Traditional Anishinabe Healing in a Clinical Setting:
The Development of an Aboriginal Interdisciplinary Approach to Community-based Aboriginal Mental Health Care

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ABSTRACT
Traditional medicine has been practiced by Aboriginal people for thousands of years at the community level. It is still practiced today outside of the mainstream health system by many Aboriginal people. However, providing this type of care in a clinical, health centre setting and in co-operation with western treatment methods is new, and requires a merging of traditional Aboriginal and western medical world views in order to develop protocols for service delivery that ensure the integrity of both systems. The groundwork required to ensure the safety of clients, providers, and organizations within the new integrated system is still largely undocumented. To address this gap, we studied factors that support the successful integration of traditional Aboriginal healing and western mental health care approaches, and document the experiences of clients and providers. To accomplish this we contextualize 10 years of experience of traditional healing services development with in-depth interviews and focus groups with 17 community service providers and 23 clients. We found that the development of traditional healing protocols, inter-professional education for providers and community members and a focus on client access to traditional Anishinabe health services provide the basis for the integration of western and traditional healing practices in the model under study. Our findings show integrated care resulted in positive experiences for clients and providers. We conclude that traditional healing approaches can be successfully integrated with clinical mental health services. Further research is necessary to improve our understanding of client experiences with this integrated approach and the impact on wholistic health and well-being.

KEYWORDS
Traditional Medicine, Traditional Healing, Aboriginal mental health, integrated services, interdisciplinary care
INTRODUCTION

I remember once sitting down with [a clan leader], and he was telling me that all the people were going down to the nursing station… because they were sick with either chest pains or colds. But while they were walking down there, they were stepping over all the medicine from the land. They were walking over the medicine that they needed! …When we go to the doctor and the nurse, we give them our power to heal us when we should have the power within ourselves to heal us (Royal Commission on Aboriginal Peoples [RCAP], 1996).

Healing traditions are a vibrant and vital aspect of Aboriginal cultures. Oral histories told by Aboriginal Elders paint a picture of a past where an understanding of healing and herbalism was an integral part of Aboriginal community life (Remembering what we have forgotten, 1998). There are many accounts of Aboriginal people sharing medicines and allowing early Europeans to observe traditional doctoring (Waldrum, Herring & Young, 2007). However, with centuries of governmental attempts to suppress Aboriginal cultures, traditions and spirituality, traditional healing went underground. Furthermore, assimilation practices such as the residential schools system made it difficult to pass traditional knowledge on to subsequent generations and disruptions in the education of traditional practitioners occurred in many communities. As a result, the knowledge of traditional healing was eroded or became dormant in many communities. However, some traditions were kept alive by concealing them from the outside; at times, traditional healing practices actually evolved in response to the changing health needs of Aboriginal people. Today, traditional healing remains an important aspect of health care system (Maar, 2004). However, in order to protect traditional healing and spirituality from further erosion, traditional knowledge keepers often remain guarded about sharing traditional knowledge with western professionals.

Research on traditional healing

The body of literature on community-based or institutional-based practice of traditional medicine in North America today is in its infancy. Much of the research to date has focused on describing the traditional healing encounter, or how Aboriginal people navigate between traditional and western health systems. For example, research has documented utilization patterns of how Aboriginal people of various cultures use traditional and western medicine (Cook, 2005; Kim & Kwok, 1998; Buehler, 1992; Gurley, Novins, Jones, Beals, Shore, & Manson, 2001; Marbella, Harris, Diehr, Ignace, & Ignace, 1998; Novins, Beals, Moore, Spicer, Manson, & AL-SUPERPFP Team, 2004; Van Sickle, Morgan & Wright, 2003). Other researchers have focused on how traditional healers conduct their work (Schneider & DeHaven, 2003; Struthers, 2000, 2003), or described traditional practices or cures (Carroll, 2002; Cohen, 1998, 2003; Hopkins, Kwachka, Lardon, & Mohatt, 2007; Morse, Young & Swartz, 1991; Nauman, 2007). Researchers have also studied patient experiences (Struthers, Eschiti & Pitchell, 2004; Struthers & Eschiti, 2005), and examined the effectiveness of traditional medicine (Mehl-Madrona, 1999; Waldrum, 2000) and its role in culturally appropriate care (McCormick, 1995; Walters & Simoni, 2002).

Generally, the research shows that traditional medicine continues to be an important aspect of well-being for many Aboriginal people. However there is little information on if, or how traditional medicine can be integrated with western medicine in a clinical setting. A better understanding of this process is needed to advance collaborative practice. We need to learn more about how bridges are built between these two systems; how practitioners of these distinct healing traditions can collaborate while maintaining the integrity of each health system, and how integrated approaches impact on the health of Aboriginal people, families and communities from a broad and wholistic perspective.

However, there are significant obstacles to conducting this kind of research. Most significantly, traditional medicine addresses health from a wholistic perspective, including physical, mental, emotional, and spiritual aspects – realms that are clearly beyond western scientific paradigms and their applications. While mainstream theoretical frameworks for health are expanding and researchers and
policy makers are increasingly acknowledging the complex impacts of social and economic determinants on health,\(^1\) western-based knowledge frameworks are still generally inadequate to engage with and make sense of the wholistic aspects of traditional healing. In addition, western-trained researchers often have difficulties collaborating across different knowledge systems such as traditional Aboriginal healing.

**Policy perspectives on traditional healing in a clinical setting**

Policy makers have been increasingly supportive of traditional healing practices in primary care for several reasons. First, in the 1980’s it became increasingly clear to researchers and governments that the poor state of Aboriginal health could not be improved by increasing western health services alone (Young, 1984). Second, the World Health Organization began to advocate for traditional healers and their recognition by the primary care system world wide (World Health Organization, 2002a, b; World Health Organization Regional Office for Europe, 2006). In Canada, this has resulted in some, albeit tentative, policy support by the First Nations and Inuit Health Branch (FNIHB) of Health Canada to provide travel support for First Nations people seeking traditional healing services; however, no funds are provided for actual traditional healing services or associated costs such as ceremonial expenses, traditional medicines or honoraria for healers (First Nations and Inuit Health Branch [FNIHB], 2005).

The province of Ontario has made further policy improvements to promote traditional healing practices. Ontario’s Aboriginal Health Policy affirms that “Traditional approaches to wellness, including the use of traditional resources, traditional healers, medicine people, midwives and elders, are recognized, respected and protected from government regulation. They enhance and complement healing, as well as programs and services throughout the health system.” (Ontario Ministry of Health and Long-Term Care, 1994). Subsequent to the release of this policy, a strategy was created which funds various Aboriginal programs, including traditional healing services (Aboriginal Healing and Wellness Strategy, 2007). In addition, Ontario’s Regulated Health Professions Act has acknowledged and exempted Aboriginal healers from regulation by government bodies (Canadian Legal Information Institute, 1991).

