framing from 2001 to 2012 has shown the governmental explanations for disadvantaged indigenous health are featured by the structural features. These structural features emphasise the primary cause of disadvantaged indigenous health lies in medical and health resources insufficiencies. In other words, the current priority setting is created under the mindset of treating indigenous health problem as the flaws in the medical system. Two examples of government’s attempts to improve indigenous health were included as a way to show how framing strategy shapes the problem itself.

5.1.2 Explanations from the Media

In analysing the news reports, four dimensions of the health framing in the media representation is recorded (see chapter 4.3). As the third dimension examines the reasons explaining for disadvantaged health, the other two dimensions are introduced as supplementing the media representation as a whole. In the following section, the second dimension is introduced to anchor the health problem identified in the media, followed by the fourth dimension.

The second dimension examines how the indigenous problem being defined in the media representation. The quotes from the media are extracted into a matrix for analysis (see appendix 3.1). Indigenous health problems are primarily identified as accidents, chronic liver diseases and cirrhosis, heart disease (cardiovascular disease), gout, tuberculosis, and other broadly defined chronic diseases. Other less frequently mentioned diseases are recorded, including ascites, liver disease\textsuperscript{56}, gastroenteritis, osteoarthritis, and rheumatism. These diseases— ranging from specific to non-specific, from acute to non-urgent, and from communicable to non-communicable— are all recorded in the second dimension while examining the 98 pieces of news reports. Apart from specific diseases, indigenous disadvantaged health is defined as epidemiological

\textsuperscript{56} They are labeled here because the information from the news is not sufficient to decide whether it’s chronic liver diseases and cirrhosis (Code number 2.1.4)
fact (coded 2.4) and demographic fact (coded 2.3). The former consists of 31 segments and the latter one consists of 75 segments. Demographic statistics, such as death rate and life expectancy, have been commonly utilised in explaining the disadvantages in Taiwanese indigenous health. It is often mentioned in political debates and aimed as political target in indigenous health promotion campaigns. Many research projects and policies have been made in response to the demographic gap between indigenous peoples and non-indigenous peoples. Thus far, most of the media framing had been focused on disease-solving and disease-prevention guided by the disciplines of epidemiology and pathology. So far, the second dimension provides the identified aspects of indigenous disadvantages in health. The reasons explaining for these problems in the media representation are introduced in the following section.

The fourth dimension records who is responsible for the disadvantaged indigenous health problem. The tendency of blaming indigenous peoples’ potential harmful genes (as in the genetic factor, coded 3.4) is observed. As indicated in table 3, the frequency of the codes are grouped with year 2000 to 2004, 2005 to 2008 and 2009 to 2012 as below, it used to be common to see the attribution of Taiwanese Indigenous peoples’ disadvantaged health to indigenous genes before the Indigenous Basic Law that was promulgated in 2005.

Table 3. Frequency grouped with year, media representation

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<tbody>
<tr>
<td>3.1 Structural factors</td>
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<td>0</td>
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<tr>
<td>3.1.1 Lack of health/medical resource</td>
<td>51</td>
<td>8</td>
<td>10</td>
<td>69</td>
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<tr>
<td>3.1.2 Lack of economic resource</td>
<td>13</td>
<td>4</td>
<td>3</td>
<td>20</td>
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<tr>
<td>3.1.3 Lack of education resource</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>6</td>
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<tr>
<td>3.1.4 Lack of job security and good working environment</td>
<td>9</td>
<td>3</td>
<td>6</td>
<td>18</td>
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<td>3.1.5 Lack of cultural-sensitive support</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>9</td>
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<td>3.1.6 Lack of infrastructure (e.g. safe drinking water)</td>
<td>12</td>
<td>0</td>
<td>3</td>
<td>15</td>
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<tr>
<td>3.1.7 Poor housing/ living environment</td>
<td>9</td>
<td>1</td>
<td>0</td>
<td>10</td>
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<tr>
<td>3.1.8 Others</td>
<td>8</td>
<td>2</td>
<td>4</td>
<td>14</td>
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<tr>
<td>3.2 Cultural factors</td>
<td></td>
<td></td>
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<td>0</td>
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<tr>
<td>3.2.1 Indigenous Peoples lost languages, cultures and identities</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>3.2.2 Indigenous Peoples’ involuntary displacement in the past</td>
<td>0</td>
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The health framing of the media is explored in the third dimension. As chart 4 indicated, the Behavioural risk factors (coded 3.5) and structural factors (coded 3.1) constitute 87 per cent of all the explanations. The former accounts for 47 per cent, consisting 190 segments (see appendix 4.2 for detailed information) in the media representation. The latter accounts for 40 per cent, composing of 161 segments in the media representation. The frequency of the genetic, cultural and political are far less mentioned in the media representation. They consist respectively five per cent, three per cent and one per cent. Below, behavioural risk factors and structural factors are introduced more in details.

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<tr>
<td>3.2.3 Indigenous Peoples lost their traditional land</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
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<tr>
<td>3.2.4 Indigenous Peoples lost their traditional lifestyle</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
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<tr>
<td>3.2.5 Others</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>9</td>
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<tr>
<td>3.3 Political factors</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
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<tr>
<td>3.4 Genetic factors</td>
<td>17</td>
<td>2</td>
<td>1</td>
<td>3</td>
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<tr>
<td>3.5 Behavioral risk factors</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>3.5.1 Tobacco smoking</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>0</td>
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<tr>
<td>3.5.2 Excessive alcohol consumption</td>
<td>51</td>
<td>31</td>
<td>15</td>
<td>97</td>
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<tr>
<td>3.5.3 Beetle nuts chewing</td>
<td>7</td>
<td>8</td>
<td>5</td>
<td>20</td>
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<tr>
<td>3.5.4 Poor diet and nutrition</td>
<td>26</td>
<td>5</td>
<td>5</td>
<td>36</td>
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<tr>
<td>3.5.5 Physical inactivity</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>7</td>
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<tr>
<td>3.5.6 Others</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>3.6 Others</td>
<td>10</td>
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</table>
Behavioural risk factors, as elaborated by AIHW, are defined as risk factors that can be eliminated or reduced through lifestyle or behavioural changes. They are the strongest health framing narratives among all other dimensions. Within the 190 segments of behavioural risk factors, 97 segments are coded with ‘excessive alcohol consumption’ (3.5.2) which stands for 52 per cent of all the behavioural risk factors. The second most commonly coded aspect is related to the poor diet and nutrition (coded with 3.5.4), followed by beetle nuts chewing (coded with 3.5.3) The frequency table can be examined in the appendix (see appendix 4.2).

Structural factors are also dominant in explaining disadvantaged indigenous health the media representation. In particular, 161 out of 409 segments are coded with structural factors, which constitutes 40 per cent in dimension three. In other words, 40 per cent of the explanations in the context of media representation are located in the structural determinism. Within the 161 segments of structural factors, 69 segments are coded specifically with ‘lack of medical/health resources’ (coded 3.1.1) which stands for 42 per cent of all the structural factors.

In brief, behaviourial risk factors and the structural factors are the foremost predominant explanations in the media representation in explaining indigenous
disadvantaged health. The former is composed of 47 per cent and the latter is 40 per cent. Together both categories constitute 87 per cent of all media representation on the reasons of indigenous peoples’ disadvantaged health. Of the behavioural risk factors, the most commonly mentioned factors are excessive alcohol consumption, poor diet and nutrition and beetle nuts chewing. Of the structural risk factors, the most commonly mentioned factors are insufficient health and medical resource, insufficient economic resource and insufficient job security and supportive working environment. Additionally, the analysis of media reporting indicated the indigenous culture should be responsible to some extent to the current disadvantaged indigenous health situation. The cultural blaming judging from the data of genetic factors is on a decrease.

5.1.3 Linking Specific Position to the Expertise

The health framing among the experts are closely linked to their specific positions and entanglement of power/knowledge. Experts can not extricate from their constituencies and positions in the institutions, disciplines and agencies. In the influence of Foucauldian theories about expertise and power/knowledge, patterns are drawn to distinguish four types of experts in this study:

1) Indigenous scholars-- IS1, IS2, IS3 and IS4, they are those indigenous peoples who received modern scientific training in the higher educational institutions and/or abroad;

2) Indigenous local doctors-- ILD1 and ILD2, the indigenous peoples who received professional medical trainings and work as doctor at their own indigenous zones;

3) Non-indigenous scholars-- NIS1, NIS2, NIS3, NIS4 and NIS5, the non-indigenous peoples who have modern scientific training in the higher educational institutions in Taiwan and/or abroad. They have close relationships with indigenous peoples in Taiwan and have been involved in the area of indigenous health/well-being in their projects;

4) Indigenous civil servants-- ICS1 and ICS2, the indigenous peoples who work in the public sector, dealing with indigenous health issues.

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57 See chapter 3.1 for more information on how knowledge/power and expertise being extricably connected.
The distinctions between these four types of experts and their health framing strategies will be discussed in regards to their positions and disciplines. The first type of experts emphasise on the indigenous subjectivity and the ongoing colonialism and form their health framing strategies accordingly. The indigenous scholars rarely attribute the health problem to the scarcity of medical resource. Instead, indigenous scholars’ health framing have two distinct features. They emphasise on the subjectivity of indigenous peoples and reiterate the ongoing impact of the colonisation in the past (and in some cases, also in the present).

They are vigilant toward the existing power imbalance reporting and policy-making and emphasise on the subjectivity of indigenous peoples. For some, the suppression of indigenous subjectivity and the ongoing colonisation are the basis of health inequality (IS1, 34:44).

Agreeing with informant IS1’s argument on indigenous subjectivity and colonisation, informant IS2 depicts the health policies made with colonial mindset were constantly haunting indigenous peoples. He explains that the governmental health promotion approach cannot expect too much success, because it is embedded in a wrong premise that indigenous peoples are morally incapable and intellectually inadequate to have correct concept about a healthy life (IS2, 35.20). The disadvantaged indigenous health is resulted from the top-down misplaced policies embedded in Han-chauvinism, which paralyse indigenous peoples in a worse economic, educational and social structure. IS2 argues the Han-chauvinism manifested in the policies placed indigenous peoples under exploited condition which explains for the disadvantaged indigenous health (IS2, 20.59).

Informant IS2 elaborates that the absence of indigenous subjectivity in policies may lead to an inefficient health policy promotion. He gives an example of a health promotion campaign he used to be involved in his earlier careers. The intervention seems to be implemented successfully because indigenous peoples’ health knowledge in answering in tests improved. However, he observes that regardless of the knowledge-promotion success, indigenous peoples did not have behaviour that were taught to be healthy in class. In other words, the health outcome remains missing regardless of the seemingly successful health promotion campaign (IS2, 35.20).
The second type of experts are medical practitioners with indigenous backgrounds. They are coded as indigenous local doctors (ILD) in this thesis. What distinguishes ILD from IS is that ILD received training to be doctors. This professional training place them in the position of perceiving indigenous peoples as patients who failed to perform normally on certain health indicators that in line with medical examination criteria. Informant ILD1 can tell immediately whether certain group of patients are from the mountain tribes by the results of medical examination papers. He relies on the experts-designed medical examination because it portrayed a comprehensive representation of health (ILD1, 37:51).

The third type of experts are non-indigenous scholars (NIS). They perceive indigenous disadvantaged health not from the ‘indigenous subjectivity’ nor on the level of ‘discrimination against indigenous peoples’, but more from their own discipline: a structural, institutional and anthropological point-of-view as a whole. They advocate less about whether the government care about indigenous peoples, instead, they rely on their professional knowledge on re-framing and re-interpret the existing health problem. One of the respondent with anthropological background points out the medical school’s training was to instil the ‘inherently’ disadvantaged indigenous health to medical students (NIS1, 0.09). Others provide their perception about the different levels of disadvantaged indigenous health problem, which allow room for exploration.

The fourth type of experts are the indigenous civil servants (ICS) who work in the public sectors relating to indigenous health. One respondent has experiences in the Department of Health so he gives a concise sketch of indigenous policies in Taiwan on the national level.

“Now we have three main themes (about the indigenous health policy): first, capacity building for the medical human resource. Second, to increase the medical accessibility, which means building facilities, such as health centers, diagnostic sonographic service. Third, improving individual’s health management knowledge by establishing tribal/community health promotion centre. In doing so, we wish to cut the medical spending.” (ICS1, 2.41)
In line with the informant ICS1, informant ICS2 emphasises on the governmental determination to ‘close the gap’. However ICS2 is not familiar with indigenous health policies except for the implementation of health delivery subsidies. This reflects the fragmented indigenous policies and detachment of indigenous civil servant due to this fragmented policy orientation. In brief, the ICSs give narratives of justifications of the current indigenous health policies.

To summarise, the health framing strategies of the government and the media are presented. The government’s health framing relies strongly on the structural factors, in particular the medical and health resources, in explaining the disadvantaged health for indigenous peoples. The media’s health framing also relies strongly on the structural factors, especially emphasising the medical and health resources. However, the behavioural factors are more commonly referred in the media representation. Among which, the excessive alcohol consumption was one of the most common one. Lastly, the experts’ specific position are identified as to recognise the entanglement to knowledge/power. Their accounts of health framing are further developed in the following section.

5.2 Explanations: Interview Analysis

The initial design of the interview analysis was to elaborate the framing strategies presented in the previous chapter within the range of the coding frame. Accordingly, special attention was paid to their narratives that were directly relevant to the coding frame (see appendix 2). Due to the data of the interviews are so rich that stretch beyond the original coding frame categories, these insights are decided to be included in the analysis. In the following analysis, the sequence of determinants of health are presented in accordance with the coding frame. Apart from the original design to elaborate the framing strategies of the government and the media, experts’ further accounts which are closely related to determinants of indigenous health are reported in the end.

5.2.1 Structural Factors

The structural factors illustrate *avoidable* social and economic conditions and their effects that determinant people’s exposure to illness and the capabilities to handle illness. To explain, the term ‘structural factors’ is used closely related to social determinants of health (SDH). It entails the circumstances in which people are born,
grow, live, work and age and shaped by the distribution of money, power, and resources (World Health Organization 2012). These structural factors include lack of health/medical resource, lack of economic resource, lack of education resource, lack of job security and good working environment, lack of cultural-sensitive support, lack of infrastructure, poor housing/living environment. These factors describe a range of determinants that lead to health inequities or inequalities, in which health inequities are avoidable inequalities in groups of people (ibid.). In both the health framing of government and the media, the insufficient health and medical resource are major factors in explaining indigenous disadvantaged health. This implied the root of the problem as health and medical resources. Similar views are pursued by experts. Respondent NIS1 utilises graphs of demographic as well as epidemiological evidence to echo the importance of medical resource availability in both of the interviews:

“Indigenous Peoples living in Taipei city have the lowest crude death rate because medical service is available to them.” (NIS1, 1st interview, 4.47)

“It’s not the case that the number of indigenous peoples (in a municipality) has positive correlation with indigenous death rate. The crucial factor is the hospitals and accessibility of medical resource.” (NIS1, 2nd interview, 13.24)

A detailed account is explained by the experts on the imbalance distribution of medical resource between the cities and the tribal areas. One informant comments that:

“In my opinion it’s because indigenous peoples can’t access to medical resource, which lead to their disadvantaged health-- (where they live is) remote, difficult to access. If you had car accident in the tribal area, chances are you’ll die because you lose too much blood. It’s difficult to find doctors and nurses in the tribes. Nowadays the advantages have been reduced, but still, it’s impossible to build a National Taiwan University Hospital in the tribes.” (ICS1, 9.30)
A similar view is pursued by another informant who opens a clinic in his hometown in the mountains. He notes the scarcity of medical resources in the mountain areas and gives himself as an example that it is difficult to open a clinic in the mountains because it is not profitable (ILD1, 45.18). A different perspective, provided by informant with the anthropological background, notes that young indigenous peoples are equally healthy as the non-indigenous people, if not more healthy. The informant observes the reasons contributing to the indigenous health crisis:

“You asked healthy indigenous youth: why do people all the time emphasise on the health crisis of indigenous peoples? It’s because medical support and social economic problem.” (NIS1, 1st interview, 6.12)

Just as respondent NIS1 states, apart from lacking health/medical resources (coded 3.1.1), economic resources (coded 3.1.2) is also one of the crucial aspect in the explanations of disadvantaged indigenous health. This brings to the second structural factor that considers the negative impact of economic shortages on indigenous health. It is commonly referred by the government and media to explain for indigenous health disadvantages. For the government framing, it is commonly seen the subsidy programs to secure indigenous peoples’ access to the healthcare system (National Health Insurance, NHI). An expert echoes the significant implications of financial difficulties by stressing the role of social economic status:

“It has relations with social economic status. Indigenous peoples are poor, they don’t have time (to exercise). Indigenous peoples and non-indigenous are the same, they will not be healthy if they are low in social economic status. The thing is that 88% of indigenous peoples have low social economic status. That’s why they seem unhealthy as a whole.” (IS2, 36.23)

Lack of educational resources (coded 3.1.3) has not been commented by the experts. An informant argues indirectly the importance of education for indigenous peoples:
“Every year I donate NT$1 200 000 to my secondary school (...) Indigenous education is lower than others, as a result we have no confidence, we have no future. (...) if the opportunity is given to change the fate by studying, I hope to give young indigenous generation this opportunity.” (ILD1, 54.05)

In regard to lack of job security and good working environment (coded 3.1.4), no data is recorded from the government via ARPH from 2001 to 2012. The media representation records 18 segments, accounting for the third most commonly mentioned factor in this dimension, in utilising job security and good working environment as health framing strategy. It has been emphasised by the experts for its importances in explaining disadvantaged indigenous health.

“The best policy? Give jobs to indigenous peoples. On one hand they are starving to death but on the other hand (the current policy aims) to change their knowledge and attitude (of healthy way of life).” (IS2, 37.10)

“On the other hand, middle-age indigenous peoples have low percentage to go to hospitals and at the same time have less life expectancy than the Han people. The statistics tells that it is not easy for them to see doctors. Maybe it’s inconvenient because of their work, or the environment.” (NIS1, 1st interview, 5.10)

The absence of cultural sensitive support is one of the major arguments that experts have in common while explaining disadvantages in Taiwanese indigenous health. Cultural sensitivity is recognised as the core element for an effective health promotion. The linguistic aspect of cultural sensitivity has been observed by IS1:

“Cultural sensitivity is indispensable to indigenous health promotion. For example, elders can’t understand what the government is talking about, or what kind of disease they have.” (IS1, 21.45)
Indeed, cultural sensitivity is crucial in the process of health service delivery. On the other hand, respondent NIS2 argues that in certain health delivery, cultural sensitivity has even more profound meaning, such as longterm care. It is argued that if the longterm care has been designed without cultural sensitivity, it causes double exploitation on indigenous peoples (NIS2, 0.23).

The respondent ICS1 agrees that cultural sensitive care is essential in reducing indigenous peoples’ health disadvantages. He urges the understanding of indigenous peoples’ culture and way of thinking through courses (ICS1, 15.08). His response reflects the background of the term ‘cultural sensitivity’ appeared in the annual report.58

Echoing reducing indigenous peoples’ health disadvantages, respondent ICS2 gives a concise picture about closing the gap between the indigenous peoples and the general population in terms of life expectancy, mortality rate and injury prevention. Cultural empowerment was proposed as one of the five policy targets:

“Through cultural competent health care, we aim to ensure Taiwanese indigenous populations receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.” (ICS2)

The importance of cultural sensitivity has been confirmed by the informants regardless of its unclear meaning. Cultural sensitivity seems to function as an empty signifier, where its meaning can be altered according to the need of the presenter.

These accounts of cultural sensitivity by experts largely enrich the health framing of government and media, for the issue of cultural sensitivity in both stakeholders are inadequately addressed. Respondent IS2 proposes one possible reason why the government did not address cultural sensitivity. He concludes that the government do not have nor understand cultural sensitivity (IS2, 13.34), from his observation in his involvement with many health promotion projects initiated by the state. The reason for that is the central government has pre-conceived judgment about indigenous peoples. As a result, government’s health campaign in tribal area that not necessarily relate to their real problems. While referring the central government as ‘people above’, IS2 notes:

58 Lack of cultural sensitive support (coded 3.1.5) was coded five times: 2007, 2009, 2010, 2011 and 2012. The percentage of this dimension is 3 per cent of all codes from the annual reports.
“People above says that no more beetle nuts chewing for Wulai. That’s because the people above gives us a structure that ‘all indigenous peoples are chewing beetle nuts. But the fact is, Atayal people do not chew beetle nuts. The habit of chewing beetle nuts belongs to Hualien-Taitong area. So the people above are clueless and feel like all indigenous people culture involves chewing beetle nuts anyways.” (IS2, 12.34)

With regard to the absence of infrastructure (coded 3.1.6 Lack of infrastructure) and adequate housing/living environment (coded with 3.1.7 Poor housing/living environment), the government does not address any of these issues directly in the annual report, while 15 segments and 10 segments were recorded in the media representation. When examining the accidents may explained for the dramatic decline of life expectancy of middle age Taiwanese indigenous peoples, respondent NIS1 proposes the lack of medical service and environment may be the main reasons for the accidents (NIS1, 1st interview, 7.45).