This exemption signifies an affirmation that mainstream biomedical bodies must not impose regulation on traditional Aboriginal healing practices - rather it is up to Aboriginal people to decide how traditional medicine is practiced and regulated. While this provides some protection of Aboriginal autonomy over traditional healing practices, it does not exempt traditional practitioners from malpractice or criminal charges, which, although rare, have occurred (Waldram, Herring & Young, 2007). Since it is not in the interest of Aboriginal people to determine the future practice of traditional healing within the judicial system, the debate on whether or how traditional providers might be regulated continues, particularly when practicing in clinical primary care settings.

Oral traditions indicate that in the past, healers were nurtured by their community. Communities identified healers and informally monitored their work. Those who had the necessary skills were sought out by community members, and those who had questionable skills were avoided. Although this informal process may still be at work in some communities, many Aboriginal people and health professionals do not have the traditional knowledge necessary to distinguish a traditional healer from a charlatan (Remembering what we have forgotten, 1998; Waldram, Herring & Young, 2007).

Still, traditionalists are often quoted as opposing any form of regulation, based on very valid concerns over past colonial policies that suppressed Aboriginal cultures (Indian and Northern Affairs Canada, n.d.; Martin Hill, 2003). In response, the Royal Commission on Aboriginal Peoples (RCAP) report advocates for traditional practitioners to self-regulate similar to western health professionals (Indian and Northern Affairs Canada, n.d.), essentially replicating the peer review model of western medicine. However, this self-regulatory model would be at odds with the cultural norm firmly anchored in many Aboriginal healing traditions, that traditional healers are validated by the community and do not necessarily even self-identify as healers (Remember we have forgotten, 1998).

In 1998, Aboriginal health professionals and Elders on Manitoulin Island were tasked with resolving these complex issues when they decided to integrate western and traditional healing approaches at their regional health centre. Finding appropriate answers to questions related to policies and regulations would be critical for the successful integration in the clinical setting, where it is the health board’s and staff’s responsibility to protect clients, healers, helpers, and the organization from avoidable risks.

In this paper, we document the process of integrating traditional Anishinabe healing practices and mainstream clinical services in a health centre setting, based on 10 years of experience developing traditional healing services on Manitoulin Island, combined with qualitative research on the experiences of clients and providers. We describe factors that have supported the successful integration of traditional
Aboriginal and western health care approaches, as well as ongoing challenges.

**METHODOLOGY**

We conducted a case study focusing on the development of the traditional healing services at Noojomowin Teg Health Access Centre over a 10-year span from 1998 to 2008. To inform our research, we conducted an organizational document review, concentrating on program descriptions, policies and annual reports. We also conducted in-depth ethnographic interviews with 17 service providers and 23 clients at the Manaamodzarwin Noojomowin Teg Mental Health Services in 2007. During these interviews we posed open-ended questions to gather information on participants’ experience with the integration of traditional healing in the clinical setting. This part of the research was guided by the university-based researcher, Marion Maar, in collaboration with community representatives selected by local health boards. The community-based researcher, Marjory Shawande, has been the traditional healing services coordinator at the health centre since its inception and therefore did not conduct interviews in order to avoid unintentionally influencing the participants. She brought a historical and cultural perspective to this research as well as first hand knowledge of the extensive community consultations that guided the early development of traditional healing services at the health centre. The local Aboriginal health boards and the Manitoulin Anishinabek Research Review Committee reviewed and approved this research.

**RESULTS AND DISCUSSION**

Commitment to full self-determination and self-government requires the federal and provincial governments to allow for — indeed to encourage — institutional development in Aboriginal nations and communities that differs from mainstream practice. Thus, Aboriginal governments and health agencies must have the authority to decide what place traditional health and healing will have in their care services (Indian and Northern Affairs Canada, n.d.).

**Core elements of integration**

Oral traditions tell us that in the Manitoulin area, traditional healing practices were, in the past, monitored within the community, and healers were recognized and identified by their community. Building on this tradition, a community-driven approach was taken to develop guidelines for traditional healing practices in a clinical setting, which would be compatible with traditional teachings of the Anishinabe of the Manitoulin area. During the interviews many service providers emphasized that the development of these traditional healing guidelines was an essential element for the successful integration of traditional and western health services at this centre.

The guidelines were developed at the inception of the program, using Aboriginal research methods to consult with Elders, people with traditional knowledge and practitioners of traditional healing in the seven local First Nations to determine how traditional healing in a clinical setting should occur in the region. Similar to consultations on this issue held elsewhere, there was not always immediate consensus (Martin Hill, 2003). The process took several years to complete and was supported by a traditional advisory working group of Elders who provided ongoing guidance and direction on contentious issues.

While the consulted community members were decidedly against formal regulations for traditional healing practices in general, there was consensus that formal guidelines were required when practicing traditional healing in a health centre setting to protect clients from inappropriate practices and to safeguard healers, helpers and health organizations from legal risks such as malpractice law suits. Foremost, Elders stressed that the guidelines they developed are rooted in local culture, and are not intended to be imposed on other Aboriginal cultures nor on healers who practice in the community outside of the clinical setting. There was also consensus that as part of the erosion of traditional culture, many community members did not have the traditional knowledge to identify Aboriginal healers. Therefore, a screening process was developed and healers are screened by the traditional coordinator and a traditional advisory group before they begin their work at the centre.

Consensus emerged also on important Anishinabe concepts that were thought to be essential to preserve in the clinical setting. These were incorporated into the traditional healing protocols for the centre (Noojmowin Teg Health Centre, 2007). Anishinabe values are often anchored in words and expressions whose meaning may be lost in translation. For example, in clinical settings a person seeking health services is thought of as a client (a consumer) or a patient (a passive receiver). This is at odds with Anishinabe values of healing, where the person is thought of as an equal partner who is engaging in a healing relationship and is therefore referred to as a relative. To reinforce this
concept, the term “relative” is used to refer to people who receive traditional healing services at Nogimowin Teg. Other Anishinabe concepts were identified as vital during the consultations, and were also incorporated into the policies. They include the Anishinabe concepts of bgidniged, debweyendaa, and michidoumowin.

Bgidniged is the Anishinabe concept of a gift that should be given to a healer by the relative or their advocate. Clients are encouraged to take responsibility for their healing by providing a practical gift to the healer based on their means. The traditional coordinator also arranges for a monetary gift to the healer to cover travel and accommodation expenses. There is an important conceptual difference between payment and the gift or bgidniged. In the Anishinabe understanding, it is impossible to put a price on traditional healing services. The traditional healer is not paid on a fee for service arrangement, but rather provided with a bgidniged reflecting the number of days that they are working with clients at the health centre. The bgidniged from the health centre is in monetary form for practical reasons. While in the past Anishinabe healers may have been gifted with food, hide, horses, or other utilitarian implements to support themselves, today it is difficult to get by without the use of money (Remembering what we have forgotten, 1998). The relative however is encouraged to provide the healer with a practical gift.