Respondent ILD1 uses ‘environment’ as a contributing factor to Taiwanese indigenous disadvantaged health in a different way. Respondent ILD1 emphasises on the basic exercise facilities as environment. It is argued that indigenous peoples could not exercise as much as urban people because there were a lot of exercise facilities in urban area (ILD1, 41.55).

In addition to the dimensions related to structural level above, other structural factors (coded 3.1.8 others) also play a role in explaining indigenous health disadvantages. These factors are identified as difficult to be put in any of the existing categories, including negative life chances and circumstances, structural skewed resource distribution, and structural population problem.

Respondent IS2 argues that indigenous peoples often find themselves in a situation filled with negative influence on their health. He argues that it is less about individual intervention, but more relates to indigenous peoples having negative life circumstances as a whole (IS2, 35.20). In this regard, respondent NIS2 gives alcohol awareness campaigns as example to illustrate the difference between intervention with and without historical understanding.
“How does Taiwan stop indigenous peoples drinking alcohol? Yes, (Taiwan) teaches them all possible methods to be away from alcohol. (...) it’s from Han perspective, such as ‘instead of drinking alcohol, why not drink tea?’ campaign. It was a very Han way to do intervention. But why indigenous peoples don’t have motivation to stop drinking? (...) On the other hand, indigenous peoples in Canada had a different method, they were asked, ‘what was it that let me end up with a broken family, where my wife and kids left me behind? What was it that made me drifted away from the land passed on to me from my ancestors? (...) These aspects (employed by the Canadian indigenous peoples) highlight the importance of history and the power to decide that could make their future different.” (NIS2, 1.15.20)

Another two aspects explaining indigenous disadvantaged health focus on the resource distribution as a whole as well as the population structure problem within tribes. The first aspect depicts the resource distribution dilemma between majority and minority. Informant ILD1 argues that the state is more likely to distribute resource in the policies that were for the interest of the majority (ILD1, 17.00). The second aspect highlights the vulnerable population structure in the indigenous zones. ILD1 observes that a lot of health delivery problems have been created because there are primarily disabled, sick, elders or kids left in the mountains. They have limited access to seek for the help from the doctors (ILD1, 20.08).

5.2.2 Cultural Factors

Out of all determinants of health, this dimension is the one of the most inadequately addressed issues in the government and the media health framing. It is evident that cultural factors does not play a main role in explaining indigenous peoples’ disadvantages in health in the government or the media representation. In comparing the accounts from the media data and interview data, two interpretation of culture were in need of clarify before the analysis.

Two interpretations that handle the interrelation between culture and health is built on the consensus that Taiwanese indigenous peoples are culturally different from the majority Han people. The first interpretation argued that Taiwanese indigenous
peoples suffered from disadvantaged health because of their distinct culture. The extreme form of this line of argument would be that indigenous genes, as affected by their culture, predisposed indigenous peoples to vulnerable health conditions. Such as gout (Bai 2005), mental disorder (Tsai 2011) and alcoholism (Chen 2007). These accounts were not included in this section for examination, instead, these statements were categorised under behavioural risk factors or genetic factors. The second interpretation perceived the role of culture different from the first account. The second interpretation suggested indigenous peoples were collectively placed in a vulnerable position in health because the absence of protection and recognition of their cultures. The cultural factors explored in this section is based on the second interpretation.

The relationship between cultural factors and disadvantaged indigenous health is established on the context that negative health consequences due to misrecognition that manifested in the “wear and tear of everyday life” (Taylor 1992; Hall and Lamont 2009). The sub-dimension includes the absence of traditional languages, cultures and identities; the historical involuntary displacement; appropriated traditional land and suppressed traditional lifestyle.

Cultural factors link back to the historical understanding of indigenous peoples’ suffering, the impact of doctrine of discovery and the past conquest. This dimension is absent in all ARPH and consisting 3 per cent in the media coverage. In this regard, experts fill in the missing piece as they give explanations of disadvantaged indigenous health in the cultural aspect. Respondent NIS1 uses the concept of social disorder in discussing the impact of losing indigenous languages, cultures and identities (coded 3.2.1 Indigenous peoples lost languages, cultures and identities). It was suggested that the increasing alcoholism among indigenous peoples was because the worsening sense of social disorder among them. It was observed that indigenous peoples were desperately in need of spiritual comfort (NIS1, 19.25).

Respondent IS2 emphasised on the cultural deprivation of losing traditional land (coded 3.2.3 Lost of traditional land), which closely associate with indigenous way of life (coded 3.2.4 Indigenous peoples lost their traditional lifestyle), had negative impact on indigenous health:

“To keep indigenous peoples’ bodies healthy, we were in good shape because we used do sowing, working and hunting. Now we are not
healthy, because the mainstream people came in the mountains to take away our woods by force since the Japanese colonisation. It was called ‘colony’, now it should be called ‘recolonisation’. Now there is no way to cut down a tree, because it’s part of the National Park; urban people want water, our lands become water conservation area; urban people want air, our lands become the property of Forestry Ministry; they tell us that animals are important, so we are forbid to hunt. (...) Indigenous peoples cannot exercise, nor hunt. So we are not healthy, we cannot move anymore. (...) We are living under the exploited condition, so of course we are not healthy.” (IS2, 20.59)”

“It is their policies that made us indigenous peoples ended up in a disadvantaged condition. Our disadvantages in economy, in education, in health, are all caused by the theft of our land.” (IS2, 31.10)

Respondent IS2 illustrates that the land theft lead to the circumstance that indigenous peoples often find themselves in a lower social-economic status. He explained that the mountain areas which used to belong to the indigenous peoples were owned by the government (IS2, 39.45). The land lost created difficulties to maintain the traditional lifestyle, which in turn had negative impact on indigenous health.

Besides the cultural factors mentioned above, additional cultural factors were mentioned among the experts to explain indigenous disadvantaged health. These factors emphasised on the lack of recognition of indigenous subjectivity and indigenous rights. As Kymlicka and Norman (1994: 372) observed, ‘the full and free development of their culture and the best interests of their people’ was not ensured. Respondent IS2 recalled, while agreeing the indigenous subjectivity was deprived because they could not govern themselves in certain issues that are important to themselves, as a consequences, their self-determination was not properly accommodated:

“Now the government deprive indigenous rights, it says, ‘don’t worry, I will give you money’ (for the tribal ceremony). Isn’t it giving the runaround to indigenous peoples, at the same time lie to others that ‘this is how indigenous peoples are, they are no better than singing, dancing
and drinking’? Why distribute so much budget in here (cultural performance)? Why give others a bad image of us indigenous peoples?”

(IS2, 18.10)

Respondent NIS2 explained that indigenous peoples define health on a level that is different from the Han people. Respondent NIS2 recalled the case that a shaman from the Thao tribe took care of the elders as an example to underline the importance of spiritual layer of indigenous health. To explain, this shaman did not regard the governmental initiatives of feeding elders or exercise first priority. What he considered to be the core issue was to revive the link between elders and the ancestral spirits, because ancestors naturally create the power to take care of elders. From this perspective, this shaman started from this angle to recuperate the link: elders need to have their way of life back like the ancestors. He believed that as long as the collective lifestyle was revived, culture passes on and the care-taking will happen by itself (NIS2, 56.53).

The cultural factors as health variables to Taiwanese indigenous peoples were examined in this section, including languages, identities, displacements, land and lifestyle. Many commentators observed that indigenous health was placed in danger when these cultural factors were not recognised. Additional cultural factors were identified, such as self-determination, indigenous subjectivity and spiritual interpretation.

5.2.3 Political Factors

Regardless of the significant impact of political factors, this dimension had been the most under documented in the health framing of the government and the media. The dimension of political factors were established to include all the factors relating to politics, more specifically the features of power, as expressed by Lukes in his explanation in the three-dimensional view of power, “What one may have here is a latent conflict, which consists in a contradiction between the interests of those exercising power and the real interests of those they exclude” (Lukes 2005: 28). The government did not cover this aspect and the media representation shown only the impacts of the formal voting process. More aspects of political factors were supplemented while analysing the experts’ interviews. Their accounts included the
agenda-setting problems, the organisation of public administration efficiency, the policy implementation challenges and the exclusion effects of the institutions under democratic system.

In the first place, agenda-setting was examined as one of the political factors that have impact on indigenous health. Respondents examined the acknowledgement of indigenous subjectivity within the governmental framework. Here, indigenous subjectivity is referring to indigenous experiences and knowledge which constitute indigenous peoples to be subjects. Respondent IS1 emphasised the indigenous subjectivity recognition as the basis of solving health inequality. The topic was raised that the government did not find it urgent to solve health inequality in indigenous peoples (IS1, 34.44). Respondent IS2 gave details about the areas that the government often find more important: culture performance and the related activities (IS2, 8.36).

“The government spent a lot of money in indigenous cultural capacity building. But I don’t think the capacity building should be only in the culture. (...) What indigenous peoples want is not culture, but to be able to feed themselves. To be economically independent, or to have a job. The government should put more emphasis on this aspect.” (IS2, 7.58)

He further explained that the biggest cause for indigenous health problem was the wrong policies. It not only worsened the negative image of indigenous peoples, but ignored indigenous peoples’ urge for self-determination. Respondent NIS2 illustrated another level of agenda-setting problem as in the political factors in explaining indigenous disadvantages in health. He argued that many policies have assumptions that exclude indigenous peoples from the very basis. He gave an example of accreditation of longterm care-givers.

“Taiwan requires care-givers to graduate at least from elementary school, to be trained 90 hours and pass exam for the certificate. (...) If we implement this law, indigenous peoples cannot take care of themselves, what’s worse, indigenous peoples cannot take care of themselves in their own way.” (NIS2, 11.27)
On the other hand, a shortcoming in policy implementation process appeared to be a problem as part of the political dimension that explains for indigenous disadvantaged health. Respondent ILD1 affirms the implementation gap by addressing the benevolence and good will of the government had been misunderstood.

“Council of Indigenous Peoples, well, actually all the mechanisms in the government, certainly have their benevolence and good will. But the problem lies in the implementation process. Council of Indigenous Peoples do not know where is the problem, but they ended up in a situation where their benevolence and good will cannot transmit to those who really need it. These people don’t have internet, don’t read pamphlets. Those in need don’t know, can’t benefit from the good will from the people above.” (ILD1, 32.58)

Respondent ILD1 affirmed the good will and benevolence from the policy-makers and criticised the flaw in bureaucratic processes, or as he puts it, ‘the lack of sincerity’, while recalling the distribution of health budget for indigenous peoples. It was argued that the amount of budget for indigenous health promotion did not matter as much as the matter of sincerity. Respondent ILD1 showed his trust in the quality of the policy from the central government and the lack of confidence in the executing process. He gave IDS as an example to show policies could be good on ideal level but became negligence when they were implemented (ILD1, 56.38). Respondent NIS2 voiced similar concerns in the implementation process in the IDS (NIS2, 6.58)

Apart from remaining skeptical towards executing level, respondent ILD1 addressed the majority-minority problem in the democratic system distrustful. It was observed that the democratic system did not encourage the real interest and survival of indigenous peoples. Being in a democratic state accounted for indigenous disadvantaged health, especially less health budget was spent on indigenous peoples due to the less amount of votes (ILD1, 48.53).

So far, experts’ narratives had supplemented the political dimensions which were less developed in the government and media data. The agenda-setting problems and the implementation problems were the most regarded factors. In addition, exclusion effects
of the institutions under democratic system had been added as one of the major concerns in the majority-minority dilemma.

5.2.4 Genetic Factors

Two main arguments could be distinguished in informants’ view when they refer to the genetic factors as health determinants of Taiwanese indigenous peoples. The first line of arguments were in support of indigenous peoples were genetically predisposed to develop diseases, whereas the second line of arguments disagreed such proposal.

The first line of the arguments were manifested in the media, where researchers’ opinions being propagated. The genetic factors were unanimously stated in a manner that indigenous peoples were genetically predisposed to develop certain diseases, including diabetes, gout, and alcoholism (Munsterhjelm and Gilbert 2010: 35). Respondent ILD1 reflected this line of opinion:

“Why do indigenous peoples have shorter life expectancy? Two reasons for that. The first part relates to the congenital problems, such as uric acid and enzyme... to get back to the point, the reason for indigenous disadvantaged health is genes.” (ILD1, 42.29)

Although not directly, the first line of the arguments were ambiguously mentioned in the Annual Reports of the commissioned research projects on indigenous peoples for their “medical healthcare demand situation, disease type distribution and medical behavior” (Department of Health 2004: 24). Many events could be identified having significant consequences on indigenous right to health were excluded in the report, the Taiwan Biobank case is one of the most illustrative one (Tai and Chiou 2008; Munsterhjelm and Gilbert 2010). Until 2009, National Science Committee and Department of Health spent more than 12.9 million euros in the Taiwan Biobank project, which was argued not only a genetic database project but contains ‘symbolic meaning of Taiwan’s pursuit to academic excellence and achieve full integration into the Western academic research’ (Hsu 2009). However, critiques were raised from other commentators. Munsterhjelm and Gilbert (2010) argues that Taiwan Biobank not only proved to be problematic in the informed consent procedure, but also in its configuration which was categorised according to racial and ethnic divisions.

59 He probably referred to alcohol dehydrogenase (ADL) and/or aldehyde dehydrogenase (ALDH).
Indigenous peoples were therefore put in significant risk for racial stigmatisation. Under such circumstance, indigenous genetic research and its ethical concerns have been very controversial, especially in the notion of biocolonialism under the global context (Harry 2011). This cirque summed up one of the main concerns of the second line of arguments.

The second line of arguments which argued against the genetisation could be identified most evidently in the narrative of respondent NIS1. He expressed his skepticism towards the need and validity of genetic research of Taiwanese indigenous peoples. He pointed out that attributing indigenous disadvantaged health to their vulnerable genes are the result of media exaggerated effect and researchers’ deliberation to apply for funding (NIS1, 16:05, 18:32). He expressed the current genetic research upon indigenous peoples in Taiwan as largely unnecessary for lacking theoretical basis (NIS1, 16.05). He expressed the reason why the genetic research that were not needed by the circumstances were taken place and the possible impact that stigmatising indigenous peoples as genetically predisposed.

“Genetic research had been misled in Taiwan, even causing the phenomenon of genetic determinism. ... a lot of people in the medical circle know it’s fabricated, but they still manipulate this issue to get research fundings.” (NIS1, 27.41)

Medical research in genetics is still finding grounds to reconcile with the indigenous peoples’ respect and human rights (Chen, Chen et al. 2010). Medical research in genetics were often ended up in making the continual function of geneticisation of diseases that “marginalises or reifies the critical social contexts of the widespread poverty, cultural loss, and systemic racism that affect Aborigines, even blaming them” (Bai 2005; Munsterhjelm and Gilbert 2010: 39).

“They used gene as excuse. Alcohol ... 40, 50 years ago, alcoholism research showed that not even 1 per cent of alcoholism behavior among indigenous peoples. However, their alcoholism behavior had increased 50 times in a decade. Not a single gene will change its behavior in two generations with the scale of 50 times differences.” (NIS1, 18.32)
The genetic factors as health framing strategy in Taiwanese disadvantaged indigenous health have been presented systematically with contrasting two lines of arguments. Commentators observed geneticisation essentialize indigenous health to genetics created challenges that further negatively influenced indigenous health. A closely related dimension, behaviour factors, will be introduced in the next chapter.

5.2.5 Behavioural Factors

Behavioural factors were perceived as behavioural risk factors--- or ‘health risk and protective factors’ that were proximal determinants of health to adverse health outcome. The aspects included in the coding frame were tobacco use, alcohol use, beetle nuts chewing, poor diet and nutrition and physical inactivity. Some of these factors were shared with Australian indigenous peoples, while other factors described a different level, such as immunisation, breastfeeding, illicit drug use (MacRae, Thomson et al. 2013). Behavioural factors were the predominant dimension in the media representation, consisting 197 segments. Of all these 197 segments, excessive alcohol consumption was the most frequently mentioned factor, consisting 97 segments. One of the informants spoke about how indigenous peoples’ certain behaviour would increase the health risk:

“(Indigenous peoples need) To avoid behaviour that causes negative effect on health, for example, smoking, drinking, staying up too late and working to the point of complete exhaustion.” (ILD1, 49.16)

Many traditional indigenous ceremonies entailed behaviours such as smoking, drinking and beetle nuts chewing. The dilemma between continuing the tradition and exposing oneself to the health risks of these practices were illustrated by one of the informants who had been involved with the national campaign of health promotion:

“We need to let indigenous peoples know how to drink, how to eat beetle nuts in a cultural appropriate way. On one hand, one knows these things are bad and have side-effects; on the other hand, one knows when to use under certain circumstances that are permitted by the
culture and tradition. For example, chewing beetle nuts used to be the lubricant between tribes.” (ICS1, 11.40)

Harmful lifestyle as a whole was a common theme among experts explaining for disadvantaged indigenous health. It was elaborated the first account in the cultural factor, where the argument was established that indigenous culture should be responsible for indigenous disadvantaged health. The advocates of the former argument supported several aspects of indigenous culture have negative implications to their health and well-being. They tended to associate indigenous lifestyle to a less healthy lifestyle and thereby provide strategies for achieving better health by suggesting restraining the traditional lifestyle.

“Apart from genes, there are also cultural and living style backgrounds that needed to be considered. For example, they drink too much and eat too much raw food in their lives. (...) Sometimes I see patients like this... they committed in overeating regardless of my advice. They said they need to eat meat, especially fat, in order to have strength to work. They said fat would generate energy.” (ILD1, 42.29)

Individual choice often played central role in the arguments of harmful lifestyle as explaining for disadvantaged indigenous health. It was argued that taking control of one’s life depends on individual’s determination and devotion. Respondent ICS agreed with treating the individual determination as essential to positive health outcome (ICS1, 11.40). Respondent ILD1 noted that whether to exercise lied in the hand of individual, it was especially true for indigenous peoples who lived in a privileged environment (ILD1, 49.16). While emphasising the individual responsibility in health, ILD1 refused to treat alcoholism as indigenous peoples’ sin. The psychological pressure originated from the financial difficulties played a central role in the indigenous drinking (ILD1, 40.35).

Apart from the harmful lifestyle arguments, other experts remained skeptical of the risk dominated indigenous disadvantaged health analysis, where the interventions were based on eliminating behavioural factors that have negative impact on health. It
was deemed too cursory to explain the indigenous health disadvantages, so they
remained reserve on such proposition.

“Health problem does not limit in public health, health problem is a
bio-cultural problem. The complexity of politics, economics, education,
culture are not necessarily viewed as important by the people from the
public health discipline.” “Sometimes the result is bad when one
employs the intervention based on eliminating the risk factors” (NIS5,
32.10)

“Policies say that all will be good if you have enough knowledge. That
is, all you need to do is increase your knowledge in how to exercise and
moderate drinking, you’ll eventually have determination and you will
have the healthy behaviours. This only explains one third of the
problem. And its disparaging logic implies that indigenous peoples
have no determination.” (IS2, 35.20)

Behavioural risk factors were examined with the experts’ interviews. Some
experts echoed the argument of harmful lifestyle of determinant of disadvantaged
indigenous health, such as ILD1 and ICS1. Others remained reserve in the effectiveness
of eliminating behavioural risk factors, such as NIS5 and IS2. In the following section,
other factors that had been used by the experts to explain indigenous disadvantaged
health will be examined.

5.2.6 Other Factors

Seven strands of explanations have been identified as the health framing strategies
for disadvantaged indigenous health. These aspects are recorded from the experts’
references to indigenous health that are beyond the original coding frame categories.
They are essential analysis as a way to explore the less mentioned discourses in the
established institutions and agencies. The determinant of health identified in the first
strand was the discrimination, stigmatisation and prejudice against Taiwanese
indigenous peoples have negative impact on indigenous health. In the Taiwanese
context, the negative impact of discrimination on population health remained under
developed. The impact of discrimination, stigmatisation and prejudice were irrelevant in the government and the media data. The second determinant of health pointed the sparsely allocated indigenous tribes may have negative consequence on the efficiency of indigenous health delivery. In fact, the government took this problem in the agenda and tackled this challenge with the Integrated Delivery System (IDS), a solution as to improve the accessibility of doctors and medical facilities to indigenous peoples. The third determinant of health was to promote health knowledge enhancement by educating indigenous peoples. Some experts were in favour of such proposition, while other do not embrace it. The fourth strand raises the attention to consider the level of analysis as well as the scope of the health notion. It flashed out that limiting the scope of health to biomedical level or medical system administration level leads to misjudgement, misunderstanding and further hinders the progress to solve the problem of indigenous disadvantaged health. The positive impact of National Health Insurance (NHI) on indigenous health was identified in the fifth strand. The NHI provides assistance to the local indigenous doctors to open clinics in the indigenous territories and taking care of the patients in need of acute treatment. The sixth strand emphasised on the importance of taking into account of historical development concerning indigenous peoples. It was observed that the colonial past has ongoing health impact on the indigenous peoples. Last but not the least, the Council of Indigenous Peoples had been recognised as a chance to better accommodate indigenous peoples’ right to health. On one hand, experts raised concerns for the process of policy implementation promulgated by the Council of Indigenous Peoples; on the other hand, experts reminded the role of the civil servants inside the Council of Indigenous Peoples. In particular, their struggle for balance of surviving the bureaucratic system on one hand, and representing the interests and needs of the indigenous peoples on the other hand. It may be difficult to achieve when the interest of the two contradict with each other.