Debweyendaa is the Anishinabe concept of the sacred trust between people and the Creator. It is invoked to convey the expectation of ethical conduct by the healer, creating an appropriate healing relationship with the relative and maintaining confidentiality of services.

Michidoumowin is the Anishinabe concept for the breach of debweyendaa, the sacred trust. It is seen as a grave transgression. Michidoumowin is used to convey violations of ethical conduct of traditional healers while providing traditional health services. At the health centre, such a breach would lead to termination of the services provided by the healer.

These important Anishinabe traditional concepts of the provision of a gift to a healer, the ethical integrity and sacred trust between healer and client, and a course of action in the event of a breaking of the sacred trust, are outlined in the traditional healing policies and have important implications for integrated practice. These Anishinabe concepts address issues that are also essential for the provision of western medical services, such as patient safety and confidentiality, and provider accountability for misconduct. Incorporating these concepts into the traditional policies has therefore also fulfilled the administrative need for risk management and provides the foundation for collaboration with clinical providers.

Health record keeping is a clinical practice that was also seen as important for the traditional services. Record keeping facilitates interdisciplinary practice and long-term follow up care for clients, as well as monitoring of herbal medicines and potential drug interactions. There was consensus that the traditional healers should not be charged with the task of recording in health records. The established protocol therefore includes the provision of an assistant for the healer to record relevant information, such as the traditional diagnosis and the prescribed treatment for the relative, a role filled by the traditional coordinator, a trained helper or another community health worker. This practice also ensures, for the protection of healers and relatives, that a third person is witnessing the visit. After the visit with the healer, the traditional coordinator is responsible to provide or arrange follow-up care to the client and the records are essential for this process. Providers, however, found that many relatives were guarded about their traditional health record, and often request that this information only be shared within a specific circle of care, such as the mental health team or the long-term care team. To respect confidentiality, traditional health records are kept physically separate, and information can only be accessed by those agreed upon by the client.

The role of teaching and education

A second focus of the groundwork was to build the readiness of community members and health professionals for traditional healing services through ongoing educational opportunities. Traditional teachings encourage life long learning. Communities, families and individuals vary in their comfort level and understanding of traditional healing. It is therefore also seen as important to offer a variety of ongoing learning opportunities, geared towards community members as well as Aboriginal and non-Aboriginal health care providers. One care provider stressed the importance of education for integrated care as follows: “Fortunately I was provided with a fair amount of training, and opportunities to go to gatherings and participate in ceremonies through the [traditional healing services] program... that was enormously helpful!” Continuing education opportunities are also essential for new staff members and contract providers. Learning opportunities at the centre have included Anishinabe life cycle teachings, language classes, story telling, workshops, and participating in Aboriginal ceremonies, dancing workshops and helping with traditional healing sessions.
The maturation of integrated services

I called them…regarding a medicine man for my child… Oh they came to our house actually, so it would be more comfortable for the children and it was really good. It’s been a while since we’ve seen the medicine man, and it was just great (relative at Mnaamodzwain Noojmowin Teg, 2007).

Today, a decade after traditional healing services were first offered at Noojmowin Teg Health Centre, the services have grown much beyond providing clients with access to healers. The demand for traditional healing services is continually increasing and outweighs the current level of services provided by healers. Therefore, follow up services are provided by the traditional coordinator and coordinated with other health care workers. This model of sharing the responsibility ensures that healers are not working in crisis mode in response to their clients’ needs. It requires an integrated interdisciplinary approach to care. The traditional coordinator is working particularly close with the long-term care and the mental health program staff, and several processes have been established to strengthen interdisciplinary integration. During interviews with the local mental health team, participants were overwhelmingly supportive of this approach and discussed many benefits.

Integration of traditional and mental health services

The interdisciplinary mental health team includes a case manager, a psychologist, a mental health nurse, two social workers, a program assistant, and the traditional coordinator. The mental health team members review new referrals at weekly intake meetings where clients are assigned to the most suitable provider, or to several providers. Services may include mental health counseling, chronic illness care, psychiatry services, and/or traditional healing services. Other needs such as long-term care or nursing requirements may also be identified, and clients are referred to other service providers in the organizations. During these meetings all team members are encouraged to exchange relevant information on treatment approaches, and provide interdisciplinary support. This team approach facilitates a high level of continuity of care for mental health clients, as well as a fast response to urgent cases. The weekly intake meeting process has further benefits. It creates an environment for new staff members to learn more about local Aboriginal communities, culture and the integration of traditional approaches. Other factors that support integrated practice were also identified, including the fact that all providers share a main office location and maintain an open door policy. Informal case consultation and case reviews of clients/relatives between members of this team also act as catalysts for integration. Within the individual First Nations clinics, similar capacity building for interdisciplinary care has taken place. At the community level, community workers such as mental health workers or community health representatives are mentored to assist the traditional healer and provide follow up services to the clients in their community. Interviews with providers showed that traditional healing approaches are accepted and respected within this team.

Impact on mental health services

It enhances the quality of care just because… I have more access to input from different professions, from different people who are from different backgrounds… A real richness of resources to choose from and to get information and support from. So, it can only help me, understand my clients better and broaden my own skills so that I’m able to meet their needs (Mental health service provider, Mnaamdozawin Noojmowin Teg, 2007).

The Noojmowin Teg approach to traditional healing services in a clinical setting has led to significant overall advancements in the integration of clinical and traditional approaches to mental health. During the interviews almost all clients expressed the belief that their workers are supportive of Aboriginal healing approaches, and that these services are accessible to clients. Service statistics show that community interest in traditional approaches to health is steadily increasing. This is an indication that more and more clients are comfortable accessing traditional services and sharing that information with clinical providers. Several clinical providers regularly inquire with each client about a referral to the traditional healing services. This development is particularly significant since a recent Canadian study showed that 92 per cent of Aboriginal people who use traditional medicine do not share this information with their primary care provider (Cook, 2005). In contrast, workers report that information about Aboriginal herbal medicines is openly shared in this service environment. For example an estimated 30 per cent to 40 per cent of those clients who receive care for geriatric or chronic mental health issues are also receiving traditional healing services.
Enhancing cultural safety

Providers explained to us that the education and interaction with traditional providers has deepened their understanding of their clients and ultimately enhanced a holistic approach and client care. One clinician explained the importance of learning about traditional culture for clinical practice as follows:

We understand something about the culture, appreciate it. You know, when clients talk about ceremonies, we have an idea what they’re talking about. When they talk about spirituality, when they talk about spirits, when they talk about dreams, when they talk about different concepts that are really important in their culture, we do understand what they’re communicating to us and what that experience might mean for them.

Care is thus becoming more culturally appropriate and clinicians are becoming aware of the danger of medicalizing Aboriginal spirituality.