In the first strand, experts reiterated that Taiwanese indigenous peoples had been discriminated, stigmatised and prejudiced against which in a way acknowledged these issues as relevant factors in indigenous health. The issues included Taiwanese society remained either ignorant of indigenous peoples, or discriminated against indigenous peoples (IS1, 27.13), Taiwanese society labelled indigenous peoples with alcohol and beetle nuts (ICS1, 13.19), indigenous peoples’ lives being criticised by the standards of the mainstream (ICS1, 17.00), and the cultural stereotypes (IS2, 9.14). These forms of
discrimination, stigmatisation and prejudice hindered the progress of indigenous health promotion in Taiwan. As NIS5 observed the Amis people, he commented that indigenous peoples’ advantages in sustaining their health were originated from their tradition and culture. Their advantages were not understood by the mainstream society and thus being distorted:

“The culture of Amis people entails abundant knowledge of vegetable. It has its logic in choosing food. We know already that there are a lot of ingredients in their food that contain elements that create functions such as liver-protecting and lowering blood sugar. (...) The mainstream society needs to learn from them, instead of condemning the as disadvantaged. I call this kind of thought ‘distortion’. Nowadays the mainstream society, not only in the media but also in the politics, they have distorted (their culture) ...” (NIS5, 12.11)

At the same time, the annual reports reiterated the challenge in managing health service for indigenous tribes, which spread widely geographically. Such feature, according to the annual reports, has disposes indigenous peoples to disadvantaged health. While sharing his observations on the reasons of indigenous disadvantaged health, respondent ILD1 agrees:

“In the mountains, there is insuperable condition. First, (they spread out in) the vast expanse of land. The land mass of Fusing township consists of 1/3 of the Taoyuan county.” (ILD1, 14.28)

Informant ILD1 announced repeatedly in the interview that the geographically dispersed indigenous tribes ended up in a vulnerable condition because they are numerically small that have been distributed disproportionally small budget due to their small voice in the democratic system on one hand (ILD1, 48.53), and the ill-connected transportation system on the other hand.

“We have small amount of people, only a bit more than 10 000 people in registration. But in the Taoyuan there are at least 2 000 000, the population density ratio is 1:600. So what is this thing called
‘democracy’? It means the majority has advantage. So why indigenous peoples cannot have health care? Because this is how it is in democracy. (...) The principle of votes...(...) the politicians takes into account how much votes he/she gets when distributing the resources.” (ILD1, 15.53)

Simultaneously, as the annual reports underlined the government’s devotion of propagating health knowledge through educating indigenous peoples, respondent ILD1 agreed that health improvement should be implemented through health behaviour education (ILD1, 55.52). The counter argument was presented by respondent IS2, who disagreed to contribute indigenous disadvantaged health on the promotion of ‘health education’. He highlighted on the more holistic level, such as indigenous peoples’ living environment and their social economic status.

“The policies promulgated by the government dispose indigenous health disadvantages--- because it destroyed indigenous peoples’ environment (...) To solve indigenous health disadvantages, one third of the reason is to be determined to change attitude so one will commit in behaviors that have positive impact on health. The rest of the reason associates with indigenous peoples’ social economic status.” (IS2, 35.20)

In the meantime, the framing of health with the public health standards had been challenged by the respondent NIS2. In the discussion of health on the level of life expectancy, he found the scope of health rather obsolete:

“For life expectancy, it is a common indicator for the gap. However, the mechanism that causes the gap of life expectancy behind the scene may be complex. Everybody scrutinises the medical level, that is, the problem in the medical system. But as I just mentioned, indigenous health does not limit to medical system and the curation of diseases.” (NIS2, 1.10.54)
Respondent NIS5 further explains the scope of health or well-being should be perceived as not only a biomedical phenomenon, but a bio-cultural one. He observed that health problem is a bio-cultural phenomenon because the concept of ‘normal’ or ‘abnormal’ of disease and health entail many kinds of explanations. What the biology of disease defines as ‘abnormal’ does not necessarily being defined as ‘abnormal’ socially (NIS5, 1.35.28). In expanding the notion of health from the biomedical perspective, NIS3 and IS3 noted that indigenous health could not be fully understood without taking into account the historical development:

“Apart from focusing in the impact from policies on indigenous health, we cannot forget the historical development of policies. For example, the policies from Japanese colonial period to the Chinese Nationalists’ period have the ongoing and profound impact on indigenous health.” (NIS3 and IS3, notes)

Last but not least, while the establishment of Council of Indigenous Peoples as the cabinet level institute that devotes in indigenous affairs had marked a new era of indigenous policy making in Taiwan, experts voiced their concerns about the function and role of Council of Indigenous Peoples in the right to health of indigenous peoples. While commenting on the short term indicators of indigenous health, IS1 remarked that subsidising insurance fee for the indigenous peoples had consumed all the health budget of Council of Indigenous Peoples. The council has been investing money into subsidies so to increase insurance coverage rate among indigenous peoples (IS1, 19.01).

On the other hand, as mentioned earlier, respondent ILD1 defined the problem of Council of Indigenous Peoples on the level of failing to deliver benevolence and good will due to the policy implementation (ILD1, 32.58). Comparatively, NIS2 accounted the failure of Council of Indigenous Peoples in persuading other governmental agencies because they do not have sufficient professional skills, especially in the area of social welfare and public health (NIS2, 1.03.41).

Thus far, this thesis has explicated seven strands of explanations that have been identified outside the original coding categories that contributes to the indigenous health framing as referenced by the experts. The basic structure had been further developed with the experts’ accounts, categorised in accordance with each coding frame
dimensions. In the subsequent section, theories proposed by Reading and Wien (2009) facilitated the explanations of three stakeholders.

5.3 Proximal, Intermediate and Distal Determinants of Health

When exploring the data of the disadvantaged Taiwanese indigenous health, whether it be governmental policies or media reports, the issue becomes that every suggested reason of the disadvantaged health or the cure for it implies a distinctive factor that would cause the health problem. In scrutinising their explanations, or health framing, the factors that have been indicated as the major reason show what the real problem implied to be. The analysis results of the media and government health framing echo closely the previous research (Ru 2012). The interview analysis highlights cultural, political and genetic factors as well as seven strands of factors. Each analysis expands the scope of the problem and factors.

Reading and Wien (2009) proposed a structure to the factors above. Instead of arbitrary factors, there is a hierarchy behind the factors. The problems on the proximal and intermediate levels have been most commonly addressed in the government and media perspectives, but not the problems on the distal level. That is, the direct impact on the indigenous health have been well-recognised by the government and the media, but not the profound determinants that caused the problems of the distal level.

The percentage of Canadian aborigines in Canada is very similar to the percentage of Taiwanese indigenous peoples in Taiwan. There is heterogeneity among the Canadian aborigines, just as the Taiwanese indigenous peoples. In ‘Health Inequalities and Social Determinants of Aboriginal Health’, Reading and Wien (2009) distinguished three levels of factors: the proximal, the intermediate and the distal. In brief, three levels of indigenous determinants of health were systematically proposed from their research. They are the proximal, the intermediate and the distal determinants of indigenous health. The proximal social determinants of aboriginal health include health behaviour, physical environment, employment and income, education, food insecurity; and the intermediate determinants of health include health care systems, educational system, community infrastructure, resources and capacities, environmental stewardship, and cultural continuity. Last but not least, distal determinants of health includes colonialism, racism and social exclusion and self-determination. They emphasised that combating Canadian aboriginal health inequalities required attention to all three levels by arguing
that “the unfavourable distal, intermediate and proximal determinants of health are associated with increased stress through lack of control, diminished immunity and resiliency to disease and social problems, as well as decreased capacity to address ill health” (ibid: 24). On one hand, it is clear that many of the proximal and the intermediate determinants of health had been addressed by the stakeholders, especially among the government and the media. On the other hand, the distal determinants of health, however, did not play major roles in the reasons of disadvantaged indigenous health under the Taiwanese context. This thesis will briefly discuss these two aspects in terms of their impact on indigenous health in the following section.

5.3.1 Proximal and Intermediate Levels

Proximal determinants of health were defined as ‘conditions that have a direct impact on physical, emotional, mental or spiritual health’. Unfavourable proximal determinants can contribute to stressors that have negative impact on health because the skills and resources to help people deal with life challenges (including illness and injury) are absent (Reading and Wien 2009: 5-6). On the other hand, intermediate determinants of health can be seen as ‘the origin of those proximal determinants’ (Reading and Wien 2009: 15). In the following section, perspectives will be drawn from the accessibility to health care system, educational system, maintenance of community infrastructure and resources, and cultural continuity.

In regard to health care system, it was widely accepted as the major reason contributing to the disadvantaged indigenous health among the government, the media and the experts. The authors give emphasis on the health care systems and argue that the federal system of health care services are not as accessible to Canadian aboriginal peoples compared with others. Similarly, Taiwanese indigenous peoples do not have equal access to the health care system (see chapter 2.3). The lack of medical support could be seen as a severe threat to the indigenous health, Integrated Delivery System (IDS) was initiated to tackle this challenge. Wu (2012) reiterated in the National Health Insurance Bimonthly that Integrated Delivery System (IDS) was implemented since 1999 as a way to better manage medical resources so indigenous peoples would not be left to pay health insurance while no medical resources available to them. The disadvantaged indigenous health explanations from the government confirmed the urgent need to make health services accessible to indigenous peoples. As a
consequence, various initiatives were made to tackle, including subsiding the transportation fee to see the doctors and the evacuation system for critical care patients. As observed in the previous chapter, experts confirmed in the fifth strand (of chapter 5.2.6) that the existence of National Health Insurance (NHI) was instrumental in sustaining indigenous health. However, under the society where discrimination against indigenous peoples was powerful and pervasive as observed in the first strand (of chapter 5.2.6), the effectiveness of the government endeavours to promote indigenous health may be limited.

As for education systems for indigenous peoples, Taiwan shared similar challenges as Canada. “Adequate education, which in many ways continues to be denied to Aboriginal peoples, has a profound impact on income, employment and living conditions.” The percentage gap between indigenous and non-indigenous students on the level of vocational schools and higher education, according to the 2009 survey, was 21.28 per cent (Council of Indigenous Peoples and Education 2011). Most of the indigenous peoples—85.88 per cent of the entire indigenous population—do not obtain diploma higher than secondary school. It has direct impact on life opportunities of indigenous peoples in terms of income and employment.

In terms of community infrastructure and resources, it has been emphasised that the health of indigenous peoples depend on them. “Limited infrastructure and resource development opportunities have been important contributors to economic insecurity and marginalisation, with subsequent deprivation among community members.” (Reading and Wien 2009: 17) In the context of Taiwan, infrastructure of the indigenous tribal areas is poor. In particular, the absence of hospitals, the low availability of tap water and the insufficient budget on road maintenance as well as human resources of fire department (Ali 2013).

Lastly, cultural continuity was defined as ‘the degree of social and cultural cohesion within a community’, according to the research done by Chandler and Lalonde (1998), the rate of suicide has negative correlations to the degree of bond to ‘land title, self-government (...), control of education, security and cultural facilities, as well as control of the policies and practice of health and social programs.’ (Reading and Wien 2009: 18). Cultural continuity was captured in the coding frame cultural factors (coded 3.2). Cultural factors were inadequately addressed among the media (three per cent), and were lack of records from the ARPH. They were mainly addressed among experts.
Language is an important component of cultural continuity. The process of indigenous language being uprooted began during the Japanese occupation period (1895-1945). The Japanese were the first to govern the whole island and were exceptionally successful in promoting Japanese language as national language in order to “foster communication, develop culture and assimilate Taiwanese people, just as Western countries impose their own languages on their new territories” (Chen 1996). The Japanese as national language was mainly promoted through national education. By 1944, more than 90 percent of indigenous pupils were included in elementary level education. From the beginning of 1929 to 1942, the percentage of Japanese speaking indigenous population had been increased dramatically. For example, among Atayals, it had been increased from 4.6% to 55.2%; among Paiwan, it had been increased from 3.6% to 48% (Afo, n.d.).

After the World War II, the Chinese Nationalists implemented Mandarin Chinese as national language thoroughly. From 1945 to 1984, a series of policies had been promulgated that lead to eliminate indigenous traditional names, imposing Chinese values and language through national education, forbidding non-Chinese language usage in daily life and church services. In brief, the Chinese Nationalist rule was repressive and imposed a period of martial law for 38 years. The national language policy with the aim to assimilate indigenous peoples had been successful. For example, at least six indigenous languages were categorised as critically endangered by the UNESCO (Afo, n.d.).

Such lost of language as an instance of discontinuity of culture has severe consequences, especially resulting in poor health. Just as Hallett and his colleagues observed “the generic association between cultural collapse and the rise of public health problem is so uniform and so exception less as to be beyond serious doubt.” (as cited in Romaine, n.d.). Research has shown that while the community is successful in promoting their linguistic and cultural heritage, they have better chance to gain a sense of control of their own lives, their well-being will thereby better secured (Romaine, n.d.).

5.3.2 Distal Level

Distal determinants, according to Readings and Wien (2009), have “the most profound influence on the health of populations because they represent political,
economic, and social contexts that construct both intermediate and proximal determinants.” (Reading and Wien 2009: 20). For indigenous peoples, the distal determinants of health entailed colonialism, racism and social exclusion, as well as repression of self-determination (ibid). Several experts had addressed the issues above as determinants of indigenous health, such as respondent IS2 mentioning ‘colonisation’ and ‘re-colonisation’, IS1 referring to ‘racism’ and ‘prejudice’ and NIS2 using the concept of ‘social exclusion’. However, the discourses of distal determinants of indigenous health in the Taiwanese context were still emerging. In the following section, issues such as social change, power and doctrine of discovery will be discussed along with their impact on indigenous health.

First, the issue of social change was closely associated with the nation building strategy. In the Canadian context, Reading and Wien (2009:21) explained the connection between the nation building movement and indigenous health. They explicated the political agenda of the 20th century was to assimilate and acculturate indigenous peoples to dominant culture. The agenda manifested in the legislations and social policies in a way that ‘reward assimilation through resources and opportunities, while punishing cultural retention through the creation of inequalities.’ (Reading and Wien 2009: 21). Modernisation and nation building movement took place simultaneously in the Taiwanese context. In hope of economy growth, modernisation became the goal of national development. In particular, it had manifested in the industrialisation and commercialisation of mountain economy which had been implemented between the 1960s and 1970s. In the light of considerable interest, indigenous peoples’ land had been encroached gradually by non-indigenous capitalists. Indigenous peoples began to have their voices in the public sphere is a recent phenomenon. It is not until mass protests against martial law, which had suspended civil liberties from 1949 to 1987, that civil society emerged in Taiwan (Blundell 2012). That is to say, it was not until the last decade of 20th century that Taiwanese indigenous peoples would be able to express their opinions and interests in the modernisation process. The political agenda that eradicated indigenous traditional values has been disguised in the name of modernisation that has negative impact on maintaining the Indigenous Peoples’ inter-generational identities, families and tribes, and more profoundly, their health. Tsai (2011) examined the mental disorder of Tao people thereby scrutinised their social suffering.
“In the sociological study, the collective mental disorder of Tao people reflects the ‘social suffering’ in the process of social change that disassembled and deranged indigenous societies. Analysing from the perspective of historical and societal root, it was being forcibly involved in the modernised social change that resulted in the high percentage of mental disorder of the Tao people.” (Tsai 2011: 93)

The account from Tsai that signified Tao people’s mental disorder was originated from the social suffering embedded in the social change was to respond the geneticisation of indigenous disadvantaged health (Tsai 2011:90-91). The genetic research on Taiwanese indigenous peoples had been pervasive. This genetic perspective declared certain genome in the indigenous peoples was naturally vulnerable to disease and mental disorder. Tsai described the traditional tribal practices supported by the unique local knowledge system have positive impact on people’s health as well as the tribe’s sustainability.

“The analysis shown that Tao tribe in the Orchid Island is a natural deinstitutionalised community. The natural and non-industrialised environment, remaining live subsistence activities, and the close family ties are all helpful for the stabilisation and recovery of the people with mental disorder.” (Tsai 2011: 92)

The argument of Tsai brought us to the second aspect of distal health determinant: power. Her emphasis on the process of social change, however, needed to confront with the questions about the role of power in the seemingly impersonal process. It would be misleading to say that the social change has negative impact on indigenous health. To elucidate the concept of social change, Lukes (2005: 121-122) suggested to stop speaking of ‘cultural inertia’ in order to concentrate in the concrete interests and privileges that are served by the complicated process of ‘transmitting culture’ or ‘social change’. Wang (2013) confirmed the role of power in institutional design while examining the long-term care policies and practices in Taiwan. He observed the policies that lack cultural competence in indigenous counties and warned its consequences may be equivalent to cultural genocide for indigenous peoples. He explained that the current
institutional design of long-term care has been built fundamentally on non-indigenous experiences. This design lacks cultural-sensitivity and rejects the idea: ‘indigenous peoples using their traditional methods to take care of their own people’ (ibid). This current power phenomenon was a direct result of colonisation under the principle of doctrine of discovery.

As the third aspect of distal determinants of health, doctrine of discovery was one of the most crucial one. It lies in the ‘historic tendency of state actors to assert a sovereign dominant authority over indigenous peoples’, known as the doctrine of discovery. Doctrine of discovery, the ‘international legal construct’ that ‘lies on the root of the violations of indigenous peoples’ human rights’, has caused ‘state claims to and the mass appropriation of the lands, territories, and the resources of indigenous peoples’ as well as ‘human rights grievances and concerns’ (Frichner 2010). It is under the doctrine of discovery and the ‘Framework of Dominance’ (Frichner 2010: 5) at the root of the policies that repress indigenous peoples’ self-determination of their own health.

Doctrine of discovery manifested in the classification of indigenous peoples in the healthcare system. The solid foundation of classification from the Japanese governance throughout the whole island was delivered to the Chinese Nationalists after WWII. The health classification of indigenous peoples, as introduced in chapter 2.2, had ongoing negative impact on their health. Regardless of various measures of legal recognition on indigenous health, this classification still dominated the healthcare design for indigenous peoples which in terms revealed that the logic of the authority to circumscribed indigenous peoples within geographical location had been similar to the Japanese colonial time. Commentators suggested that this mindset to define indigenous peoples to geographical, instead of cultural, dimension were evident in various health and social policies (Wang 2013).

Except from the lingering colonial mindset manifested in the classifications, some commentators argued further that such doctrine of discovery not only asserted sovereign over indigenous peoples, but indigenous sovereignty. Shih (2012) advocates that the sovereignty of indigenous peoples was taken illegally in the first place and transferred from the former settler to the latter one: from the Spanish to the Republic of China (Taiwan). Cheng (2012:114-125) supplemented that the statehood of indigenous peoples was evident when examining by the international law. She supported her observation by giving the example that according to anthropological evidence, the pan-atayal people
had already fulfilled each and every requirements of statehood\textsuperscript{60} by the end of 19th century.

One of the solutions to remedy the ongoing manifests of doctrine of discovery is to initiate reconciliation by realising self-determination. Self-determination in health can be seen as the pivoting factor of positive impact on health. Self-determination in health refers to the health care of indigenous peoples, by indigenous peoples and for indigenous peoples. Self-determination in health should be based on indigenous peoples’ own needs, experiences and aspiration. The advocates of this argument emphasise on government’s role of active facilitating “Indigenous Peoples-- using their own traditional methods-- taking care of themselves” (Ru 2012; Wang 2013). Wang (2013) pointed out that the current institutional design regarding long term care excludes the possibilities for indigenous peoples to take care of themselves. While recognising the Taiwanese legal arrangement on indigenous to be pluralistic, Ru (2012) identified three core challenges for indigenous health in the Taiwanese context: medicalisation, individualisation and generalisation. He urged the realisation of self-determination in health through tackling health from eco-health perspective that striking balance in the bio-system through promoting biodiversity.

In brief, the proximal and intermediate determinants of health are illuminated with Taiwanese examples in the accessibility to health care system, educational system, maintenance of community infrastructure and resources, and cultural continuity. The distal determinants of health are discussed from the perspectives of social change, power and doctrine of discovery. The levels of explanations of Taiwanese disadvantaged health deepen with introducing the framework that categorises proximal, intermediate and distal social determinants of health.