Clients and providers agreed, however, that culturally competent care must go beyond offering and appreciating traditional healing services. In fact, some Aboriginal clients preferred clinical mental health services because traditional practices are not part of their way of life. Many clients told us that an important aspect of culturally competent services is that they can present themselves without fear of judgment and receive services that are right for them and their beliefs, religions and personal background. The notion that providers need to be “respectful of whatever the client is comfortable with” is in line with the concept of cultural safety developed by Māori researchers (Ramsden, 1990).

During the interviews, clients repeatedly expressed the belief that their workers facilitated cultural safety. Many saw this as a feature of the Mnaamodzawin Noojmwon Teg services, which was clearly different from mainstream approaches.

One client explained this in these words:

Living on the reserve is a different way of life…a different way of thinking. Maybe some needs are different. A lot of people I talked to in the past who were counselors that hadn’t worked for Mnaamodzawin or Noojmowin – they didn’t understand certain things that seem like it’s a part of your life when you’re on the rez. It’s a different way of thinking. A different way the whole community deals with things. These two counselors [at this centre] understand that; it’s not even an issue.

Ongoing Challenges for Integration

We really don’t have the opportunity to sit down and have long meetings with healers, to tell you the truth! (Mental health service provider, Mnaamdozawin Noojmowin Teg, 2007).

There are many accomplishments related to integration of clinical and traditional services. However, many challenges still remain. For example, the chronic underfunding of Aboriginal mental health services creates a service environment where client case reviews and interdisciplinary collaboration take a back seat compared to the high demand for direct client services. Staff members discussed that greater collaboration between all mental health team members and the traditional healer, as well as a psychiatrist, is desirable. However, this is not possible at this time because the need for direct services is very high and resources are limited. More time with healers is also required for direct services. Staff turn over is an ongoing challenge for integration because new clinical providers often face a considerable learning curve.

We also discovered that requests for referrals for traditional healing services are not necessarily forthcoming from clients once they receive clinical services. Our client interviews showed that although clients believe their workers to be culturally competent and supportive of traditional healing, some Aboriginal clients are not comfortable discussing traditional healing options with non-Aboriginal providers. For example, one client commented “I didn’t request any traditional approaches, I just went along with what the worker said.” Another participant questioned if the clinicians actually “believed fully” in traditional healing. This is evidence of the subtleties of the clinical encounter that can discourage Aboriginal clients from requesting traditional medicine even if the clinician is perceived as being open to traditional approaches. Another client explained his barriers even more bluntly, saying “I would be uncomfortable talking about Indian spiritual needs with my worker.”

Other clients mentioned that they did not ask their clinical provider about traditional approaches because they were unsure how this interdisciplinary approach would work. For example, one client stated, “What could you incorporate [in terms of Traditional Medicine]? Unless you want someone to smudge you or pray with you before you speak to your worker – I don’t need that to sit down and talk to somebody.” Clearly, based on their previous experience with the mainstream health care system, many Aboriginal people
expect a separation of traditional and clinical approaches to health. Clients we spoke to who reported accessing the traditional healing services were generally self-referred. Provider-initiated referrals do occur, however our interview results show that cultural and communication barriers still exist. Ongoing education and promotion regarding integrated care for clients and providers is therefore essential. In contrast, clients who were admitted through the traditional healing services were freely and frequently referred to the clinical mental health services.

CONCLUSION

People think [traditional and clinical healing perspectives] are so far apart but I never see it that way. I always think there are so many possible meeting points, when I listen to the healer speak it’s like: okay, I’m with you on this and this is… You know, to me, there is some sort of partner concept, [something] I can sort of see (Mental health service provider, Mnaamdozawin Noojmowin Teg, 2007).

While some challenges certainly remain, the Mnaamdozawin Noojmowin Teg mental health team has made significant progress over the past decade in the development of an interdisciplinary team approach that includes both clinical and traditional Aboriginal approaches, with a particular focus on client choice related to services.

The development of local guidelines, rooted in local culture, was an essential element for the successful integration of traditional and western services, because this protocol has alleviated uncertainties for clients and the interdisciplinary team of providers. Ongoing education for providers, as well as communities has resulted in improved understanding of traditional healing, Aboriginal and non-Aboriginal mental health team members alike expressed observing positive results in clients who accessed traditional healing. Many expressed a desire to increase the level of interdisciplinary collaboration, and believed this would be beneficial for their clients/relatives. Many also believed that increasing formal opportunities for collaboration would allow providers to further explore the congruence between the two healing approaches, and therefore improve treatment and healing approaches to the most prevalent mental health disorders.

Further research is necessary to help us better understand factors that facilitate the integration process. Research is also necessary to improve our understanding of the healing experience of Aboriginal individuals and their families who use this integrated approach to care. We are interested in how the traditional healing services have helped to support families from a wholistic perspective, such as decreasing violence in the home and encouraging healthy parenting, and how clinical services can best complement traditional approaches. At this point, there is just anecdotal evidence of this. However, research on outcomes of the integrated services should not attempt to force traditional healing practices into clinical mental health evaluation models, because clinically established outcome measures or efficacy research are likely inappropriate. The interdisciplinary approach can only be researched using a collaborative and empowering approach that employs a merging of traditional and clinical health indicators, and a focus on wholistic impacts on community, health, families, and individuals.

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REFERENCES


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END NOTES


3. Information on this ethics committee is available at http://www.noojmowin-teg.ca/default5.aspx?l=,1,613
Aboriginal Midwifery: A Model for Change

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ABSTRACT
This paper will discuss indigenous knowledge and epistemologies of health and well-being as essential practices to improving the health status of Aboriginal communities. These methods will be illustrated through the practice of Aboriginal midwifery and birthing practices currently being revitalized in Aboriginal communities. Indigenous knowledge of health, well-being, medicine, and healing practices have historically sustained the health and well-being of Aboriginal communities for centuries pre-contact. However, these traditional epistemologies of health and healing have been eroded through centuries of colonial oppression and the imposition of western scientific methodologies and legislation. Through decades of acculturation, much of the traditional knowledge of health, medicine and healing has been lost. However, a recent resurgence of traditional Aboriginal midwifery has occurred in an effort to retain, revive and restore the indigenous knowledge of Aboriginal communities. The revival of traditional Aboriginal midwifery has resulted in the development of Aboriginal birthing centres that blend traditional knowledge, medicine and healing practices with contemporary medical services, to provide culturally significant maternal care services for Aboriginal women and families. Currently, there are Aboriginal birthing centres and services in, Nunavut, Quebec and Ontario. The high quality of community-based maternal care, access to culturally significant health services - utilizing traditional medicine and employing traditionally trained Aboriginal midwives has shown improved outcomes, impacting community healing, cultural revival, and community capacity building. The traditional methodologies employed by Aboriginal birthing centres will be detailed to exemplify the significance of indigenous knowledge and epistemologies of health in providing improved health care services to Aboriginal communities.