\textsuperscript{60} According to ‘Montevideo Convention on the Rights and Duties of States’ (1933), article 1.
6. Conclusion and Discussion

This thesis explored the health framing of Taiwanese disadvantaged indigenous peoples by examining the explanations from the three stakeholders: the government, the media and the experts and thereby supplemented the current debate of right to indigenous health in the Taiwanese context. It filled in the gap in the current literature via examining the missing factors of Taiwanese disadvantaged indigenous health from the three stakeholders. The missing factors underline the need for further research on the distal determinants of indigenous health.

Annual Reports of Public Health (ARPH) and news reports were utilised to analyse the framing of Taiwanese indigenous health for the government and the media respectively. Qualitative content analysis was applied for all parts of analysis. The ARPH from 2001 to 2012 were analysed for the governmental health framing. For the media health framing, 98 pieces of news concerning indigenous disadvantaged health from 2000 to 2012 were segmented and coded. The results from the governmental analysis indicated for the recent ten years, structural factor of the medical and health resources insufficiencies has been the primary health framing strategy of the government. From analysing the ARPH, 82 per cent were associated with structural factors. Within these factors insufficient health and medical resources were the primary reasons, making up 63 per cent of all the codes. The results from the analysis from the media representation indicated both structural factor and behavioural risk factors were the main reasons explaining for disadvantaged indigenous health. In particular, they were structural factor of medical and health resources insufficiencies and behavioural risk factors in excessive alcohol consumption. The behavioural factors constitute 47 per cent of the coding, followed by structural factor in the media representation which constitutes 40 per cent of the media’s health framing.

In brief, the implied cause to the root of the problem were primarily identified as medical and health resources insufficiencies for the government and a combination of not only medical and health resources insufficiencies but also behavioural risk factors with negative health impacts in the media representation. The implied problem were critically interrogated in the interview analysis.
Experts were first presented via analysing the linkage between their specific positions and expertise. The interview analysis brought attention to the factors of determinants of indigenous health, which were less discussed in the framings of the government and the media. These factors were political factors, cultural factors, and genetic factors. The political factors were the least addressed among the three. The experts discussed the aspects entailed in the political factors, such as agenda-setting, policy implementation, exclusion in democratic system. As for the cultural factors, an interrelation between culture and indigenous health was first clarified. Cultural factors were developed in the experts’ interview with three aspects: self-determination, indigenous subjectivity and spiritual interpretation. The experts’ narratives diverged on whether to see genes as disposing factors to disadvantaged health. Based on the interview analysis, seven strands were identified on the determinants of health that stretched beyond the original coding frame. It extended the scope of the problems from the basic framework proposed by the framing of the government and the media to a wider range of factors.

These factors referred by the three stakeholders were better structured by incorporating the three levels of indigenous determinants. Based on the theory proposed by Reading and Wien, instead of arbitrary factors, there is a hierarchy behind the factors. The factors that have been recapitulated by the government and media concentrate on the level of proximal and intermediate levels, while the factors that have been omitted by these two stakeholders seemed to be on the distal level. That is to say, the direct impacts on the indigenous health have been well-recognised by the government and the media. However, not the distal determinants that have the most profound influence on health. As indicated from the interview analysis, the missing factors of the distal determinants are (i) the negligence of social change that are closely related to nation-building model which resulted in disassembled and deranged indigenous peoples, (ii) the role of power in the design of health institutions which manifested in the absence of cultural sensitivity and (iii) the ongoing impact of doctrine of discovery in Taiwan.

So far, how disadvantaged indigenous health has become a problem was scrutinised and problematised. By studying the health framing strategies, stakeholders

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61 See chapter 5.2.6 for more detailed information
ascribed the Taiwanese disadvantaged indigenous health to different levels of problems. Proposals and policies reflected how one understood as the ‘problem’. The issue of ‘disadvantaged indigenous health’ should not be taken unproblematic because assumptions and justifications that give shape to the problem are rarely unproblematic.

Due to the limit of time and funding, this thesis could not conduct a comparative research so to provide experiences from indigenous peoples. Their experience would have been valuable and interesting in terms of their advantage and challenges to achieve self-determination in both health and well-being. Much research still needed to be included, such as conducting a comparative studies on indigenous health inequalities between countries, expending the research scope to include indigenous peoples as direct informants, and inquiring the function of power in governance within the health framing.
Appendix

Appendix 1. Maps

1.1 The distribution map of Austronesian Languages

[Map of Austronesian Languages]

Source: Li 2010: front cover insert

1.2 The distribution map of Austronesian Languages in Taiwan

[Map of Austronesian Languages in Taiwan]

Source: Li 2010: front cover insert
Appendix 2. Coding Frame

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Content of dimension</th>
<th>Category definition</th>
</tr>
</thead>
</table>
| Dimension 0 | 0. Technical codes  
|            | 0.1 Background information Dimension 1 (D1)  
|            | 0.2 Reasons given for bad health Dimension 3 (D3)  
|            | 0.3 Attribution of the problem Dimension 4 (D4)  |

<table>
<thead>
<tr>
<th>Dimension 1</th>
<th>1. Publishers</th>
</tr>
</thead>
</table>
|             | 1.1 News articles  
|             | 1.1.1 National News  
|             | 1.1.2 Regional News  
|             | 1.1.3 Others  
|             | 1.2 Editorials, columns and opinion pieces  
|             | 1.3 Feature stories  
<p>|             | 1.4 Others  |</p>
<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Content of dimension</th>
<th>Category definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimension 2</td>
<td>2. Health Problem Mentioned</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1 The top ten causes of death (2009)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1.1 Malignant neoplasms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1.2 Accidents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1.3 Chronic liver disease and cirrhosis</td>
<td>Including chronic liver disease and/or cirrhosis</td>
</tr>
<tr>
<td></td>
<td>2.1.4 Cerebrovascular disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1.5 Pneumonia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1.6 Diabetes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.1.7 High blood pressure</td>
<td>Including four other death causes: heart disease (i.e. cardiovascular disease), chronic respiratory system disease, septicemia, self-hurt, and disease of the genitourinary system</td>
</tr>
<tr>
<td></td>
<td>2.1.8 Other reasons for death</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2 Other common disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2.1 Gout</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2.2 Obesity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2.3 Mental problem</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.2.4 Other</td>
<td>Other common causes of death</td>
</tr>
<tr>
<td></td>
<td>2.3 Demographic facts in general</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.4 Epidemiological facts in general</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.5 Others</td>
<td>Other aspects of health ‘problem’, but not within the traditional understanding of the ‘presence of sickness’, including aging, grandparenting, and so on</td>
</tr>
<tr>
<td>Dimensions</td>
<td>Content of dimension</td>
<td>Category definition</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Dimension 3</td>
<td>3. Reasons given for poor health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1 Structural factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1.1 Lack of health/medical resource</td>
<td>It can be rephrased as &quot;insufficient health resource/medical resource&quot;, including all problems relating to the medical resource. For example, health care, health clinics and hospitals can be all counted as medical resources</td>
</tr>
<tr>
<td></td>
<td>3.1.2 Lack of economic resource</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1.3 Lack of education resource</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1.4 Lack of job security and good working environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1.5 Lack of cultural-sensitive support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1.6 Lack of infrastructure (e.g. safe drinking water)</td>
<td>Most commonly seen as lacking drinking water, safe road, and so on</td>
</tr>
<tr>
<td></td>
<td>3.1.7 Poor housing/ living environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.1.8 Others</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2 Cultural factors</td>
<td>It takes into account the perspective of indigenous culture and well-being and the impact of history of conquest</td>
</tr>
<tr>
<td></td>
<td>3.2.1 Indigenous Peoples lost languages, cultures and identities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2.2 Indigenous Peoples’ involuntary displacement in the past</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2.3 Indigenous Peoples lost their traditional land</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2.4 Indigenous Peoples lost their traditional lifestyle</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2.5 Others</td>
<td></td>
</tr>
</tbody>
</table>
### 3.3 Political factors
Mostly having racial connotation, describing certain deficiency in genetics due to their cultural characteristics

### 3.4 Genetic factors

### 3.5 Behavioral risk factors
Risk factors that can be eliminated or reduced through lifestyle or behavioral changes

#### 3.5.1 Tobacco smoking
#### 3.5.2 Excessive alcohol consumption
#### 3.5.3 Beetle nuts chewing
#### 3.5.4 Poor diet and nutrition
#### 3.5.5 Physical inactivity
#### 3.5.6 Others
Lifestyles other than tobacco, alcohol, diet, physical activity are categorized here

### 3.6 Others
Reasons other than structural, cultural, political, genetic or behavioral

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Content of dimension</th>
<th>Category definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3 Political factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4 Genetic factors</td>
<td></td>
<td>Mostly having racial connotation, describing certain deficiency in genetics due to their cultural characteristics</td>
</tr>
<tr>
<td>3.5 Behavioral risk factors</td>
<td></td>
<td>Risk factors that can be eliminated or reduced through lifestyle or behavioral changes</td>
</tr>
<tr>
<td>3.5.1 Tobacco smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5.2 Excessive alcohol consumption</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5.3 Beetle nuts chewing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5.4 Poor diet and nutrition</td>
<td></td>
<td></td>
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<td>3.5.5 Physical inactivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5.6 Others</td>
<td></td>
<td>Lifestyles other than tobacco, alcohol, diet, physical activity are categorized here</td>
</tr>
<tr>
<td>3.6 Others</td>
<td></td>
<td>Reasons other than structural, cultural, political, genetic or behavioral</td>
</tr>
</tbody>
</table>

### 4. Who is to blamed
It can be rephrased as ‘Who is responsible for the problem’, or ‘to where the problem can be attributed to’

#### 4.1 Individual
Labeling individual as duty-carrier. Such inhabitants of certain area, citizens, and so on

#### 4.2 Indigenous culture
Labeling and in most cases essentializing indigenous peoples as duty-carriers

#### 4.3 Corporations
Corporations or legal person with investment capitals
<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Content of dimension</th>
<th>Category definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4 Politicians</td>
<td>Politicians, often referring to the individuals that struggle to their respective elections</td>
<td>Politicians, often referring to the individuals that struggle to their respective elections</td>
</tr>
<tr>
<td>4.5 Prevailing conditions</td>
<td>i.e. structural conditions</td>
<td>i.e. structural conditions</td>
</tr>
<tr>
<td>4.6 Others</td>
<td>None of the above, such as statehood, problem of the ‘cultural transformation’ in history, and so on</td>
<td>None of the above, such as statehood, problem of the ‘cultural transformation’ in history, and so on</td>
</tr>
</tbody>
</table>
Appendix 3. Matrix on Paraphrases