KEYWORDS
Indigenous knowledge, healing, Aboriginal philosophies of health, traditional Aboriginal midwifery

INTRODUCTION
Indigenous people in Canada experience some of the worst social, economic and environmental circumstances in the Nation (Canadian Population Health Initiative, 2004). For example, rates of diabetes are three times higher in First Nations and Inuit populations, and rates of cardiovascular disease, hypertension, obesity, and arthritis/rheumatism are all higher than Canadian rates (First Nations and Inuit Regional Health Survey, 1999; Kinnon, 2002). Sexually transmitted infections, particularly HIV/AIDS, is a growing concern with Aboriginal people representing 15 per cent of new cases of HIV/AIDS (Health Canada, 2000a). Also of concern is the maternal and child health of Aboriginal populations. It is reported that Aboriginal women experience perinatal and still birth rates that are twice the national average and 2.5 times greater in Inuit communities (Royal Commission on...
Aboriginal Peoples [RCAP], 1996). The First Nations and Inuit Regional Health Survey has found that Aboriginal infant mortality rates are roughly 3.5 times the national rates (Assembly of First Nations, 1999), and levels of Fetal Alcohol Syndrome and Fetal Alcohol Effects are considered to be “alarmingly high” in many First Nations communities (National Aboriginal Health Organization, [NAHO], 2004, p.12). Further disturbing is the suicide rate among First Nations and Inuit youth and young adults. Health Canada reports that suicide and self-injury are the leading cause of death among First Nations youth, accounting for 38 per cent of all causes of death among Aboriginal people (Health Canada, 2003). As a result of these grave health circumstances, First Nations women and men’s life expectancy is decreased by five and seven years less than the general Canadian population respectively (MacIntosh, 2005). While among the Inuit, life expectancy is 14 years less for women and six years less for men (MacIntosh, 2005).

On almost all measures of health and social well-being, the statistics are startling. Indigenous Peoples across the country fare much worse than our non-Indigenous counterparts (Durie, 2004). This state of health has been described by many as simply unacceptable and is considered by many as a “national disgrace” (Romanow, 2002; Native Women’s Association of Canada, 2007, p.3).

Recent census data from Statistics Canada (2008), reports that in 2006, Aboriginal populations surpassed the 1 million mark with a national population of 1,172,179. As a result, Aboriginal people account for 3.8 per cent of the Canadian population and have a growth rate of 45 per cent compared with only 8 per cent of the non-Aboriginal population (Canadian Population Health Initiative, 2004; Statistics Canada, 2008). With half of the Aboriginal population under the age of 24 (Statistics Canada, 2008) the young and growing population of Aboriginal Canadians, combined with the illustrated health disparities, creates an urgent need to address Aboriginal health care concerns.

A recent attempt to address the serious health concerns of Aboriginal populations has called for the integration and utilization of Traditional Indigenous Knowledge. Health Canada, public health officials and many Aboriginal organizations have begun to acknowledge the pivotal role that culture loss has played in shaping the health conditions of Aboriginal Peoples and have recognized the possible benefits of indigenous knowledge, language and spirituality in health services for Aboriginal people (Health Canada, 2003; Van Wagner, 2007; Kinnon, 2002). It has also been recognized that the current bio-medical model, upon which the Canadian health care system is based, is ineffective for servicing the unique health care needs of Aboriginal people (NAHO, 2008; RCAP, 1996). An approach which attempts to address indigenous knowledge and philosophies of health can be exemplified in the practice of traditional Aboriginal midwifery (Ross Leitenberger, 1998). The contemporary practice of Traditional Aboriginal midwifery is based in traditional knowledge, medicine and practices of maternal and child health and complements this practice with modern medicine.

This paper will discuss indigenous knowledge and philosophies of health and well-being as essential foundations for restructuring health care service models in First Nations communities to address the health concerns of Canada’s Aboriginal population. The history, significance, and legitimacy of indigenous knowledge and practices will be established followed by a description of current traditional Aboriginal midwifery services in Canada that exemplify models of health care service rooted in indigenous pedagogy. The complications and politics of utilizing indigenous knowledge and philosophies of health will be discussed.

Indigenous Philosophies of Health
Indigenous knowledge systems have historically operated to sustain the health and well-being of Indigenous Peoples worldwide for centuries pre-dating modern medical care (Waldrum, Herring & Young, 2000). However, indigenous knowledge systems have been shattered to various degrees through centuries of colonial domination. Speck (1987) argues that through colonial oppression, Aboriginal knowledge of social, physical, spiritual and mental health were deemed inferior and subordinate to western knowledge systems (NAHO, 2008). It has been further argued that the cultural destruction and loss of indigenous knowledge systems experienced by Indigenous populations has produced severe consequences, creating the destitute social, environmental, and health conditions facing Aboriginal Peoples (RCAP, 1996; Durie, 2004). The National Aboriginal Health Organization reports that in a 2002 opinion poll, 57 per cent of Métis and 63 per cent of First Nations respondents identified loss of culture and land as significant factors contributing to poor health (NAHO, 2008). Accordingly, culture and ethnicity have more recently begun to be considered as key determinants of health as recognized by Health Canada, Aboriginal advocates and Aboriginal organizations such as the National Aboriginal Health Organization (NAHO, 2008).

An Aboriginal model of health has been generalized for the purposes of this paper; however, it is acknowledged...
that much diversity about conceptions of health and well-being exists among Aboriginal populations (Kinnon, 2002). Still it is known that many Aboriginal people share similar core values, beliefs, practices, attitudes, behaviours, and worldviews (Aboriginal Health, 1992; Royal Commission on Aboriginal Peoples, 1996; Letendre, 2002). A traditional Aboriginal model of health is thought to be inherently based in the concepts of balance and holism (Eschiti, 2004; RCAP, 1996). Through a traditional Aboriginal way of life, medicine and spirituality are consistently interwoven and everything is seen as interdependent: mind, body, spirit, and emotions; all of which are viewed as essential to achieve optimal health (RCAP, 1996; Cook, 2007). Eschiti (2004) describes a holistic model as a way of viewing everything as working together to form a whole, instead of considering things as fragments or parts and suggests holism is believed to have significant implications for ideas about wellness, illness and disease. Classic concepts in Aboriginal models of health and healing propose that elements of life are interdependent and by extension well-being flows from balance and accord among the elements of personal and collective life giving equal significance to the mental, physical, spiritual, and emotional aspects of the individual (RCAP, 1996; Battiste & Henderson, 2000). It is believed that if a person is to be healthy they must be in balance not only within themselves, but within their social environment as well.

The described Aboriginal approach to health and well-being is similar to health promotion and population health approaches that have been advocated both nationally and internationally in public health (NAHO, 2008; McIntosh, 2005; RCAP, 1996). When the Royal Commission on Aboriginal Peoples (RCAP, 1996) explored Aboriginal philosophies of health, researchers were amazed by the parallels of traditional Aboriginal models of health to the leading edge work on the social determinants of health and well-being. Through these insights researchers began to believe that there is a promising meeting point of these two systems that poses potential for improving the health and well-being of Aboriginal people and non-Aboriginals (RCAP, 1996; Durie, 2004).

Indigenous Knowledge and Science

Modern science presents itself as a superior knowledge system, and throughout history has positioned other systems as irrational, superstitions, and more recently has labelled Indigenous knowledge and medicine as “alternative.” Indigenous knowledge is often discredited on the premise of scientific evaluation methodology, which discredits anything that cannot be supported by empirical evidence (Durie, 2004). However, Battiste and Henderson (2000) describe indigenous ecological knowledge as a valid science in and of itself:

The traditional ecological knowledge of Indigenous people is scientific, in the sense that it is empirical, experimental, and systematic. It differs in two important respects from western science, however; traditional ecological knowledge is highly localized and it is social. Its focus is on the web of relationships between humans, animals, plants, natural forces, spirits, and land forms in particular locality as opposed to the discovery of universal laws (p. 44).

Indigenous Peoples have begun to contest the superior position of science and begun to promote the benefits of indigenous knowledge (Durie, 2004; NAHO, 2008). Similarly, governmental and indigenous organizations across the country are increasingly recognizing the potential benefits to applying indigenous knowledge to public health and health programming in Aboriginal communities (NAHO, 2008). How to best utilize Indigenous knowledge in contemporary practice is however, a contentious debate. Martin-Hill (2003) discusses the contemporary use of traditional Aboriginal medicine in her research with Elders/healers, and points out that the most consistent request by Elders/healers was for those in policy or academia to restore the “respect and honour of Indigenous knowledge and medicines” (p. 25). The Elders/healers further warn that a healthy respect for indigenous knowledge and traditional medicine by leaders, health care providers and decision makers is essential (Martin-Hill, 2003). The Elders/healers proclaim that it is not enough for traditional medicine and knowledge to simply be tolerated and humoured but that it needs to be acknowledged and accepted for its historical as well as contemporary legitimacy (Martin-Hill, 2003).

What this article advocates is not a fusion of modern science and indigenous knowledge but systems that acknowledge both knowledge systems for their strengths, and utilize those qualities to best meet the holistic health care needs of Aboriginal Peoples. It is proposed that
constructions of health care for Aboriginal Peoples should be based on indigenous knowledge systems of those being served. Aboriginal communities each have unique needs and those needs need to be addressed in the fundamental structure of health care service models.

Traditional Aboriginal Midwifery
A successful approach which encompasses modern medicine into a culturally-based indigenous knowledge framework of health care service for Aboriginal Peoples can be illustrated in the modern practice of traditional Aboriginal midwifery. Traditional Aboriginal midwifery is based in traditional knowledge, medicine and practices of maternal and child health, and complements this practice with modern medicine to deliver culturally significant health care services for Aboriginal families. Aboriginal midwifery incorporates all elements of the mother and child; spiritual, mental, physical, and emotional health through ceremony, use of traditional herbal medicine and counselling to address the totality of needs of mother and child (Ross Leitenberger, 1998). Traditional midwife Katsi Cook (2007) comments that in learning Aboriginal midwifery, her focus was on “integrating indigenous knowledge with the biomedical skills necessary to be a safe practitioner” (p.12).

Historically in Aboriginal cultures, pregnancy and childbirth were regarded as sacred events that were part of the natural life cycle governed by the Creator (Carroll & Benoit, 2004; Ross Leitenberger, 1998). The birth of a child signified new life and the powerful balance between the spiritual and physical worlds (Carroll & Benoit, 2004). A woman’s ability to give life and raise children, therefore, placed her in a highly esteemed, sacred, authoritative and respected role within Aboriginal cultures (NAHO, 2004; Carroll & Benoit, 2004). Fiske (1992) reports that, “reproductive roles were central to women’s claims to social prominence” (p. 201), and the women who were successful in raising children and providing care became influential as family spokespersons. Likewise, the profession of a traditional midwife was a respected role within Aboriginal communities and was considered an art that was passed down through familial generations of women (NAHO, 2004; Carroll & Benoit, 2004). Fiske (1992) reports that, “reproductive roles were central to women’s claims to social prominence” (p. 201), and the women who were successful in raising children and providing care became influential as family spokespersons. Likewise, the profession of a traditional midwife was a respected role within Aboriginal communities and was considered an art that was passed down through familial generations of women (NAHO, 2004; Carroll & Benoit, 2004). Traditional Aboriginal midwifery was considered a calling and thought to be the Creators work (Carroll & Benoit, 2001). Traditionally, midwives played essential roles, facilitating the childbirth process and were highly involved in the knowledge transmission of traditional value systems from one generation to the next (Carroll & Benoit, 2004; NWAC, 2007). However, the respected traditional roles of women and Aboriginal midwives have been diminished through centuries of colonial influence and assimilation policies.

The traditional Aboriginal model of maternal health care was weakened during much of the twentieth century by laws that made midwifery illegal and punishable by law (NWAC, 2007; NAHO, 2008). Carroll & Benoit (2001) explain that as a result of these colonial practices, many traditional Aboriginal customs have been lost and midwives today struggle to pass on surviving indigenous knowledge to their people. Oakley and Houd (1990) describe the exclusion of women from the birthing profession as a “colonization” of midwifery that was once women-centred and controlled, stating: “female midwives were part of a female controlled reproductive case system...and it was precisely this that posed so much of a threat to the church, the state and the emerging medical profession” (p.26).

Oakley and Houd (1990) also describe the medicalization of childbirth as a process that systematically excluded issues of race, gender, class, and culture. Oakley and Houd (1990) conclude that the medicalization of the birthing process served to redefine pregnancy as an illness and the practice of midwifery as incompetent. The medicalization of birthing institutionalized the birthing process and removed birth from Aboriginal communities and placed it in often distant hospitals. As a result many Aboriginal women are still evacuated from their communities to give birth in hospitals (NAHO, 2004). The removal of birthing from Aboriginal communities is reported to have “had profound spiritual and cultural consequences, which are difficult to quantify” and that have affected entire Aboriginal communities in measures of health and well-being (NAHO, 2004).