3.1 Quotes from the news and the categories, second dimension

<table>
<thead>
<tr>
<th>Quotes illustrating the category (‘Health Problem Mentioned’)</th>
<th>Category Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Indigenous life expectancy is 10 years less than the general area of Taiwan. Their death rate is three to five times higher.” (P2)</td>
<td>Demographic Facts in General</td>
</tr>
<tr>
<td>“For a long time, accidents and the related negative impacts have been the top death cause for indigenous peoples.” (P18)</td>
<td>Accidents</td>
</tr>
<tr>
<td>“Some indigenous peoples to drown their sorrow in drinks, resulting in drunk driving, and higher rate of getting liver disease as well as gout.” (P19)</td>
<td>Gout, Chronic liver disease and Cirrhosis</td>
</tr>
<tr>
<td>The problem of malignant neoplasms is the second biggest cause to death in Ren-Ai Township. (P11)</td>
<td>Malignant Neoplasms</td>
</tr>
<tr>
<td>According to the Annual Statistics of Taiwanese Indigenous peoples, higher indigenous death rate appeared in cerebrovascular diseases, compared with citizens of Taipei City. (P74)</td>
<td>Cerebrovascular Diseases</td>
</tr>
<tr>
<td>Indigenous Peoples’ death rate for Diabetes used to be lower compared to the average. However in the recent 10 years the rate has been higher than the average. (P65)</td>
<td>Diabetes</td>
</tr>
<tr>
<td>For problems like diabetes, gout and high blood pressure, the incidence rate is higher among Austronesians than others.</td>
<td>Diabetes, Gout, High Blood Pressure</td>
</tr>
<tr>
<td>Ditmanson Medical Foundation Chia-Yi Christian Hospital pointed out that because habits of massive nutrition intake, obesity become a common problem among indigenous peoples. (P41)</td>
<td>Obesity</td>
</tr>
<tr>
<td>Abnormal rate of uric acid among Nan-Ao villagers is higher than the municipal rate. (P35)</td>
<td>Epidemiological facts in general</td>
</tr>
</tbody>
</table>

3.2 Quotes from the news and the categories, third dimension

The quotes illustrating the category may contain more than one segment which may be coded in other dimensions. For example, there are at least three different segments in the quote “People in the mountains have mental problems. Such
phenomenon may result from alcoholism as well as living standards”. The ‘mental problem’ was not present in the category name, because it had been coded in the second dimension Health Problem Mentioned. As for the segment ‘alcoholism’, the decision rule has made that ‘alcoholism’ should be distinguished from excessive alcohol consumption (coded 3.5.2). The former is a disease whereas the latter is a matter of habit.

### 3.3 Quotes from the fourth dimension

#### Quotes Illustrating the category (‘Attribution of the problem’) Category Names

<table>
<thead>
<tr>
<th>Quotes Illustrating the category (‘Attribution of the problem’)</th>
<th>Category Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous peoples’ higher rate of smoking, drinking and chewing beetle nuts lead to their (poorer health). (P6)</td>
<td>Tobacco smoking, excessive alcohol consumption, beetle nuts chewing</td>
</tr>
<tr>
<td>Health problems are originated in drinking, smoking, imbalanced intake of food and lack of exercise. Consequently, improving eating habits is very important. (P51)</td>
<td>Tobacco smoking, excessive alcohol consumption, physical inactivity</td>
</tr>
<tr>
<td>Villagers do not have correct medical concept of seeing doctors in time and take medicines regularly, which result in gout getting worse. (P1)</td>
<td>Individual</td>
</tr>
</tbody>
</table>
In order to facilitate indigenous peoples for establishing correct concept of health… so the indigenous peoples would be self-aware and make brand new tribes themselves. (P15)

Indigenous Peoples are again colonized and marginalized because indigenous lands have been losing rapidly and the resources been abused by corporations from outside (P34)

President Chen claimed to establish a “government of human rights” when he inaugurated (…) but indigenous peoples are feeling “flourish outside while poor within”. Indigenous health policies should be re-examined and improved with the medical indicators in mind. (…) In this way, the government would not attract criticisms of wasting tax payers’ money and ‘oligopoly’. (P61)

It is actually a series social problem, because (indigenous peoples) not respected in the society. This leads to the lack of self-confidence that would easily make them alcoholics.

There are structural factors behind indigenous problems…

<table>
<thead>
<tr>
<th>Quotes Illustrating the category (‘Attribution of the problem’)</th>
<th>Category Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order to facilitate indigenous peoples for establishing correct concept of health… so the indigenous peoples would be self-aware and make brand new tribes themselves. (P15)</td>
<td>Indigenous culture</td>
</tr>
<tr>
<td>Indigenous Peoples are again colonized and marginalized because indigenous lands have been losing rapidly and the resources been abused by corporations from outside (P34)</td>
<td>Corporations</td>
</tr>
<tr>
<td>President Chen claimed to establish a “government of human rights” when he inaugurated (…) but indigenous peoples are feeling “flourish outside while poor within”. Indigenous health policies should be re-examined and improved with the medical indicators in mind. (…) In this way, the government would not attract criticisms of wasting tax payers’ money and ‘oligopoly’. (P61)</td>
<td>Politicians</td>
</tr>
<tr>
<td>It is actually a series social problem, because (indigenous peoples) not respected in the society. This leads to the lack of self-confidence that would easily make them alcoholics.</td>
<td>Prevailing condition</td>
</tr>
<tr>
<td>There are structural factors behind indigenous problems…</td>
<td>Prevailing conditions</td>
</tr>
</tbody>
</table>
Appendix 4. Coding frequency in numbers

4.1 Most Commonly Referred Indigenous Health Problems by the Media, second dimension

<table>
<thead>
<tr>
<th>Name of the Codes</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2.3 Demographic Facts in General</td>
<td>75</td>
</tr>
<tr>
<td>2 2.2.1 Gout</td>
<td>72</td>
</tr>
<tr>
<td>3 2.2.4 Others</td>
<td>68</td>
</tr>
<tr>
<td>4 2.1.3 Accidents</td>
<td>37</td>
</tr>
<tr>
<td>5 2.1.4 Chronic Liver Disease and Cirrhosis</td>
<td>33</td>
</tr>
<tr>
<td>6 2.4 Epidemiological Facts in General</td>
<td>31</td>
</tr>
<tr>
<td>7 2.5 Others</td>
<td>16</td>
</tr>
<tr>
<td>8 2.1.6 Diabetes</td>
<td>14</td>
</tr>
<tr>
<td>9 2.1.8 Other Reasons for Death</td>
<td>12</td>
</tr>
<tr>
<td>10 2.2.2 Obesity</td>
<td>9</td>
</tr>
</tbody>
</table>

4.2 Number of Primary Document Codes in media analysis

<table>
<thead>
<tr>
<th>Reasons given for poor health</th>
<th>TOTALS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Structural factors</td>
<td>0</td>
</tr>
<tr>
<td>3.1.1 Lack of health/medical resource</td>
<td>69</td>
</tr>
<tr>
<td>3.1.2 Lack of economic resource</td>
<td>20</td>
</tr>
<tr>
<td>3.1.3 Lack of education resource</td>
<td>6</td>
</tr>
<tr>
<td>3.1.4 Lack of job security and good working environment</td>
<td>18</td>
</tr>
<tr>
<td>3.1.5 Lack of cultural-sensitive support</td>
<td>9</td>
</tr>
<tr>
<td>3.1.6 Lack of infrastructure (safe drinking water)</td>
<td>15</td>
</tr>
<tr>
<td>3.1.7 Poor housing/living environment</td>
<td>10</td>
</tr>
<tr>
<td>3.1.8 Others</td>
<td>14</td>
</tr>
<tr>
<td>3.2 Cultural factors</td>
<td>0</td>
</tr>
<tr>
<td>3.2.1 IPs lost languages, cultures and identities</td>
<td>0</td>
</tr>
<tr>
<td>3.2.2 IPs’ involuntary displacement in the past</td>
<td>0</td>
</tr>
<tr>
<td>3.2.3 IPs lost their traditional land</td>
<td>2</td>
</tr>
</tbody>
</table>
### 4.3 Number of Codes in government analysis

<table>
<thead>
<tr>
<th>Reasons given for poor health</th>
<th>Number of codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Structural factors</td>
<td>0</td>
</tr>
<tr>
<td>3.1.1 Lack of health/medical resource</td>
<td>111</td>
</tr>
<tr>
<td>3.1.2 Lack of economic resource</td>
<td>8</td>
</tr>
<tr>
<td>3.1.3 Lack of education resource</td>
<td>0</td>
</tr>
<tr>
<td>3.1.4 Lack of job security and good working environment</td>
<td>0</td>
</tr>
<tr>
<td>3.1.5 Lack of cultural-sensitive support</td>
<td>5</td>
</tr>
<tr>
<td>3.1.6 Lack of infrastructure (safe drinking water)</td>
<td>0</td>
</tr>
<tr>
<td>3.1.7 Poor housing/living environment</td>
<td>0</td>
</tr>
<tr>
<td>3.1.8 Others</td>
<td>22</td>
</tr>
<tr>
<td>3.2 Cultural factors</td>
<td>0</td>
</tr>
<tr>
<td>3.2.1 IPs lost languages, cultures and identities</td>
<td>0</td>
</tr>
<tr>
<td>3.2.2 IPs’ involuntary displacement in the past</td>
<td>0</td>
</tr>
<tr>
<td>3.2.3 IPs lost their traditional land</td>
<td>0</td>
</tr>
<tr>
<td>Reasons given for poor health</td>
<td>Number of codes</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>3.2.4 IPs lost their traditional lifestyle</td>
<td>0</td>
</tr>
<tr>
<td>3.2.5 Others</td>
<td>0</td>
</tr>
<tr>
<td>3.3 Political factors</td>
<td>0</td>
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<tr>
<td>3.4 Genetic factors</td>
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</tr>
<tr>
<td>3.5 Behavioural risk factors</td>
<td>0</td>
</tr>
<tr>
<td>3.5.1 Tobacco smoking</td>
<td>0</td>
</tr>
<tr>
<td>3.5.2 Excessive alcohol consumption</td>
<td>0</td>
</tr>
<tr>
<td>3.5.3 Beetle nuts chewing</td>
<td>0</td>
</tr>
<tr>
<td>3.5.4 Poor diet and nutrition</td>
<td>0</td>
</tr>
<tr>
<td>3.5.5 Physical inactivity</td>
<td>0</td>
</tr>
<tr>
<td>3.5.6 Others</td>
<td>0</td>
</tr>
<tr>
<td>3.6 Others</td>
<td>31</td>
</tr>
<tr>
<td>TOTALS:</td>
<td>177</td>
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</table>
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