Recently, traditional Aboriginal midwifery is increasingly becoming popularized and revived through the political lobbying of Aboriginal women and organizations, as well as by the move toward community controlled and community based health care models (Van Wagner, 2004; Carroll & Benoit, 2004). Aboriginal women have initiated the restoration of more traditional models of health and ways of life, and many Aboriginal women in communities across Canada have attempted to reclaim their position within their communities as “givers of life” through the practice of Aboriginal midwifery (Carroll & Benoit, 2001, p.1). The traditional cultural, spiritual, physical, and emotional significance of birthing practices necessitate the revitalization of traditional Aboriginal midwifery and birthing practices as essential methods to improving the health and well-being of Aboriginal women, children and communities (Ross Leitenberger, 1998).
Traditional forms of midwifery included pre-natal, ante-natal and post-natal care which included frequent monitoring and counselling by an Elder or traditional midwife, an appropriate diet, traditional medicines and physical fitness regimens (Jasen, 1997). It is suggested that Aboriginal midwives were herbalists, gynaecologists, obstetricians, and nutritionists all rolled into one (Ross Leitenberger, 1998). Midwives were reported to be able to reduce the intensity and pain of labour, and save the lives of women and infants (Native Women’s Association of Canada, 2007). In traditional Aboriginal cultures, pregnancy and childbirth is regarded as a sacred period in a woman’s life, with several customs and practices to be adhered to throughout. There are many instructions on what foods to eat and how to conduct oneself during this sacred time (Ross Leitenberger, 1998). For example, women of the Carrier Nation of British Columbia reported that foods such as raspberries are restricted as they are thought to cause “raspberry birthmarks,” red blotches on the skin of babies (Ross Leitenberger, 1998, p. 79). Similarly, customs such as avoiding negative actions, sights and sounds as they can pass through the pregnant women to the unborn child are recommended (Ross Leitenberger, 1998). Further, traditional practices were also used to prevent complications such as breech births, and to alleviate labour pains and prevent haemorrhaging (Ross Leitenberger, 1998). It is important to note that although these cultural customs differ from one Aboriginal community to another, there are many similarities between Nations (Ross Leitenberger, 1998). In examination of historical literature, evidence suggests that although Aboriginal midwives were thought to be limited in capacity for solving obstetrical emergencies, mortality and morbidity for mother and baby were in all probability lower in the pre-colonial era (Doblyn, 1983).

Cook (2007) comments that the knowledge and use of these traditional medicines is categorized as “Complementary and Alternative Medicine, but is simply, but no less significantly, the cultural knowledge we have had to depend on to maintain our health and well-being” as Indigenous Mohawk people. Cook (2007) further explains that the resilience and survival of Aboriginal people is based in our traditional medicines and practices. Katsi Cook, a traditionally and medically trained midwife and activist suggests that the traditional knowledge of sacred medicines has become removed from Aboriginal societies to the extent that people are unfamiliar with the medicines and are unaware how to use them (Cook, 2007). Cook describes how mothers no longer know the difference between a sick baby and a baby that can be cared for at home, by which there are several medicines that can cure a number of minor baby conditions (Cook, 2007).

The loss of indigenous knowledge and medicine in Aboriginal cultures has been described by many leaders and Elders as the root of many contemporary health and well-being issues, faced by Aboriginal Peoples. For example, Elders describe that we did not experience health issues such as post-partum depression, indicating that there were medicines to help renew and heal a woman after giving birth, and to bring her “spirits back up” (Interview, June, 2008). However, it is believed that because we may have lost this knowledge of medicine and do not use traditional birthing medicines, many of our women experience post-partum depression, mental health concerns, and subsequent alcohol and drug abuse. It is expressed that our knowledge of ceremony and medicine can have great benefits to improving health and well-being among Aboriginal populations.

Modern Practice of Aboriginal Midwifery

Although the knowledge and practice of traditional Aboriginal midwifery survives throughout various remote and urban locations in Canada, there are currently only three established Aboriginal birthing centers in Canada. The Inuulitisivik Health Center in Puirirmituq, Quebec was the first centre to open in 1986, followed by the Rankin Inlet Center in Nunavut in 1995, and the Tsi Non:we Innakeratsha Ona:grahsta: Six Nations Maternal and Child Centre in Ohsweken, Ontario in 1996 (Carroll & Benoit, 2004). Each centre provides maternal care services based in traditional Aboriginal health and birthing practices complimented by modern forms of medical care in unique manners specific to their respective community (Carroll & Benoit, 2004). Through these centres, Aboriginal women
are able to plan their birth, choosing to deliver in the centre or at home, as well as have access to traditional Aboriginal herbal medicines for pregnancy, and are able to incorporate traditional ceremonies and rituals into their service.

The Inuulitsivik birthing centre in northern Quebec is an Inuit midwifery project that trains Inuit midwives and provides maternal care and delivery services to surrounding communities (Carroll & Benoit, 2004; NAHO, 2004). The women at the Inuulitsivik Centre are able to communicate with the staff in Inuktitut and birth as they choose incorporating cultural practices (Carroll & Benoit, 2004). The Inuulitsivik Centre is one of the most renowned Aboriginal birthing centres in Canada and is also one of the oldest (Carroll & Benoit, 2004). However, since 1990, the centre has been considered a pilot project to determine the feasibility of traditional Inuit midwives as legitimate professionals (Carroll & Benoit, 2004). In 1999, the Quebec government legitimized midwifery as a profession, however this victory has not influenced Aboriginal midwives, since there are clauses in the act that pertain to Aboriginal “traditional” midwives, stating that the midwives from Inuulitsivik are prohibited from practicing outside the Nunavik territories, and the communities are required to consult with the Ministry of Health for arrangements of the practice of “traditional” midwives (Carroll & Benoit, 2004).

The Rankin Inlet Birth Centre, in Nunavut provides birthing and midwifery services to women residing in the central Arctic region (Carroll & Benoit, 2004). The centre began as a Keewatin Regional Health pilot project for low risk pregnancies in 1993, staffed by certified nurse-midwives, prior to which, women had to be evacuated from the community to give birth in southern hospitals (Carroll & Benoit, 2004). In 1995, the centre became an established program staffs three midwives, two Inuit maternity workers and a clerk-interpreter (NAHO, 2004). Unique to this program is a multidisciplinary committee that determines whether a client can deliver within the centre or must fly south to deliver at a hospital (NAHO, 2004). Although the program provides culturally appropriate services to the Inuit communities that have in the past had to receive maternity care in a language and community foreign to them, it is operating without a legislative framework on midwifery as there is currently no legislation in Nunavut (NAHO, 2004; Carroll & Benoit, 2004). Furthermore, because there are no Aboriginal midwifery training programs, the availability of midwives in the north is limited and staff shortages are a recurring issue (NAHO, 2004).

The Tsi Nون:we Іonnakeratsha (which means, “the place they will be born” in Mohawk) Ona:grahsta: (which means, “a birthing place” in Cayuga) Six Nations Maternal and Child Centre is located on the Six Nations of the Grand River Reserve in southern Ontario, and opened in 1996 through funding from the Aboriginal Healing and Wellness Strategy (NAHO, 2004; Carroll & Benoit, 2004). The Six Nations Maternal and Child Centre offers a range of maternal care services to complement their personal beliefs and customs through a balance of traditional and contemporary services; for example, women are given the choice to give birth in their home or in the centre (NAHO, 2004). The centre has also developed an Aboriginal midwifery training program to train midwives in traditional Aboriginal midwifery (NAHO, 2004; Carroll & Benoit, 2004). The centre has done an excellent job in educating the community and providing traditional services through the use of traditional medicines and Elders participating in workshops and community ceremonies (Carroll & Benoit, 2004).

The described Aboriginal birthing centres are examples of great achievements in the area of traditional Aboriginal health and healing services for Aboriginal populations. The described Aboriginal birthing centres have been able to bring maternal health care to their communities, and bring the birthing process back to women and to the community. Aboriginal birthing services exemplify how traditional Aboriginal knowledge and medicine can be bridged with contemporary practices to better meet the medical, cultural and spiritual needs of Aboriginal women.

Further, limited research evaluating traditional Aboriginal midwifery practices has been positive. Through community interviews and a literature review of Aboriginal birthing services, specifically in Inuit communities, Couchie and Sanderson (2007) report that Aboriginal maternity centres can safely manage low-risk births. The researchers further conclude that training Aboriginal midwives to work in the community was shown to improve the prenatal care and birth experiences of Aboriginal women as well as improves overall community health and healing (Couchie & Sanderson, 2007; Archibald & Grey, 2000).

Nevertheless, there is much more to be done. There are only three Aboriginal birthing centres in Canada which means thousands of Aboriginal communities in Canada are without access to culturally significant, Aboriginal midwifery and birthing services. Furthermore, Ontario is the only province to provide legal exemption to Aboriginal midwives and only a few provinces, such as Quebec and Nunavut, publicly fund midwifery care (Carroll & Benoit, 2004).
The Politics

Inherently problematic in the provision of health care services to First Nations and Inuit communities are historical and legal issues of jurisdiction. MacIntosh (2005) concluded that in regards to Aboriginal health, the Canadian health care system is fundamentally inadequate as it reflects historical and legal divisions of power and responsibility. The provision of health care for Aboriginal Peoples is described as a “complex myriad of mechanisms and jurisdictionally separated agencies, provincial departments and federal ministries” with little coordination (MacIntosh, 2005). The complexity is further complicated by issues of status, eligibility, place of residence (on-reserve and off-reserve), and provincial residence which consequently produces gaps in service (MacIntosh, 2005).

It is noted that in recent years, Aboriginal populations have been given greater responsibility for their health care but still do not have the power to make fundamental changes with the provision of health care services. Speck (1987) exemplifies the predominant governmental ideology on the provision of health care for Aboriginal populations with a quote from Robert H. McClelland, Minister of Health for British Columbia, 1979, which states:

There is no question native Indians should have the right to determine their health care needs and how they can be met most appropriately. But….native peoples should make these decisions within the established democratic process of this country and within the context of one comprehensive health care system (as cited in Speck, 1987, p. 147).

This quote illustrates the problematic paradigm of which the current Canadian health care system operates for Aboriginal populations. In this system, community controlled health care is an illusion. Although the Canadian government has given most Aboriginal communities responsibility for a great deal of the delivery of their health care, the delivery must be within the context of western constructs of the medical system, which poses immense limitations for providing culturally significant services based on traditional Aboriginal philosophies of health. What is needed is the power to develop health care service models that are based on the unique community needs and based in Aboriginal conceptions of health and healing. It is not sufficient to simply be “culturally appropriate,” these efforts merely represent window dressing for western ideologies and constructions of health to be represented as Aboriginal specific through hiring Aboriginal secretaries or using Aboriginal art in clinics. These efforts do not address the fundamental structural problems inherent within the health care system for addressing the distinctive needs of Aboriginal populations. The National Aboriginal Health Organization states:

The respect for, and use of, indigenous knowledge and practices in the development and implementation of public health programs can only hope to succeed if the holders of that knowledge are allowed to define the how, when, where, who, what and why of its utilization in the best service of Aboriginal Peoples (NAHO, 2008, p.17).

However, the current situation of health care for Aboriginal populations has been described as the optimal phase to facilitate change in the structure and delivery of health care services for Aboriginal Peoples (NAHO, 2008).

CONCLUSION

Evidenced by the described social, environmental and health circumstances of Indigenous Peoples, it is extremely clear that the current health care system is ineffective for serving Canada's Indigenous Peoples (RCAP, 1996; NAHO, 2004). Yet at present, little has been done to modify the current health care services for Aboriginal peoples and what has been accomplished is fragmented and done on an “ad hoc basis” (NAHO, 2008, p.8). For example, despite the support and success of modern practices of traditional Aboriginal midwifery, there are only three base centres in Canada which leaves thousands of reserves without community based, traditional Aboriginal maternal and birthing services. Attention, resources, the acknowledgement of indigenous knowledge and medicine are required to facilitate the development of culturally significant health care services for Aboriginal Peoples. Contemporary Aboriginal midwifery provides a framework for the development of culturally significant health care services as Aboriginal midwifery illustrates a health care model based within indigenous knowledge, philosophy and medicine, complemented with modern medicine that has proved successful in addressing health care needs and gaps within Aboriginal communities. The Aboriginal midwifery model demonstrates the integrity and contemporary utility of indigenous knowledge and philosophies of health. Further, Aboriginal midwifery illustrates a promising model for the application of indigenous knowledge to other sectors of the health care system servicing Aboriginal Peoples. Durie (2004) points out that although we tend to appreciate indigenous knowledge for its historical significance and “traditional
qualities,” by doing so we tend to overlook the present value of such philosophies which have potential to be applied in Canadian health services, in parallel with other knowledge systems (p. 1139).

However, fundamental to the successful utilization of indigenous knowledge and medicine in the broader context of Canada’s health care system is the acknowledgement and respect of indigenous knowledge and medicine as an equally valuable health care service for Aboriginal Peoples.

Mohawk scholar Marlene Brant Castellano (1982) states:

Substantive Indian participation in all phases will require a radical revision of the structural relationships, which have prevailed in a colonial environment. Both Indians and government personnel will need to engage in a re-education process to facilitate. The absorption of new knowledge about other’s ways, attitudinal change and the development of organizational structures to translate the promise of consultation into the reality of social change (p.127).

If the health policy in Canada is going to address the Aboriginal health crisis, that attempt requires a fundamental restructuring of the health system to encompass the appropriate respect and dignity of indigenous knowledge and medicine. In doing so, Aboriginal communities would be better able to develop, implement and define how best that knowledge is implemented (NAHO, 2008).

REFERENCES


Aboriginal Midwifery: A Model for Change

Health Canada. (2000a) HIV and AIDS Among Aboriginal people in Canada. 10/10/01.


Native Women’s Association of Canada. (2007). Aboriginal women and reproductive health, midwifery, and birthing centres: An issue paper. National Aboriginal Women’s Summit, Corner Brook, NL.


